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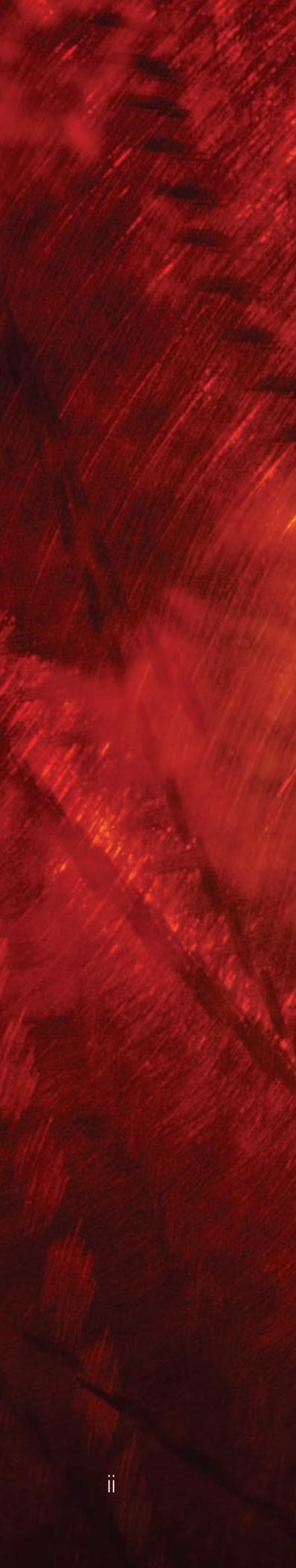
National Institute of
Environmental Health Sciences

