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Commentary

COMMENTARY

Dealing with Community Mental Health post the Fukushima disaster: lessons learnt for the COVID-19 pandemic

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Summary: Under the COVID-19 pandemic, mitigation of psychological distress is required. At present, the demand for remote intervention for the numerous affected people is increasing, and telephonic support can be useful. Since the Fukushima nuclear disaster in 2011, we have been developing a large-scale telephonic support system and implementing brief interventions for the Fukushima people identified at risk of psychological problems such as depression and post-traumatic stress disorder. In this article, we report the lessons from the Fukushima disaster that can be applied to the COVID-19 pandemic and describe how the telephonic intervention facilitates easier access to psychological help for people with a broad range of psychological distress who are not able to visit treatment or care resources. In our telephonic intervention, we first sent a mental health and lifestyle survey to the people affected by the Fukushima disaster. The counselor team then provided telephonic intervention to high-risk persons as identified on the basis of the survey results. The individuals had expected to receive from the telephonic system help mainly in the form of stress-coping methods, social resource information such as schools, public offices or medical facilities, and lifestyle advice. Since we also experienced that psychological care for telephone counselors was necessary to mitigate the substantial emotional burden, we used the following three approaches: (i) regular supervision of the telephone counseling methods, (ii) seminars for improvement of counseling skills and (iii) individual psychological support. The positive loops between counselors and consulters will help advance a society affected by a disaster.

The COVID-19 pandemic and the measures to contain it, including isolation, pysical distancing and lockdown, have caused drastic changes in our society. Mitigation of psychological distress, including post-traumatic responses and depression induced by long-term restriction of daily life, isolation for quarantine and exposure to the public stigma, is required at both community and individual levels.[1] The demand for remote intervention for the numerous affected people is increasing, and telephonic support can be feasible and useful. Since the Fukushima nuclear disaster in 2011, we have been developing a large-scale telephonic support system and implementing brief interventions for the Fukushima people identified at risk of psychological problems such as depression and post-traumatic stress disorder (PTSD) based on the Fukushima Health Management Survey.[2] Over the past 8 years, more than 30 000 affected people have received such telephonic support. Here, we share the lessons from the Fukushima disaster that can be applied to the COVID-19 pandemic and describe how the telephonic intervention facilitates easier access to psychological help for people with a broad range of psychological distress who are not able to visit treatment or care resources.[3]

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A telephonic intervention is generally performed passively (i.e. only waiting for the person in distress to call), as occurs in most hotline services, our telephonic intervention is performed more actively. In this support, we first sent a mental health and lifestyle survey to approximately 210 000 people affected by the Fukushima disaster. The counselor team comprising clinical psychologists, nurses and social workers then provided telephonic intervention to high-risk persons as identified on the basis of the results of standardized measurements for screening psychological status [the PTSD Checklist, Kessler's six-item questionnaire for psychological distress or strengths and difficulties questionnaire[4]], or lifestyle status (e.g. lifestyle diseases, sleep disturbance and alcohol habits). In general, the interventions start from relationship building (e.g. acknowledgment of the individual's participation in the survey) and then move toward careful listening to the individuals' feelings, concerns about daily life or other issues related to long-term evacuation life, collection of health information (e.g. physical and psychological health status, family relationship and social network) and provision of brief interventions (e.g. psychoeducation and psycho-clinical advice). As necessary, counselors encourage people to visit medical or mental health facilities. In case of an emergency such as domestic violence and suicide ideation, counselors cooperate with local workers or care facilities in municipalities. The follow-up evaluation, which was conducted 5 years after the disaster using individual interview methods for the respondents, revealed that the individuals had expected to receive from the telephonic system help mainly in the form of stress-coping methods (36.6%), social resource information such as schools, public offices or medical facilities (29.4%) and lifestyle advice (28.8%).[3] Approximately 75% of the people were satisfied with the telephonic intervention.[5] Notably, our survey found that those who need support tended to experience bereavement and lack social resources.[6] As they would likely hesitate to seek help due to prejudice against psychological support or fear of being regarded as weak, an active telephone counseling system has the advantage of reaching out to them.

We also experienced that psychological care for telephone counselors was also necessary to mitigate the substantial emotional burden. The counselors were sometimes required to call the affected people, irrespective of hope and expectations that the affected people might have. The counselors sometimes had to face negative reactions from the affected people such as anger or complaints, sometimes resulting in compassion fatigue. To prevent counselor exhaustion and burnout, we used the following three approaches: (i) regular supervision of the telephone counseling methods, (ii) seminars for improvement of counseling skills and (iii) individual psychological support. One of the counselors' greatest demands is to enjoy a feeling of self-efficacy in this telephone counseling approach as medical professionals. The positive evaluation from consulters encouraged the counselors. Furthermore, the results of telephone counseling were soon fed back to the counselor teams. This feedback and peer-support system would improve the care system and provide the counselors the feeling of self-efficacy. The positive loops between counselors and consulters will help advance a society affected by a disaster.

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