TECHNICAL GUIDELINE FOR MENTAL HEALTH IN DISASTER SITUATIONS AND EMERGENCIES

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Psychosocial problems and mental disorders are often heightened in disaster and emergency situations. The horrors, losses, and uncertainties experienced, as well as numerous other stressors related to these traumatic events, place people at greater risk of suffering from and being affected by mental health problems. Psychosocial support consists not only of care provided by the health services, but also encompasses multiple forms of support, including support and comfort from one's family and community. These forms of support must be coordinated, and it is here that health systems should play a central role.

A community model of mental health—one that respects local traditions and cultural diversity, while meeting the needs of the most vulnerable groups—should be the platform for all such interventions in emergencies. The objective is to promote and protect the mental health of the population, as well as contribute to recovery of everyday life.

This document provides suggested evidence-based technical guidelines for the planning and implementation of psychosocial and mental health interventions in emergency and disaster settings.

1. Mental health and psychosocial support: a broad and inclusive conceptual framework

Based on global and regional experience, as well as on the criteria of the Inter-Agency Standing Committee (IASC), this guideline uses a broad and inclusive conceptual framework, designed to be acceptable to all. Its essential consensus points are as follows:
- Agencies outside the health sector tend to speak of "psychosocial support/well-being".
- The health sector has commonly used the term "mental health".
- Exact definitions vary across agencies and countries.
- A consensus has been reached that the concepts of "mental health" and "psychosocial support" are closely interrelated and partially overlap; they are different but supplemental approaches.
- The purpose and field of work is broad: to protect and promote psychosocial well-being as well as prevent, identify, and treat mental disorders.

Mental health and psychosocial problems in emergencies go far beyond post-traumatic stress and depression. Selective care approaches that are concerned only with these two conditions are inappropriate, as they are unaware of many other psychosocial problems that occur in emergencies, and tend not to appropriately assess resources and family and community support systems.

The impact of disasters in terms of mental health-related morbidity is summarized in the following table. It bears stressing that the line between mild pathological responses and "understandable"—and not necessarily pathological—emotional reactions is very imprecise. Although the broad range of reactions and psychosocial problems elicited by human suffering is difficult to quantify, all of these responses require humane care and support.

Table 1: Impact of disasters on morbidity attributable to mental disorders

Mental disorders and stress reactions	BEFORE A DISASTER 12-month prevalence	AFTER A DISASTER 12-month prevalence
Severe mental disorders (e.g., psychosis, severe depression, incapacitating anxiety disorders)	2-3%	3-4%
Mild or moderate mental disorders (e.g., mild or moderate depression and anxiety)	10%	15-20% (declines over time)
"Normal" stress reactions (no disorder)	No conclusive estimate	High, declines substantially with time

Source: van Ommeren M. Aid after disasters. BMJ. 2005;330:1160-1. Available at:
http://www.bmj.com/content/330/7501/1160/suppl/DC1

One of the most frequent problems encountered in disaster and emergency situations is a health system weak and ill-prepared to face a traumatic event; resources are very limited, primary care has little response capacity, and no mental health component is integrated into the health services network, among other issues. In these conditions, it is indispensable that the response be mobilized from the community itself, strengthening the first line of contact of the health services with the population affected by the disaster and decentralizing the delivery of specialized resources. An appropriate intervention entails improving the mental health component within the framework of comprehensive health services, without medicalizing human suffering, "institutionalizing", or necessarily depending on specialist intervention. Disasters can become opportunities to strengthen health systems.[1]

2. Key lines of action

Nine key actions (adapted/modified from the Sphere Project) and six principles for the care of people with mental, neurological, and substance use conditions (adapted/modified from the mhGAP-HIG) have been identified. For each key action, core references that provide additional information are cited.

- ✓ The Sphere Project. *Humanitarian Charter and Minimum Standards in Humanitarian Response; third edition.* UK, 2011. http://www.ifrc.org/PageFiles/95530/The-Sphere-Project-Handbook-20111.pdf http://www.spherehandbook.org

- ✓ WHO/ UNHCR. *mhGAP Humanitarian Intervention Guide (mhGAP-HIG). Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies.* WHO: Geneva; 2015. http://www.who.int/mental_health/publications/mhgap_hig/en/

2.1 Key Action #1: Ensure interventions are developed on the basis of identified needs and resources.

Damage assessment and needs analysis, as well as a survey of the available resources, is a priority action that should be conducted immediately after any traumatic event to allow planning and implementation of evidence-based psychosocial and mental health interventions. In the assessment process, it is

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[1] Particular attention to Key Action lines #4 and #7 is recommended.

important to consider the cultural context and traditions of the affected community, to ensure a better outcome for the actions that will be carried out.

