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EDUCATION AND CONSULTATION

Two of the principal components of any disaster project are education and consultation. Once the project has been planned, administrators and practitioners must turn their attention to problem solving when the community, the care-giving agencies, and their own staff present a lack of knowledge, skill and confidence. Through educational and consultation activities, mental health professionals not only disseminate information and problem-solving skills, but also create a positive environment of support for the disaster program.

Educational activities generally include two elements, education of the public and training and orientation of disaster workers. The targets of these educational activities are the community at large; civic, social, or political groups in the area· human service and disaster relief agencies; and the staff of the mental health program This presentation assumes that a disaster has occurred, but it is also important to keep in mind the usefulness of these educational elements as a means to orient the general public and mental health professionals in communities that are disaster prone Predisaster education in the area of mental health is an important aspect of the total preparedness of a community

Consultation, a key activity of community psychiatry, is also a cornerstone of any postdisaster mental health project. Consultation is the professional activity of a disaster program that is designed to promote the incorporation of mental health procedures into disaster assistance approaches. Specifically its purpose is the early identification and use of human resources to alleviate the disastrous effects of traumatic experiences among disaster victims As a method of problem solving consultation generally addresses the issues at the case and program levels in order to achieve these purposes.

To implement educational and consultative activities, mental health workers must be sensitive to a number of issues. These include sanction, relationship, definition and boundaries of the problem, and professional trust. As professionals these workers must have an intimate knowledge

of the community and must also have established contacts that allow them a point of entry. With the proper identification of key decision makers, sanction is readily gotten and maintained. Without this sanction, the chances of success are limited. Both education and consultation depend upon the development of relationships that define the mature boundaries of the problem and the role of the mental health professional in disaster assistance programs. Trust is gained by listening to others as they define their problems, creating an atmosphere of working collaboratively, demonstrating competence, and always maintaining confidentiality.

This chapter presents some of the dimensions of educational and consultation activities for a mental health program for disaster victims. The main purpose of these activities is to provide knowledge, sharpen skills, instill confidence, foster collaboration, and create support for a mental health effort following a natural catastrophe.

EDUCATION

In the implementation of educational activities, mental health specialists must have skill in community organization, communications (both verbal and written), treatment interventions, and supervision. Perhaps, the most needed skill is that of teacher—the ability to impart to others the knowledge, methods or confidence for understanding disaster behavior and for the psychological assistance of calamity victims. This section discusses the requirements for public relations and for the orientation and training of disaster workers.

Public Education

The purposes of a public education campaign associated with the project are threefold:

- To gain widespread support for the program;
- To publicize services; and
- To report to the community on the program's activities and progress.

Community sanction and support are necessary for the effective planning and implementation of a mental health project for disaster victims, and without these the program may experience difficulties associated with lack of support or low visibility. When a program begins, public information about the project's activities and location is essential. This type of publicity may take several forms:

- It may educate the public to the fact that certain physical and emotional discomfort following a calamity are normal reactions to stress;
- If there is a need for help, victims may seek assistance from the project by calling or visiting its office; and

- The general public has a right to know about the activities and progress of the mental health project.

For example:

> The Managuan mental health project was on the verge of collapse due to the publication of a team member's criticism of the government when the second U S team arrived in May 1973 One of the new arrivals, a psychologist who was also an expert in media communications, decided to develop a campaign to save the project. Through an appearance on a popular TV program and subsequent articles in the local newspapers, this person conveyed the message that it is normal to feel anxious and sad when one has experienced great loss from an earthquake. The psychologist's theme was that Managuans were, in effect, heroes, a theme that was repeated for some time by the media.
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> The result of this media message was (1) to publicize the availability of service to those who felt they needed to talk with someone, (2) to convey the message that is was acceptable to feel strong emotions of loss; and (3) to re-establish support for the project For the team members, this was a turning point

Public education must begin immediately after the disaster strikes and should continue until the project terminates. The emphasis of the effort varies over time. Getting support is usually the first priority, followed by public education and then reporting to the community.