NIEHS Stakeholder Meeting on Mental Health and Training

REPORT



NIH...Turning Discovery Into Health

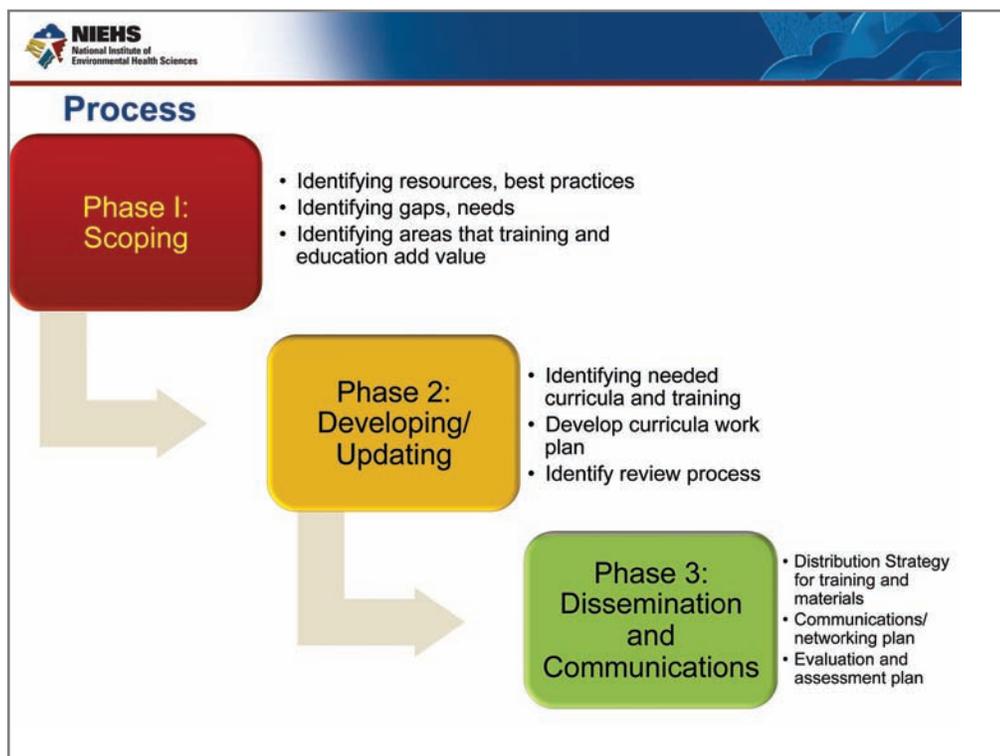


NIEHS Stakeholder Meeting on Mental Health and Training

Report

DATA COLLECTED AFTER THE DEEP WATER HORIZON (DWH) OIL SPILL DISASTER INDICATE A SIGNIFICANT MENTAL HEALTH COMPONENT TO THE HEALTH CONSEQUENCES OF THE EVENT. DATA FROM PREVIOUS DISASTERS HAVE DEMONSTRATED SIMILAR MENTAL HEALTH CONSEQUENCES. STUDIES ALSO INDICATE THAT HIGH QUALITY TRAINING MAY IN FACT REDUCE THE MENTAL HEALTH BURDEN IN WORKERS WHO RECEIVE THAT TRAINING. IN MAY 2011, THE NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES (NIEHS) CONVENED A MEETING TO EVALUATE THE WORKER EDUCATION AND TRAINING PROGRAM (WETP) TRAINING PERFORMED IMMEDIATELY FOLLOWING THE DWH SPILL. OBSERVATIONS FROM THAT SESSION SUGGESTED THAT WORKER TRAINING CAN BE IMPROVED AND THAT TO ADDRESS THE MENTAL HEALTH IMPACT EXPERIENCED BY WORKERS, AN INTEGRATED, COLLABORATIVE EFFORT NEEDED TO BE UNDERTAKEN AND THAT PRIMARY CARE PROVIDERS MUST BE MORE KNOWLEDGEABLE IN MENTAL HEALTH DIAGNOSIS AND TREATMENT.

Following the May meeting, NIEHS, WETP proposed a three phase process to address the mental health training issues identified post-DWH. Phase 1 is a stakeholder meeting to scope out best practices and gaps. Phase 2 will be curriculum development. Finally, Phase 3 will examine best ways to disseminate the training material.



On June 25, 2012, Phase 1 was conducted as NIEHS held a listening session with stakeholders from the Gulf Coast states to discuss issues related to mental health training for disaster workers responding to environmental incidents. The meeting participants included: community groups; Gulf Coast primary care physicians; Gulf Coast mental health providers; academia; federal partners; and grantees from the WETP. Three objectives were identified for the meeting: identify and highlight best practices; identify collaborations/networks, and identify gaps in mental health training for workers. Ultimately, the expected products include: a revised set of pre and post disaster training tools and a mechanism to effectively and efficiently disseminate the training.

Overarching Themes

Two main themes came out of the meeting: 1) Pre-training of workers provides more competent and resilient workers. Participants understood that while “just-in-time”/incident specific training has an impact, pre-disaster training of workers is highly recommended. 2) Performing as a community team, involving public health, primary care, community programs, and mental health providers results in better outcomes than does working in silos.

Best Practices

The best practice discussion included some unifying themes. One unifying theme was the use of community workers as advocates for the affected populations. Volunteers from community organizations are out in the field providing services. Tulane’s community health worker program has been providing certificate level training of these individuals who have been linking underserved individuals to needed services in a culturally appropriate way. Referrals for this program have come from the very programs that have been active in providing assistance during and following DWH.

A formal program for Community Health Workers (CHWs) was discussed as a best practice. Based on the post-Katrina REACH NOLA program, lay people from the community receive training at Tulane for this purpose. CHWs add sustainable infrastructure to the community and are not displacing other service providers. They are getting training in providing services that many were doing before their training. They are culturally appropriate and advocate for their communities. Discussion noted some partnering with others (BISCO and BPSOS) but not as much as desired. They did not have peer trainers for DWH, but think that would have been useful. Training manuals and videos, care management can be found at: www.reachnola.org and <http://reachnola.org/mhrproject.php>.

Links to related professional organizations include:

APHA Community Health Worker section

<http://www.apha.org/membersgroups/sections/aphasections/chw/>

National Association of Community Health Representatives <http://www.nachr.net/>

focused on Tribal health workers and communities.

Another example is the Alabama department of public health. Project Rebound (crises counseling format in collaboration with dept. of public health), established an infrastructure for non-profits and charitable organizations to coordinate. Public and mental health in Alabama have an established working relationship.

- Project Rebound gave out mental health grants. Continued project rebound meetings with non-profits even though grant funding has run out.
- Project Rebound provided organizational coordination and infrastructure to volunteer groups that minimized duplicative efforts

The Coastal Family Health Center, a federally qualified health center in Mississippi, is an example of another best practice. After Katrina this children’s health fund placed mobile vans on the coast to get to populations fairly quickly and stay around to deliver care; during the oil spill they started a peer-listening program across the coast with other groups. Their mental health staff trained lay people. The model was based off of the Alaska oil spill program. Program modified to look at children too; interfaith disaster workforce (pastors). Deals with trust issue. In their local command center, they’ve integrated a mental health person.