For this purpose, PAHO has developed the *Damage Assessment and Needs Analysis in the Health Sector in Disaster Situations* (DANA-Health 2010), which includes a mental health component. In addition, WHO and UNHCR jointly published the *Toolkit for humanitarian settings* (2012), which can be used to evaluate psychosocial and mental health needs and resources.

These tools are designed to guide those responsible for assessment and implementation of response actions at the different levels of the health system.

- ✓ PAHO. Damage Assessment and Needs Analysis in the Health Sector in Disasters Situations [In Spanish only] *Evaluación de daños y análisis de necesidades de salud en situaciones de desastres. Organización Panamericana de la Salud.* OPS: Washington, DC; 2010. http://www.paho.org/disasters/index.php?option=com_content&view=section&layout=blog&id=110&Itemid=895&lang=en&limitstart=54

- ✓ WHO/UNHCR. *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Settings.* WHO/UNHCR: Geneva; 2015. http://apps.who.int/iris/bitstream/10665/159202/2/9789243548531_spa.pdf?ua=1

2.2 Key Action #2: Strengthen the capacities of community members, including marginalized people, through self-help mechanisms and mutual support.

During a disaster, health teams should encourage the population (including marginalized people) and volunteer workers to promote and strengthen community self-help and mutual aid through multiple formal and informal mechanisms of social interaction.

Examples of community mobilization include participation in relief works and rescue efforts, management of shelters, education, supporting food and water supply efforts, sanitation, etc. Cooperation and communication among different community groups facilitate recovery efforts and prepare countries to tackle future emergencies in a more integrated and coherent manner.

- ✓ IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. *Mental health and psychosocial support in humanitarian emergencies: What should humanitarian health actors know?* WHO: Geneva; 2010. www.who.int/mental_health/emergencies/what_humanitarian_health_actors_should_know.pdf

- ✓ WHO. *Building back better: Sustainable mental health care after emergencies.* WHO: Geneva; 2013. http://www.who.int/iris/bitstream/10665/85377/1/9789241564571_eng.pdf?ua=1

2.3 Key Action #3: Ensure that humanitarian aid workers, community agents, response teams (including volunteers), and health services personnel are trained in and offer psychological first aid to victims and to all those who are in acute distress after exposure to extreme stressors.

It is important to make sure that field workers are properly trained in Psychological First Aid (PFA). PFA is a humane, supportive response that implies listening to and comforting those who suffer.

A handbook on PFA is available—*Psychological first aid: Guide for field workers* (WHO, War Trauma Foundation, World Vision International, 2011). This guide was written for people who can help others that have experienced a traumatic event.

In 2009, a WHO working group evaluated the available evidence on psychological first aid (PFA) and debriefing, concluding that PFA, rather than psychological debriefing, should be offered to people after a recent and severe exposure to a traumatic event.

Backed by many international organizations, the PFA field guide reflects current scientific evidence and international consensus on how to support people immediately after highly stressful events.

    ✓   WHO. *Psychological first aid: Guide for field workers.* WHO/War Trauma Foundation/World Vision International: Geneva; 2011. http://whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf

2.4 Key Action #4: Ensure that frontline (primary care) health teams have ability to identify and address the most common psychosocial and mental health problems, and that specialized services are strengthened and brought closer to the community.

Suffering, pain, and the need for emotional support are conditions that affect the majority of people, and are considered natural, transient psychological responses to significant traumatic events. However, for a minority of the population, extreme misfortune induces clearly pathological mental manifestations, such as depressive disorder, acute stress, post-traumatic stress disorder, and prolonged grief. In addition, people with severe preexisting conditions, such as psychosis, intellectual impairment, and epilepsy become more vulnerable. Finally, excess use of alcohol and drugs poses serious health hazards and increases violence in its different forms.