All types of media can be employed during the public relations campaign. Local newspapers usually publish information on community services. This may be encouraged by writing press releases and inviting reporters to project meetings or activities. Local radio and television stations also have time available for community programming. These programs may include talk shows, reports, or specialized formats, such as health information or community concerns. Arrangements to use the media require some knowledge of reporting requirements and providing information to the appropriate reporter, program director, or responsible person.

Project personnel may also develop a speaker's bureau to educate certain groups in the community, such as politicians; teachers; religious, civic, or social leaders, or directors of human service organizations. A developed presentation, including video materials, slides, or graphics, will aid education objectives and will, in some instances, encourage collaboration among services. For example

> The Massachusetts mental health program, Project Concern, received many requests from the public media and other disaster agencies for information about the psychological consequences of the blizzard and flood Although staff appeared on television and radio talk programs, it was impossible to meet the many requests of civic and social groups for information At that point, a video tape on human behavior in the wake of disaster and on the crisis intervention techniques was suggested With the participation of mental

health workers, Red Cross volunteers, and a graduate school of nursing, Project Concern and three disaster experts prepared a one-hour video tape. The local branch of the University of Massachusetts donated video facilities and specialists to make the film.

Copies of the tape were widely distributed to local mental health clinics, the Red Cross, the federal disaster agency, and universities. The actual collaboration of various groups in making the film, as well as the hundreds who relived it, contributed to a greater understanding of disaster reaction, awareness of the mental health project, and the support rendered the program.

Orientation and Training of Project Staff

A number of objectives have been formulated to meet the needs of project personnel and volunteers for knowledge, skill, and orientation. Usually, training goals include the following:

- Knowledge of disaster behavior;
- Skill in the use of treatment modalities;
- Understanding the system of disaster aid;
- Esprit de corps; and
- Supervision.

To accomplish these training objectives, mental health administrators must design short- and long-term programs for professionals and nonprofessionals. In the immediate aftermath of a catastrophe, both mental health and relief workers need a quick, flexible orientation. There is seldom sufficient time to plan these training sessions, which are generally put together on the spur of the moment. Later on, a more planned effort to provide continued training and support for the project's professional and nonprofessional staff must be devised. Training content will vary depending upon the experience, specific needs, and educational background of the trainees.

Disaster Behavior: The primary training need is knowledge and understanding of how disaster victims react after a mishap. By reviewing the time phases of disaster (preimpact, impact, and postimpact) participants can examine the types of physical and emotional problems victims can be expected to suffer at each phase. Although the study of victims' emotional behavior following a calamity is in its infancy, there are enough information and research findings to orient workers.

Included in the study of victims' symptoms are concepts related to understanding and diagnosing their problems. Training in the concepts of crisis/stress, loss and mourning, systems of social and emotional support, and coping/adaptation are crucial in gaining mastery of disaster problems.

Treatment Skills: Another goal of training is presenting ways to help victims in distress. Depending on the knowledge and skill trainees already have, trainers may wish to focus on such techniques as:

- Crisis counseling;
- Group therapy for adults;
- Play therapy for children;
- Family group therapy; and
- Short-term focus therapy.

Trainees also need to know about outreach, advocacy, and community organization. Because disaster victims seldom seek service from a mental health clinic, project workers must acquire techniques for entering the community in search of victims. In an outreach model, individuals are located outside the project's office and treatment is frequently provided under nontraditional circumstances. Skill in community organization prepares the project workers to mobilize citizen support, work with communities, and organize agency resources to aid both the project and the victims

Disaster Aid System: Disaster victims who present emotional problems also have a variety of real needs that must be resolved, such as needs for shelter, medical care, home repairs, and financial assistance. Mental health workers thus need a thorough knowledge of the community's resources Because these resources vary from community to community, a trainee must understand the local system of health and human services, as well as the range of relief services provided by private and public organizations at the local, state, and federal levels. Mental health workers will need knowledge of the services offered, the criteria for getting those services, and methods for referring clients.

