WORLD HEALTH ORGANIZATION

Mental Health in Emergencies

Albania / refugees from Kosovo. Photo courtesy of UNHCR/B. Press

Mental and Social Aspects of
Health of Populations Exposed to Extreme Stressors

Department of Mental Health and Substance Dependence
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Mental Health in Emergencies

Background

The World Health Organization (WHO) is the United Nations agency responsible for action to attain the highest possible level of health for all people. Within WHO, the Department of Mental Health and Substance Dependence provides leadership and guidance to close the gap between what is needed and what is currently available to reduce the burden of mental disorders and to promote mental health.

This document summarises the present position of the Department of Mental Health and Substance Dependence on assisting populations exposed to extreme stressors, such as refugees, internally displaced persons, disaster survivors and terrorism-, war- or genocide-exposed populations. WHO recognises that the number of persons exposed to extreme stressors is large and that exposure to extreme stressors is a risk factor for mental health and social problems. Principles and strategies described here are primarily for application in resource-poor countries, where most populations exposed to disasters and war live. The mental health and well-being of humanitarian aid workers also warrant attention, but their needs are not addressed in this document.

In this document the term social intervention is used for interventions that primarily aim to have social effects, and the term psychological intervention is used for interventions that primarily aim to have psychological effects. It is acknowledged that social interventions have secondary psychological effects and that psychological interventions have secondary social effects as the term psychosocial suggests. WHO in its constitution defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Using this definition of health as an anchor point, this statement covers the Department's current position regarding the mental and social aspects of health of populations exposed to extreme stressors.

Our objectives, with respect to the mental and social aspects of health of populations exposed to extreme stressors are:

1. to be a resource in terms of technical advice for field activities by governmental, nongovernmental and intergovernmental organizations in coordination with the WHO Department of Emergency and Humanitarian Action.

2. to provide leadership and guidance to improve quality of interventions in the field.

3. to facilitate the generation of an evidence base for field activities and policy at community and health system level.

General principles

Informed by a range of documents by acknowledged experts on guidelines, principles and projects, the Department of Mental Health and Substance Dependence draws attention to the following general principles:

1. *Preparation before the emergency.*
   National preparation plans should be made before occurrence of emergencies and should involve: (a) development of a system of co-ordination with specification of focal persons responsible within each relevant agency, (b) design of detailed plans to prepare for an adequate social and mental health response, and (c) training of relevant personnel in indicated social and psychological interventions.

Return of refugees from West Timor. Photo courtesy of UNHCR/M. Kobayashi

2. *Assessment.*
   Interventions should be preceded by careful planning and broad assessment of the local context (i.e, setting, culture, history and nature of problems, local perceptions of distress and illness, ways of coping, community resources, etc). The Department encourages in emergency settings a qualitative assessment of context with a quantitative assessment of disability or daily functioning. When assessment uncovers a broad range of needs that will unlikely be met, assessment reports should specify urgency of needs, local resources and potential external resources.

3. *Collaboration.*
   Interventions should involve consultation and collaboration with other governmental and nongovernmental organizations (NGOs) working in the area. Continuous involvement preferably of the government or, otherwise, local NGOs is essential to ensure sustainability. A multitude of agencies operating independently without co-ordination causes wastage of valuable resources. If possible, staff, including management staff, should be hired from the local community.

4. *Integration into primary health care.*
Led by the health sector, mental health interventions should be carried out within general primary health care (PHC) and should maximise care by families and active use of resources within the community. Clinical on-the-job training and thorough supervision and support of PHC-workers by mental health specialists is an essential component for successful integration of mental health care into PHC.

5. *Access to services for all.*
Setting up separate, vertical mental health services for special populations is discouraged. As far as possible, access to services should be for the whole community and preferably not be restricted to subpopulations identified on the basis of exposure to certain stressors. Nevertheless, it may be important to conduct outreach awareness programmes to ensure the treatment of vulnerable or minority groups within PHC.

6. *Training and supervision.*
Training and supervision activities should be by mental health specialists - or under their guidance - for a substantial amount of time to ensure lasting effects of training and responsible care. Short one-week or two-week skills training without thorough follow-up supervision is not advised.

7. *Long-term perspective.*
In the aftermath of a population's exposure to severe stressors, it is preferable to focus on medium-and long-term development of community-based and primary mental health care services and social interventions rather than to focus on the immediate, short-term relief of psychological distress during the acute phase of an emergency. Unfortunately, impetus and funding for mental health programmes is highest during or immediate after acute emergencies, but such programmes is much more effectively implemented over a protracted time during the following years. It is necessary to increase donor awareness on this issue.