2.4.1 Primary care

In emergency situations, a significant increase in mental health needs is often accompanied by a lack of mental health resources to implement an appropriate response at the local level. This situation is made more complicated by the use of shelters or refuges and/or the displacement of large numbers of people, dispersion of families, abandonment, and lack of humanitarian support, among other factors. In such circumstances, access to specialized services can be very difficult, especially during the first days or weeks. Hence the need for primary health care (PHC) services or frontline health teams to have basic skills for the detection and management of mental health conditions and the delivery of psychosocial support. It is also recommended that at least one staff member at each health facility or team be properly trained to manage the most common psychosocial and mental health problems.

2.4.2 Specialized care and stratification of services

Mental disorders may be the result of the emergency itself, preexisting, or both. People with mental disorders (especially those with moderate and severe manifestations or with associated risk factors) should have access to specialized clinical care, as well as to a social support network. Organizing mental health care usually involves rapid training, support, and supervision of general/primary health staff; in some cases, adding a mental health professional to primary health teams deployed to critical points

(e.g., shelters, morgues, etc.) is recommended. The establishment of mobile mental health teams is also advised. The objective is to bring mental health care closer to the community, in a manner closely tied into PHC and humanitarian aid teams.

People with mental, neurological, and substance use disorders, whether preexisting or diagnosed during the emergency, should be assured appropriate treatment and the continuity thereof for as long as they need it. Essential antiepileptic and psychotropic medicines need to be available for prescription by specialized physicians, as well as by generalists who have received training in mental health. The use of benzodiazepines should be highly restricted.

Within such contexts, practical and user-friendly tools are urgently needed. The *mhGAP Humanitarian Intervention Guide* (2015) published by WHO describes essential, evidence-based interventions for mental, neurological, and substance use conditions in emergency settings. This guide contains recommendations for frontline management geared to nonspecialized health care providers working in humanitarian emergencies. It lists the following conditions:

- o Acute stress (ACU);
- o Grief (GRI);
- o Moderate-severe depressive disorder (DEP);
- o Post-traumatic stress disorder (PTSD);
- o Psychosis (PSY);
- o Epilepsy/Seizures (EPI);
- o Intellectual disability (ID);
- o Harmful use of alcohol and drugs (SUB);
- o Suicide (SUI); and
- o Other significant mental health complaints (OTH).

This process of training and organization/stratification of services will require establishing efficient mechanisms for referral and counter-referral, as well as systematic support from specialized providers and at the primary care level. It is essential that a health information system (which includes mental health) be in place and that it integrate all factors that are participating in the response.

- ✓ WHO/ UNHCR. *mhGAP Humanitarian Intervention Guide (mhGAP-HIG). Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies*. WHO, Geneva, 2015. http://www.who.int/mental_health/publications/mhgap_hig/en/

2.5 Key Action #5: Manage and support security measures and measures to ensure the basic needs and rights of institutionalized people with mental health problems are respected

Psychiatric hospitals and community-based residential homes for people with severe mental health problems need to be visited regularly, because the risk of severe neglect or abuse of people in these institutions is very high. During a humanitarian crisis, it is essential that safety, basic needs (water, food, shelter, hygiene, etc.), human rights surveillance, and medical care be provided.

Programs for treatment (including pharmacotherapy) of people with longstanding mental disorders, whether institutionalized (at hospitals, care homes, day centers, etc.) or living at home, should be guaranteed and sustained over time, as should extramural programs for people with addictions.

- ✓ WHO/UNHCR. *Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings.* WHO/UNHCR: Geneva; 2015. http://apps.who.int/iris/bitstream/10665/76796/1/9789241548533_eng.pdf [We recommend reading Tool 4: "Checklist for site visits at institutions in humanitarian settings", pages 42-46]

2.6 Key Action #6: Minimize harm related to alcohol and drugs

Problems related to the use of alcohol and other psychoactive substances can be enhanced by the dynamic of disaster and displacement. Victims are at risk of self-medicating with prescription drugs and/or alcohol and illicit substances to cope with their suffering and stress. Accordingly, humanitarian aid workers should be familiar with simple prevention techniques and brief interventions for people with these conditions.

Brief interventions have proven to be effective in the management of individuals with hazardous and harmful drinking, supplementing primary prevention efforts and facilitating referral for specialized management in severe cases.

Health promotion and protection actions that are carried out as part of the response to emergencies constitute an important setting for working with people who engage in hazardous and harmful use of psychoactive substances; especially relevant aspects are how affected people use their time and their integration into community tasks, including decision-making.