Esprit de Corps High staff morale depends upon the clarity of project goals and the importance of purpose. Because it is essential for effective operation of the mental health project, another purpose of training is building and maintaining the staff's esprit de corps.

Low staff morale results from several factors, including lack of support, lack of skill in doing a job, and job pressures. Workers need to talk about their work-related problems and need visible support and reassurance from the project's authorities. Staff who are poorly equipped to assist victims will react with frustration, guilt, and anger. Probably one of the most serious problems of mental health workers in disaster assistance is overwork leading to fatigue and withdrawal This is especially grave in the first days after the disaster because workers toil long hours under stress and chaos. The outcome of these conditions is frequently a "burnt-out" feeling and a lowering of morale.

Training programs should address these potential problems directly by incorporating time during the sessions to discuss and share problems and feelings. Social activities from time to time also serve to maintain group sentiment, dispel frustration, and lead to more effective work.

Supervision: Major tasks of supervision include continued orientation and training of staff, effective delivery of service to victims, support of project workers, and overall integration of the project. The program's personnel should continue to learn by reviewing with the supervisor knowledge areas and techniques that are useful to performing the job. This educational component is an integral part of the supervisory process.

Workers will also need consultation and assistance in dealing with their clients' problems. Although related to the educational component, this supervisory step is problem-focused, so that staff members can apply knowledge and techniques to each victim's situation. Project staff are often tired, overworked, and frustrated, due to the long hours and pressures of their activities. Supervision must therefore address the staff need for sharing, reassurance, and support. Maintenance of staff morale is facilitated by the supervisor and includes the important process of terminating when the project ends.

It is also necessary for all project members to follow certain established procedures. The administrative requirements of the project, which include standards of service, the need for information, and contacts with other agencies, lend the program an overall consistency and integration Therefore, the administrative element is also a goal of supervision.

Supervisors have various techniques in their work. The more traditional approach includes regular meetings between worker and supervisor to cover educational, problem-solving, morale, and administrative issues Other supervisors may prefer to cover these issues in small groups, relying upon the dynamics and interactions of workers to enhance the supervisory process. Often these approaches may be combined for maximum effect.

Training Tools Several things are important to remember when carrying out training activities Training, including supervision, is a process that begins on the first day of the project and ends when the program closes Training activities during this time must be planned so that learning objectives are sequenced and consistent. The plan for training and supervision should include a published schedule of dates and times of meetings so that all will know about them. One procedure is to have a set date for these activities and to announce in advance the topics for presentation or discussion Trainers and supervisors must also put together all types of materials, including video tapes, slides, movies, and

case materials for use during training sessions. The training format may include didactic presentations, discussions, problem solving, and role playing. It is commonly believed that techniques which enhance involvement and sharing are effective tools in learning. The trainers chosen may be project participants, consultants, local agency or university personnel, or speakers who have specific knowledge about a service or about behavioral reactions or intervention.

CONSULTATION

Mental health consultation is one of the essential ingredients of an organized intervention program following a community disaster. Members of the mental health consultation organization must articulate a plan that harmonizes with all the other elements of the disaster-assisting agencies. The main mission of all these agencies is to support and concretely reorganize the lives of the citizens affected. A mental health consultant working in a temporary shelter or a one-stop federal center is more than an independent professional responding only to the necessity of aiding the victims. S/he must also help other agency staff deal with upset individuals by using skills appropriate for mental health workers. The consultant must place him/herself within a dynamic interplay of social system factors that are continually being modified by the situation in the postdisaster area. Each helping agency there will have specific goals and relative priorities, according to the most pressing needs of the population, the supply of resources, and the availability of other assisting services. All these factors must be carefully coordinated to reach a large number of victims with effective and efficient approaches because needs usually exceed resources