8. *Monitoring indicators.*
Rather than as an afterthought, activities should be monitored and evaluated through indicators that need to be determined, if possible, before starting the activity.

Intervention strategies for health officials in the field

Informed by the literature and the experience of experts and with the aim to inform current requests from the field, the Department of Mental Health and Substance Dependence advises on intervention strategies for populations exposed to extreme stressors. The choice of intervention varies with the phase of the emergency. The acute emergency phase is here defined as the period where the crude mortality rate is substantially elevated because of deprivation of basic needs (i.e. food, shelter, security, water and sanitation, access to PHC, management of communicable diseases), due to the emergency. This period is followed by a reconsolidation phase when basic needs are again at a level comparable to that before the emergency or, in case of displacement, are at the level of the surrounding population. In a complex emergency, (a) different parts of a country may be in different phases or (b) a location may oscillate between the two phases, over a period of time.

Rwandan returnees. Photo courtesy of UNHCR/A. Hollman

1. Acute emergency phase

During the acute emergency phase, it is advisable to conduct mostly social interventions that do not interfere with acute needs such as the organization of food, shelter, clothing, PHC services, and, if applicable, the control of communicable diseases.

1.1 *Valuable early social interventions may include:*

• Establish and disseminate an ongoing reliable flow of credible information on (a) the emergency; (b) efforts to establish physical safety for the population, (c) information on relief efforts, including what each aid organization is doing and where they are located; and (d) the location of relatives to enhance family reunion (and, if feasible, establish access to communication with absent relatives). Information should be disseminated according to principles of risk communication: e.g., information should be uncomplicated (understandable to local 12-year olds) and empathic (showing understanding of the situation of the disaster survivor).

- Organize family tracing for unaccompanied minors, the elderly and other vulnerable groups.

- Brief field officers in the areas of health, food distribution, social welfare and registration regarding issues of grief, disorientation and need for active participation.

- Organize shelter with the aim to keep members of families and communities together.

- Consult the community regarding decisions where to locate religious places, schools and water supply in the camps. Provide religious, recreational and cultural space in the design of camps.

- If at all realistic, discourage unceremonious disposal of corpses to control communicable diseases. Contrary to myth, dead bodies carry no or extremely limited risk for communicable diseases. The bereaved need to have the possibility to conduct ceremonious funerals and - assuming it is not mutilated or decomposed - to see the body to say goodbye. In any case, death certificates need to be organized to avoid unnecessary financial and legal consequences for relatives.

- Encourage the re-establishment of normal cultural and religious events (including grieving rituals in collaboration with spiritual and religious practitioners).

- Encourage activities that facilitate the inclusion of orphans, widows, widowers, or those without their families into social networks.

- Encourage the organization of normal recreational activities for children. Aid providers need to be careful not to falsely raise the local population's expectations by handing out types of recreation materials (i.e., football jerseys, modern toys) that were considered luxury items in the local context before the emergency.

- Encourage starting schooling for children, even partially.

- Involve adults and adolescents in concrete, purposeful, common interest activities (e.g., constructing/organizing shelter, organizing family tracing, distributing food, organizing vaccinations, teaching children).

- Widely disseminate uncomplicated, reassuring, empathic information on normal stress reactions to the community at large. Brief non-sensationalistic press releases, radio programmes, posters and leaflets may be valuable to reassure the public. Focus of public education should primarily be on normal reactions, because widespread suggestion of psychopathology during this phase (and approximately the first four weeks after) may potentially lead to unintentional harm. The information should emphasise an expectation of natural recovery.

1.2 *In terms of psychological interventions in the acute phase the following is advised:*

- Establish contact with PHC or emergency care in the local area. Manage urgent psychiatric complaints (i.e., dangerousness to self or others, psychoses, severe depression, mania, epilepsy) within PHC, whether or not PHC is run by local government or by NGOs. Ensure availability of essential psychotropic medications at the PHC level. Many persons with urgent psychiatric complaints will have pre-existing psychiatric disorders and sudden discontinuation of medication needs to be avoided. In addition, some persons will seek treatment because of mental health problems due to exposure to extreme stressors. Most acute mental health problems during the acute emergency phase are best managed without medication following the principles of 'psychological first aid' (i.e., listen, convey compassion, assess needs, ensure basic physical needs are met, do not force talking, provide or mobilise company from preferably family or significant others, encourage but do not force social support, protect from further harm).