- ✓ WHO/UNHCR. *Rapid Assessment of Alcohol and Other Substance Use in Conflict-affected and Displaced Populations: A Field Guide.* WHO-UNHCR: Geneva; 2008. http://www.who.int/mental_health/emergencies/unhcr_alc_rapid_assessment.pdf?ua=1

- ✓ WHO. *Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care.* WHO: Geneva; 2001. http://www.who.int/substance_abuse/publications/audit_sbi/en/

2.7 Key Action #7: As part of early recovery, initiate plans to develop a sustainable community mental health system.

Early recovery efforts after a disaster create opportunities for the undertaking of programs and initiatives to promote development and prepare the community for future disasters. Constructing a sustainable community mental health system can improve resilience in the face of adverse situations and help establish better-quality health care.

We recommend the WHO report *Building back better: Sustainable mental health care after emergencies,* which narrates the experience of creating higher-quality, sustainable mental health systems in 10 areas around the world affected by various types of emergencies, despite extremely challenging circumstances. In all cases, the population's short-term interest in mental health was successfully converted into lasting long-term improvements.

✓ WHO. *Building back better: Sustainable mental health care after emergencies.* WHO: Geneva; 2013. http://www.who.int/iris/bitstream/10665/85377/1/9789241564571_eng.pdf?ua=1

2.8 Key Action #8: Contribute to appropriate risk communication and information management in disaster and emergency response.

Providing truthful, transparent information is essential for keeping emotions in check and helping the population remain calm. This requires high-quality information, available on a timely basis, and coordinated work with major stakeholders, including the media and the affected populations. Risk communication is essential to protect the mental health of people, as well as to create a climate of mutual trust between the community, authorities, and communicators.

PAHO has published a specific manual to facilitate mass communication efforts by the health sector. It provides recommendations to help drive information management and communication with the public in emergency settings.

✓ PAHO. *Information Management and Communication in Emergencies and Disasters: Manual for Disaster Response Teams.* PAHO: Washington, DC; 2009. http://www.paho.org/disasters/index.php?option=com_docman&task=doc_download&gid=594&Itemid=&lang=en

2.9 Key Action #9: Ensure priority psychosocial support in conditions identified as high-risk

- Priority should be given to the psychosocial support of especially vulnerable groups, such as: 1) responders who worked on the emergency and personnel who handled corpses; 2) older adults, people with disabilities, and the severely mentally ill; and 3) people living in extreme poverty.
- Children are less able to understand traumatic events and face limitations in communicating what they feel. Some adults may assume, erroneously, that a child will forget what has happened, but children are capable of recalling the traumatic experience once their fear is under control. During catastrophes, violations of children's rights may occur. Although emergency settings affect all aspects of child development, assistance has usually focused on addressing physical vulnerabilities to the detriment of children's losses and fears.
- The presence of large numbers of corpses as a consequence of a catastrophe or epidemic creates fear in the population due to inaccurate information about the danger the bodies of the dead represent. There is also tension and a feeling of widespread mourning; the reigning chaos and emotional climate can lead to difficult-to-control behaviors.

✓ Source: *Management of dead bodies after disasters: a field manual for first responders.* PAHO: Washington, DC; 2002. http://www.paho.org/disasters/index.php?option=com_docman&task=doc_download&gid=2468&Itemid=&lang=en

3. Principles for the care of people with mental, neurological, and substance use conditions

3.1 Communication

In emergency settings, health care providers are under pressure to see as many patients as possible in the shortest amount of time. Consultations should be brief, flexible, and focused on the most urgent issues. Good communication skills will help providers deliver effective and compassionate care.

3.2 Clinical assessment

Involves identifying the person's clinical conditions or symptoms, as well as their own understanding of their problems. It is also important to assess the person's strengths and weaknesses, and to always pay attention to the overall appearance, mood, facial expressions, body language, and speech of the person.

3.3 Management

Many mental, neurological, and substance use conditions are chronic and require mid- and long-term monitoring and follow-up. In humanitarian contexts, however, continuity of care can be difficult; as a result, it is important to recognize and support the caregivers of people with mental conditions, i.e., those who provide care and support throughout the crisis, including family members, friends, and other trusted people.

3.4 Reducing stress and strengthening social support

Reducing stress and strengthening social support is an integral part of comprehensive care for people with mental, neurological, and substance use conditions in settings where people experience high levels of stress. This includes not only the stress felt by people themselves due to their condition, but also the stress felt by their loved ones. Stress contributes to worsening existing psychosocial conditions; conversely, social support can diminish the adverse effects of stress.