There is a need to develop an appropriate set of conceptual models in order to provide the mental health staff with the guidelines and the language to develop the consultation program. Consultation is one method the mental health professional can use to facilitate the work of other professionals helping the population in the disaster area. The first steps in the process of consultation include creating proximity and establishing a relationship that allows for the opportunity to demonstrate competence and eagerness to help, while at the same time respecting the right of other agencies to develop their tasks and functions After achieving this basic goal by offering collaborative co-professional services for the victims, mental health workers must begin to understand the operations of their counterparts in the other agencies and to formulate ways they can assist. This will sometimes mean accepting the "referred case" without delay or questions about whether or not the case is suitable for psychological assistance This stage is followed

by a rapid development of communications changes, which involve identifying the key members of the assisting networks who have access to the significant groups of line workers, as well as to the authority system at the affected site. Mental health consultants then must work out the terms of the consulting arrangements so that agency needs will be communicated to the consultant, who can then respond rapidly.

There are two types of obstacles to free communication between the consultant and agency personnel. The first type emanates from realistic conflicts of interest. This requires compromises in the development of a common language to clarify objectives, guidelines, and tasks. The second type of obstacle results from distorted perceptions or unrealistic expectations. Thus agency staff may view the consultant as either "all knowing" or "ignorant and irrelevant." In either case, these issues must be resolved before proceeding with the consultation

Conflicts between consultants and staff of the problem-solving agency can easily occur. For example, it may be possible that Red Cross workers have developed a variety of ways to deal with victims' problems over the years. Each of these workers will have his or her own method of approaching a problem. Each may feel, with specific emotional reactions, that a mental health consultant may be ignorant of issues of assistance, may influence the process, and may change the methodology of operations. Methodology developed over a long period of time by the Red Cross worker can be threatened when different approaches seem more efficient Workers may also be threatened if someone helps them do a better job, this sets up an ambivalent reaction of both gratefulness and distrust or fear of being found inept. Until the consultant finds out what each worker has been doing and carefully defines a role which does not overlap that domain, and unless the consultant succeeds in communicating this clearly, other workers may overtly or covertly oppose entry into their system The consultant needs to look at the following tasks and rapidly find ways to accomplish them:

- Dealing with any distorted perceptions and expectations of the agency workers;
- Developing trust and respect;
- Developing both verbal and nonverbal communications;
- Ensuring grounds for collaboration, and
- Designing successive stages of roles, according to the phases of the disaster

Following is an example of developing the consultation model in the first phase The mental health consultant will be regularly assigned for service in the shelter during a certain period of time This consultant may be from any of the mental health disciplines, that is, a psychiatrist, psychologist, social worker, or psychiatric nurse. He or she will attend to any situation the agency staff wishes to discuss in relation to mental

health issues presented by victims. For example, a consultee might wish to clarify his understanding of symptoms observed in a victim. The worker's approach to the problem may be devised on the basis of information or comments from the consultant. However, the consultant should not make any direct suggestions for choice or action. If workers need to reach a decision on what to do in the face of alternatives, their supervisor should guide them according to customary agency policy.

The content of all discussions with a consultant is geared to the situation of the victim and not to the feelings of the disaster assistance worker or his own life experiences. It is taken for granted that the worker is concerned about certain perplexing or unclear aspects of the victim's situation, and the consultation will be limited to this area. The worker's own feelings, important as they may be, are considered inappropriate for discussion. Neither is it considered appropriate to analyze any possible reasons for differences of opinion between staff workers or between staff and supervisors. A worker who wants to meet with a consultant should ask a supervisor to find one in the shelter or to contact a consultant in the specific area of crisis counseling. The following case study is illustrative.