Afghan refugees. Photo courtesy of UNHCR/A. Banta

- Assuming the availability of volunteer/non-volunteer community workers, organize outreach and non-intrusive emotional support in the community by providing, when necessary, aforementioned 'psychological first aid'. Because of possible negative effects, it is not advised to organize forms of single-session psychological debriefing that push persons to share their personal experiences beyond what they would naturally share.

- If the acute phase is protracted, start training and supervising PHC workers and community workers (for a description of these activities, see section 2.2).

2. Reconsolidation phase

2.1 In terms of social interventions, the following activities are suggested:

- Continue relevant social interventions outlined above in section 1.1.

- Organize outreach and psycho-education. To educate the public on availability or choices of mental health care. Commencing no earlier than four weeks after the acute phase, carefully educate the public on the difference between psychopathology and normal psychological distress, avoiding suggestions of wide-scale presence of psychopathology and avoiding jargon and idioms that carry stigma.

- Encourage application of pre-existing positive ways of coping. The information should emphasize positive expectations of natural recovery.

- Over time, if poverty is an ongoing issue, encourage economic development initiatives. Examples of such initiatives are (a) micro-credit schemes or (b) income-generating activities when markets will likely provide a sustainable source of income.

2.2 In terms of psychological interventions during the reconsolidation phase, the following activities are suggested:

- Educate other humanitarian aid workers as well as community leaders (e.g., village heads, teachers, etc) in core psychological care skills (e.g., 'psychological first aid', emotional support, providing information, sympathetic reassurance, recognition of core mental health problems) to raise awareness and community support and to refer persons to PHC when necessary.

- Train and supervise PHC workers in basic mental health knowledge and skills (e.g., provision of appropriate psychotropic medication, 'psychological first aid', supportive counselling, working with families, suicide prevention, management of medically unexplained somatic complaints, substance use issues and referral). The recommended core curriculum is WHO/UNHCR's (1996) *Mental Health of Refugees.*

- Ensure continuation of medication of psychiatric patients who may not have had access to medication during the acute phase of the emergency.

- Train and supervise community workers (i.e., support workers, counsellors) to assist PHC workers with heavy case loads. Community workers may be volunteers, paraprofessionals, or professionals, depending on the context. Community workers need to be thoroughly trained and supervised in a number of core skills: assessment of individuals', families' and groups' perceptions of problems,

'psychological first aid', providing emotional support, grief counselling, stress management, 'problem-solving counselling', mobilising family and community resources and referral.

- Collaborate with traditional healers if feasible. A working alliance between traditional and allopathic practitioners may be possible in certain contexts.

- Facilitate creation of community-based self-help support groups. The focus of such self-help groups is typically problem sharing, brainstorming for solutions or more effective ways of coping (including traditional ways), generation of mutual emotional support and sometimes generation of community-level initiatives.

Georgia / Abkhazia Republican Hospital. Photo courtesy of UNHCR/A. Hollman

Above interventions are suggested for implementation in synergy with ongoing mental health system development priorities:

- Work towards developing or strengthening feasible, strategic plans for national-level mental health programmes. The long-term goal is to downsize existing psychiatric institutions ('asylums'), strengthen PHC and general hospital psychiatry care, and strengthen community and family care of persons with chronic, severe mental disorders.

- Work towards proper and relevant national mental heath legislation and policy. The long-term goal is a functional public health system with mental health as a core element.

WHO resource materials

The following list of WHO resource materials covers: (i) mental health documents that are likely relevant to all populations whether or not exposed to extreme stressors and (ii) specific mental health documents relevant to populations exposed to extreme stressors.

WHO (1990). *The introduction of a mental health component into primary care.* WHO: Geneva.
http://www5.who.int/mental_health/download.cfm?id=0000000040
Note: This classic document covers integration of mental health care into PHC.

WHO (1994). *Quality assurance in mental health care. Checklists, glossaries, volume 1.* WHO: Geneva.
http://whqlibdoc.who.int/hq/1994/WHO_MNH_MND_94.17.pdf

WHO (1996). *Mental health of refugees.* Geneva: World Health Organization in collaboration with the Office of the United Nations High Commissioner for Refugees.
http://whqlibdoc.who.int/hq/1996/a49374.pdf
Note: This document is written for PHC and community workers to treat a variety of mental health disorders and problems in refugee camp settings.