Good Practices

There was discussion of practices that were felt to be useful, but didn't necessarily have the evidence base to be described as a best practice. Each needs more assessment for its utility as a best practice.

- Psychological first aid was described as the technique that has replaced, at least in some areas, Critical Incident Stress Management (CISM) as a means of mitigating adverse mental health effects. It was aptly reported that while psychological first aid is being employed, there is no evidence that indicates it is effective or more effective than other methodologies.
 - Lack of federal guidance on which mental health interventions are most effective and which ones should be used and which training components are effective
- Federal crisis hot lines. These were described as a way to get workers referred to their local mental health services. The national hotline was lauded by some, but others thought it to be duplicative of local efforts and in some cases, there were no mental health services locally for referral.
- The National Institute for Occupational Safety and Health (NIOSH) has spent many years focused on the issue traumatic incident stress among emergency workers. NIOSH resources on the topic may be found at <http://www.cdc.gov/niosh/topics/traumaticincident/>.

Gaps, Challenges, Obstacles

Numerous challenges were presented in this portion of the meeting.

Data collection (and the general lack of baseline information) was perceived as being very useful in characterizing problems and issues. However, difficulties have been encountered in data collection, to include difficulties finding people, language barriers, trust, and stigmas. The absence of baseline information about the affected populations makes characterization of issues difficult. Additionally, data related to measuring program effectiveness is lacking.

One concern expressed about health studies was that the results need to be better explained; otherwise they are not seen as beneficial by the community.

Early in the meeting, command, control and communications issues were advanced as being critical impediments to the success of a response and recovery. Having public health officials integrated into the unified command structure and having an "ombudsman" advocate for community services were to ideas put forward as important. Community organizations felt there were duplicative efforts and that outside organizations created separate infrastructure that didn't utilize existing programs and thus not sustainable in the long-term.

- In a recently released after action report (AAR), the US Coast Guard recommended the addition of a senior health officer to the Unified Command structure. All agreed that a constant public health presence at the Unified Command would ensure that health and medical issues be kept center-stage at the Command level.
- The concept of a neutral party ombudsman to advocate for community services and funding was put forth as a means to coordinate and integrate service provision and to reduce the level of distrust that exists between the feds and locals.

- Lack of inventory of mental health services available locally
 - Many participants stated that there were few mental health services available for referral and that primary providers were unable to provide the necessary services
 - Mental health training for primary care providers is lacking. Needs to be training that can be provided through electronic venues, such as webinars or internet. Continuing Medical Education credits would attract providers
 - Develop a community resource guide so referrals can be made more easily and that providers can know what mental health resources are available
- Coordination of efforts and resources was presented as a best practice. Since there is a general lack of resource typing for mental health services and few (New Orleans) resource guides for mental health services, referrals from practitioners are difficult to make. Specific discussion points are listed below.
- Credentialing of workers
 - Outside organizations have a tendency to bring people into a community without the community knowing what specific skills those outside workers have.

Training Issues

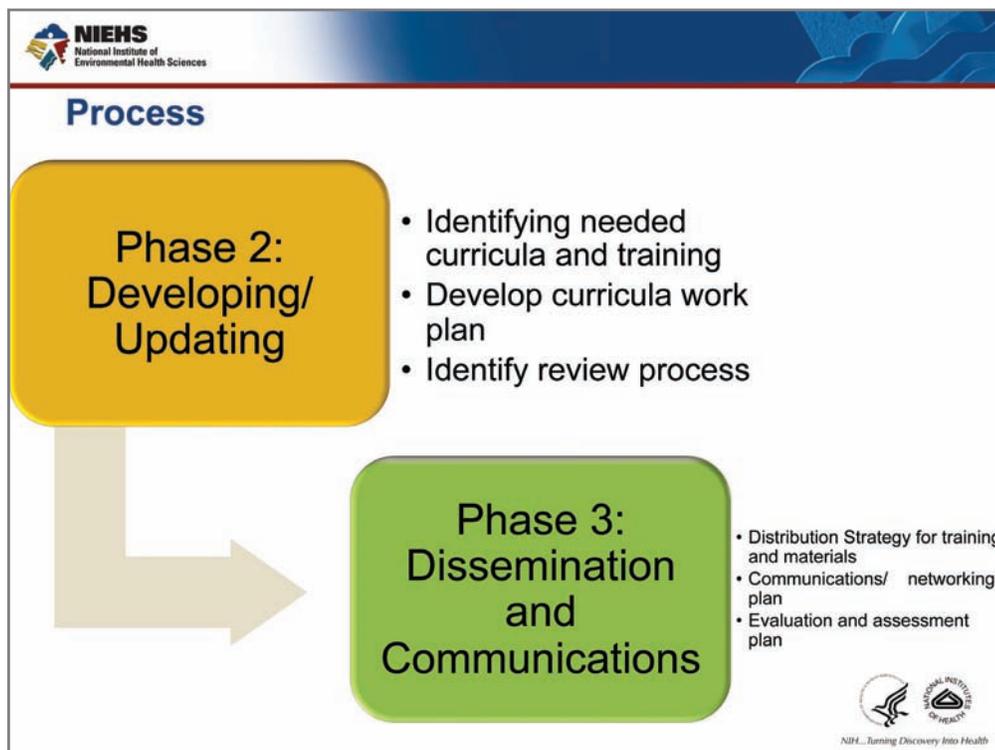
There was concern expressed about the variety of training programs and which ones were the most effective. Additional concerns included how to find the time in existing programs for mental health training and how to enforce the requirements for such training. WETP training was felt to be good, but the minimum training needed. The majority of the audience agreed that pre-disaster training was very important and that just in time training was valuable but not enough. Individual comments include the following.