> The director of the community supports agency, one of the disaster relief agencies in a town devastated by a tornado, asked for consultation because his staff was showing emotional strain and fatigue. At the time of the request, the area affected by the tornado was still in shambles, houses had been destroyed and rubble littered every square foot. The affected population had been relocated to a college dormitory, and agency staff were serving the victims in all types of daily living, housing, food, and recreation needs. They had been working around the clock for ten days. Town policies, enforced by the mayor, did not allow flexibility to change some of the procedures that would offer relief and better schedules for the workers. The agency director was urged by one of his staff to seek consultation in dealing with the problems.
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> The director and his staff met with the consultant and, at their first meeting, outlined the problems as decreased energy and increased staff frustration due to continuous and increased complaints by the victims. The major complaint was that people had no privacy, everything was too structured, and nothing was working because little individual or group help was available. This problem was most acute when dealing with the displaced adolescents. Efforts to involve the parents in looking at this problem (involving, for example, vandalism to the college property) and efforts to find solutions were not effective.
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> When the administrator turned to the consultant for a possible solution, the consultant raised the issue of needing specific data on how the families were grouped in the dormitory, how the day was organized, how the staff was dealing with the problems, and how the recipients of all this help felt about the effort. It was suggested that some of the data could be gathered by the consultant in small group meetings at the college dormitory, but the consultant wanted the staff members to participate, too. This last idea was resisted because the staff felt that they had enough to do and because they were

ambivalent about reviewing their own behavior and procedures. After more clarification of how important the data gathering would be in finding ways to alleviate the load of the workers, some volunteers met with the consultant In this meeting, it became clear that most of the staff were tired and angry over servicing victims who were seen as ungrateful, manipulative, selfish, and greedy They were also disturbed because they did not know how long the families would stay before they could return to some temporary housing

Several areas were delineated for further fact finding First, which were the most difficult families? Second, what were their losses and how capable were they in planning for the future? Third, what type of things seemed to bring out the most irritation and anger in these families? Fourth, what could be helpful in making staff members feel more relaxed and capable? The staff undertook the task of finding data to answer these questions They were also asked to note any procedures that were especially effective in handling the problems faced in helping the victims It was hoped that this information might provide insight for further discussion.

Two days later the staff presented their findings, and it became clear that many approaches of the staff signaled their own frustrations. As a result of the mass of data gathered, a number of ideas about effecting change in routine and approaches were brought forth. With the support of the consultant and agreement of the administrator, several changes in schedules, procedures, and duties were tried These changes reflected a more realistic way to run the agency A stronger link with Red Cross volunteers and crisis counselors was also established The volunteers developed recreation plans for the adolescents, and the crisis counselors had small group meetings with the parents Discussion focused on how the crisis in their lives had disrupted their routines and exasperated them. They were thus able to ventilate many emotional issues At the same time, the victims were asked to suggest ways they could work with the agency staff

All this material was gathered by the consultant, who in turn helped the staff see their stereotyped reactions to the victims and realistically understand the victims' plight and reactions to their losses With enhanced communication between the groups, the assistance program, which lasted two more weeks, became a more satisfying and less harassing experience for the agency

Victim-Centered Case Consultation

Victim-centered case consultation is the type most often needed in a disaster center Disaster workers often have difficulty dealing with the mental health problems presented by victims and can use the assistance and advice of mental health workers. Usually the relief worker will present the problem to the mental health professional, but at times the latter can also examine the victim, reach a diagnostic impression, and make recommendations The agency worker can then translate appropriate aspects of the recommendations into a plan that seems feasible in the shelter or other disaster assistance setting.

The primary task of this type of consultation is to develop a plan that

will help the victim. When the mental health consultant intervenes to help a specific victim, it is assumed that this victim has difficulties of an unusual nature and that very few other victims will have the same difficulties or will need a similar approach to resolve them. In most cases, the mental health consultant will personally investigate the victim's needs. In this way, the agency workers gain an increasing awareness and understanding of certain aspects of the case through discussion with the consultant. The mental health professional will try to obtain accurate, specific, and reliable information on the victim and may then come to a conclusion and offer diagnostic recommendations. The prescription for disposition and management of the case should be clear, acceptable, and feasible to the agency worker, who will then be responsible for taking action. Cases and approaches vary through the various phases of a disaster program. Following is an example:

A Red Cross worker asked for consultation on Mr. S., a displaced teacher living in a motel room. He had been exhibiting disruptive behavior, and had been constantly intruding into groups assembled in the sitting areas of the motel, where part of the displaced population had been housed after a flood. At the initial meeting, the mental health worker noted an edge of hostility as the Red Cross worker described Mr. S.'s behavior and his refusal to accept any controls. As the consultant sympathized with the problem of controlling Mr. S.'s behavior, the Red Cross worker felt supported and was able to present both Mr. S.'s problems and her own frustration. The consultant suggested that data on Mr. S.'s previous life and the effects of the disaster on him be obtained. The Red Cross worker commented that she had met with Mr. S. several times to discuss his numerous problems, which included the loss of three other teaching jobs due to occasional alcohol abuse.