WHO (1997). *Quality assurance in mental health care. Checklists, glossaries, volume 2.* WHO: Geneva.
http://whqlibdoc.who.int/hq/1997/WHO_MSA_MNH_MND_97.2.pdf
Note: These two documents cover quality assurance, monitoring and evaluation of mental health services in a variety of settings.

WHO (1997). *Promoting independence of people with disabilities due to mental disorders: A guide for rehabilitation in primary health care.* WHO: Geneva.
http://whqlibdoc.who.int/hq/1997/WHO_MND-RHB_97.1.pdf
Note: This is a manual with guidelines for treatment of mental disability by the PHC worker.

WHO (1998). *Mental disorders in primary care.* WHO: Geneva.
http://whqlibdoc.who.int/hq/1998/WHO_MSA_MNHIEAC_98.1.pdf
Note: This document contains an educational programme to assist PHC providers in the diagnosis and treatment of mental disorders.

WHO (1998). *Diagnostic and management guidelines for mental disorders in primary care: ICD-10 Chapter V Primary Care Version.* WHO: Geneva.
http://www.who.int/msa/mnh/ems/icd10/icd10pc/icd10phc.htm

WHO (1999). *Declaration of cooperation: Mental Health of refugees, displaced and other populations affected by conflict and post-conflict situations.* WHO: Geneva.
http://www.who.int/disasters/cap2002/tech.htm
Note: This declaration summarises guiding principles for projects for populations exposed to extreme stressors.

WHO (1999, revised 2001). *Rapid assessment of mental health needs of refugees, displaced and other populations affected by conflict and post-conflict situations: A community-oriented assessment.* WHO: Geneva.
http://www.who.int/disasters/cap2002/tech.htm
Note: This document outlines qualitative assessment of the context of the refugee situation. The document focuses on preparation, scope of assessment and reporting.

WHO (2000). *Preventing suicide: A resource for primary health care workers.* WHO: Geneva.
http://www5.who.int/mental_health/download.cfm?id=0000000059
Note: This booklet summarises basic knowledge on suicide prevention for the PHC worker.

WHO (2000). *Women's mental health: An evidence based review.* WHO: Geneva.
http://www5.who.int/mental_health/download.cfm?id=0000000067
Note: This report provides the latest research evidence pertaining to the relationship between gender and mental health, with a focus on depression, poverty, social position and violence against women.

WHO (2001). *World Health Report 2001. Mental health: New understanding, new hope.* WHO: Geneva.
Note: This is an authoritative and comprehensive review on the epidemiology, burden, risk factors, prevention and treatment of mental disorders world-wide. This report provides the framework for organizing country mental health programmes.
http://www.who.int/whr2001/2001/main/en/pdf/whr2001.en.pdf
(English version) or

http://www.who.int/whr2001/2001/main/fr/pdf/whr2001.fr.pdf
(French version)

WHO (2001). *The effectiveness of mental health services in primary care: The view from the developing world.* WHO: Geneva.
http://www5.who.int/mental_health/download.cfm?id=0000000050
Note: This is a review and evaluation of the effectiveness of mental health programmes in PHC in developing countries.

WHO (2002). *Working with countries: Mental health policy and service development projects.* WHO: Geneva.

http://www5.who.int/mental_health/download.cfm?id=0000000404

Note: This document describes a variety of technical assistance activities of mental health policy-making and service development at the country level.

WHO (2002). *Nations for Mental Health: Final report.* WHO: Geneva.

http://www5.who.int/mental_health/download.cfm?id=0000000400

Note: This document summarises WHO's recent strategies: to raise awareness to the effects of mental health problems and substance dependence, to promote mental health and prevent disorders, to generate capital for mental health promotion and care provision and to promote service development.

WHO (2002). *Atlas: Country profiles of mental health resources.* WHO: Geneva.

http://mh-atlas.ic.gc.ca

Note: This updated, online searchable database provides available information on mental health resources in most countries of the world, including countries with large populations exposed to extreme stressors.

Further information and feedback

For further information and feedback, please contact Dr Mark Van Ommeren (vanommerenm@who.int, fax: +41-22 791 4160), resource person within WHO on mental health in emergencies, in the team Mental Health: Evidence and Research (Coordinator: Dr Shekhar Saxena).

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