- Seek community input into training
 - Assess Substance Abuse and Mental Health Services Administration (SAMHSA) materials for appropriateness
 - *Perhaps an inventory of all the relevant mental health training resources would be useful, rather than just a focus on SAMHSA material.*
 - Make sure that all know their professional boundaries and cover this in the training, e.g. where crisis counseling ends and professional treatment begins
- Develop tiered training for supervisors and workers to include mental health components
 - Should supervisors have more mental health training than workers?
- Training needs to be role specific
- Refresher courses need to be developed
 - Online
 - Available in libraries
 - *The challenge is how to let workers know how to find the material*
- Training must be available in all appropriate languages
- Identify safety net providers (providers in federally qualified health centers) and train them
 - Bring the training to the providers
 - *Include available resources*
 - *Telemedicine consultation with subject matter experts*
 - *Telephone calls e.g. Centers for Disease Control calls with clinical providers*

- Make sure all get training
 - E.g. Inmates worked on the spill-not sure if they ever received any training
- Add mental health module to HAZWOPER training
 - Add resiliency training to an existing and lasting (training) structure
 - Concern was express about adding additional time to existing training when there is pressure to minimize the training hours
- Training delivery should be flexible and use a variety of mechanisms
 - Web based
 - Use peer trainers
 - Reach the following audiences
 - *Providers*
 - *Lay healthcare workers*
 - *Community workers*
 - *Disaster site workers*
- Consider special populations in curriculum

Process and Next Steps

WETP laid out the process for moving forward with this project to include developing new or updating existing curricula and then working to communicate the existence of the materials and working to get them integrated into the existing training programs or finding new opportunities in which to provide the material.



Next Steps: Curricula Development

The next steps for this project will be the creation of a training advisory work group to help identify curriculum content, review curriculum and pilot the curriculum. The goal is to develop curricula for workers, providers, and community health workers that include material to mitigate and/or prevent the mental health consequences of disaster site work. Information from the June 25th scoping meeting will be used to inform curriculum development. Following that effort will be a third meeting to develop methodologies to best disseminate the curricula developed in phase two of this project. Information from this meeting will also inform a subsequent meeting on mental health research sponsored by NIEHS and SAMHSA.

- Formation of Training Advisory Workgroup
 - Identification curriculum content
 - Review curriculum
 - Pilot curriculum
- Identification of resources
 - Referral networks
 - Community resource guides
 - Best practice curriculum
- Identify training that targets:
 - Providers
 - Lay health care workers (Community Health Workers, Peer companions)
 - Workers/Community
 - *Maybe tiered with one version aimed at supervisors and another at workers*
- Training Content that considers:
 - Cultural competency and language
 - Underserved and disadvantaged
 - Special populations (children, prisoners, pregnant women, pet owners)
 - Training Content that is modular and flexible:
 - Able to be incorporated into existing training (HAZWOPER, Disaster Site Worker)
 - Can be used as preparedness training as well as tailored for incident specific training
 - Has a refresher component
 - Adaptable to a variety of delivery methods.

In conclusion, WETP thanks all of the meeting participants for contributing their time and knowledge on this important topic. We look forward to continuing to work with all of the participants as we move forward on the next steps.



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