3.5 Protection of human rights

People with mental, neurological, and substance use conditions need protection because they are at higher risk of human rights violations. They often experience difficulties in taking care of themselves and their families, in addition to facing discrimination in many areas of life. They may have poor access to humanitarian aid and experience abuse or neglect in their own families, and are often denied opportunities to participate fully in the community.
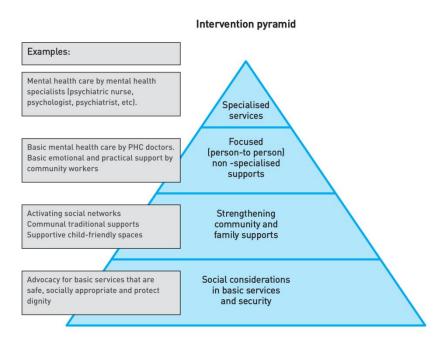
3.6 Attention to overall well-being

In addition to quality clinical care, people need other supports to achieve an appropriate level of well-being. This is especially true in humanitarian settings, where basic services, social structures, family life, and security are often fractured. People face additional needs and challenges and need to be helped.

✓ Adapted with modifications from: *mhGAP Humanitarian Intervention Guide (mhGAP-HIG). Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies*. WHO, Geneva, 2015. http://www.who.int/mental_health/publications/mhgap_hig/en/

4. Psychosocial support of children and safe education

- Children are especially vulnerable to the effects of disasters. Their reaction patterns differ from those of adults and depend on many factors, especially age and presence of a protective family unit.
- Emotional impact is often expressed by behavioral changes.

- It is essential that parents and all those involved in the health care of children affected by a disaster learn which typical reactions should be expected, as well as learn to recognize warning signs that recovery is not happening as it should be and that the child will probably require individualized care or specialist intervention. The role of teachers is especially important.
- Continuous assessment of risks and implementation of actions for their control is essential.
- In psychosocial support of children and adolescents, it is essential to ensure that: their basic needs are met; they are protected and monitored; and their lives return to normal (which includes resuming school attendance) as quickly as possible. Reuniting the family is also important.
- Interventions should be simple, group-based, and implemented during children's daily activities (e.g., school).
- Group activities can be supplemented by individual attention from teachers and health workers in especially high-risk cases.
- Non-specialized group interventions can be classified into two categories: psychoeducation or psychosocial support.
- Psychosocial interventions should be adapted to the moment the affected children are living (which depends on the time elapsed since the disaster) and, obviously, to their age. These interventions should be appealing and motivating, and are thus usually combined with play, games, athletic activities, etc.
- It is essential that activities be adapted to the cultural realities of the affected populations and to the resources available to the community, and that they be approved and supported by parents.
- Training programs should be implemented to ensure that teachers, health workers, and humanitarian aid personnel have the necessary competencies for psychosocial support of children and adolescents.

In lieu of a conclusion, we present the intervention pyramid for mental health and psychosocial support in disaster situations:

Intervention pyramid

Source: *Mental health and psychosocial support in humanitarian emergencies: What should humanitarian health actors know?* (IASC Reference Group, 2010)

Mental health and psychosocial support interventions require a program framework (work plan) to ensure appropriate implementation of actions and coordination among the different actors participating in the response. The activation of previously designed action plans and the coordination of efforts to achieve harmonious integration, which should include the community, are essential.

5. Further reading

- Inter-Agency Standing Committee. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: 2007.
  http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

- Organización Panamericana de la Salud. *Apoyo psicosocial en emergencias y desastres: Guía para equipos de respuesta*. PAHO; Panama City: 2010.
  http://www.paho.org/hq/index.php?option=com_content&view=article&id=935&Itemid=1106&lang=es

- Pan American Health Organization. *Mental Health and Psychosocial Support in Disaster Situations in the Caribbean*. PAHO; Washington, DC: 2012.
  http://www.paho.org/disasters/index.php?option=com_content&view=article&id=1647%3Amental-health-and-psychosocial-support-in-disaster-situations-in-the-caribbean&catid=895%3Abooks&Itemid=924&lang=en

- Rodriguez J. et al. (eds.). *Guía práctica de salud mental en situaciones de desastres* (Serie Manuales y Guías sobre Desastres). PAHO; Washington, DC: 2006.
  http://www.who.int/mental_health/paho_guia_practicade_salud_mental.pdf