The consultant told the worker that he had had experience with Mr. S.'s types of problems, thereby implying that she might want to share the responsibility of taking care of Mr. S. with another professional. He also assured her that the behavior manifested by Mr. S. was not due to a lack of professional knowledge on her part. The consultant promised to meet with the worker a couple of times a week after he interviewed Mr. S. so that both could consider how Mr. S.'s emotional problems were related to his uncontrollable behavior. Together they could decide on the best method to help Mr. S.

An interview with Mr. S. revealed helpful information. He told about his lonely life as a 47-year-old bachelor with few friends. He said that his family lived in another state, and that he lost his teaching job in a nearby school when it closed after the disaster. He generally was shy, quiet, and worried about people talking about him. To lower his anxiety and boredom, he often drank in excess and had been expelled from two previous positions because of his drinking. Having to leave his apartment, live and sleep in a shelter with no privacy, and then stay in a motel with no possibility of leaving because of the flooding waters had unleashed intense anger in him and he could not control his irritability. He had very few social skills to adapt to group living.

The consultant met again with the Red Cross worker and made clear that

Mr S 's aggressive and negative behavior had a long history but had been well defended by isolation and work habits. In the motel setting, however, this man had few defenses to deal with his feelings. The consultant suggested to the worker ways in which she could intervene to help Mr. S structure his routine in a more satisfactory way, which in turn would strengthen his usual defenses a. d lower his obnoxious behavior The worker smiled and her face brightened as she remarked, "Yes, these are difficult times for all of us."

Program-Centered Consultation

Another type of consultation focuses on the orientation or modification of program structures and administrative procedures for the purpose of prevention, early diagnosis and treatment, and rehabilitation of disaster-related mental disturbances. Mental health intervention following a natural calamity is one of the components in a system of help and support for victims. Other programs, such as the Red Cross, Family Service, welfare department, church agencies, and local mental health clinics, may wish to develop a specialized service for disaster refugees.

Leaders in adjacent areas impacted by the catastrophe may also desire to set up a crisis intervention and counseling project for their affected population. In either instance, an expert mental health professional may provide consultation centered upon the design or modification of a program to provide psychological assistance to victims as part of the overall package

The type of problems addressed by the consultant are varied, but will probably include such issues as

- Program planning;
- Appropriate administrative structures;
- Methods of service delivery,
- Policy setting;
- Recruitment, training, and utilization of staff; and
- Establishment of linkages with other human services.

The recipient of the consultation may be an administrator, a group of program directors, or a committee, such as a task force or board of directors The consultant's focus could be either a program in question or the consultee's abilities to master problems in planning and administration of a project

These two types of consultation, victim-centered and program-centered, involve an intervention between the mental health expert (consultant) and the person dealing with a task that presents a problem (consultee). In all instances, the consultant is presumed to have the *knowledge* to help resolve the problem now and in the future, while the consultee always maintains *responsibility* for the case or the program. The role of the consultant is to examine goals, methods, and techniques in order to overcome a lack of knowledge, skill, and/or confidence In

using this problem-solving method, the consultant employs many aspects of his role, including teaching, analyzing, planning, coordinating, collaborating, negotiating, or counseling. In all instances, the consultant is concerned with promoting the incorporation of mental health components in communities devastated by disaster. Those components should be designed to help organize the lives of victims and ensure the early detection and prompt treatment of those who suffer psychological consequences from the calamity