DAMAGE ASSESSMENT AND NEEDS ANALYSIS IN THE HEALTH SECTOR IN DISASTER SITUATIONS
Mental Health Component
DANA-MH Assessment Guide
Mental Health and Substance Use Unit, Pan American Health Organization (PAHO/WHO), 2016

I. INTRODUCTION

Disasters have negative effects on health. These effects vary according to different factors, such as the type and magnitude of the event, the affected area and its socioeconomic characteristics, the degree of exposure of the population and its prior preparedness, the existing infrastructure, and the available response capacity, among others.

Damage assessment and needs analysis (DANA) by the health sector is an essential measure for proper decision-making in disaster scenarios. This process entails not only assessment of the health of the population but also of existing health conditions as a consequence of the event, in addition to assessment of the state of health facilities. Such evaluation is a dynamic and continuous process and should be conducted with instruments that facilitate data collection and analysis.

Rapid assessment of the mental health situation after a disaster or emergency is an integral part of DANA in the health sector (DANA-Health), and should not be viewed as an isolated component or parallel procedure to analysis of the health situation of the affected population. Mental health evaluation requires information on health and on the general context of the disaster; any comprehensive assessment of health, in turn, requires and benefits from information on psychosocial factors.

II. BACKGROUND

In 2004, the Pan American Health Organization (PAHO) published the *Manual on damage assessment and needs analysis in health in disaster situations and emergencies*, but later experiences obtained and lessons learned by the health sector in countries demonstrated the need for regular updates to this document. Accordingly, a new version was published in 2010. For this update, recent technical documents and other publications on the subject were used as a reference, as well as a consultation with experts.

The 2010 edition of the guide for *Damage Assessment and Needs Analysis in the Health Sector during Disaster Situations* (DANA) highlights the organization of the health sector, analyses the characteristics of the DANA model, and provides forms for information collection and analysis. The purpose is to ensure that decision-making is based on reliable data, so as to allow prioritization and planning of the necessary interventions and resources
(http://www.paho.org/disasters/index.php?option=com_content&view=article&id=1364&Itemid=1&lang=es).

A specific DANA for the field of mental health (DANA-MH) was published within the context of the *Field guide for mental health in disaster situations* (pages 9-42) (PAHO, 2006). This instrument was based on and formulated as a result of the 2004 DANA-Health. It was developed and validated by a group of Central American experts.

Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Settings (WHO/UNHCR, 2015).

In 2015, WHO and UNHCR published a toolkit to help those involved in the design and/or implementation of psychosocial and mental-health assessments in humanitarian crises, including large natural or man-made disasters, as well as complex emergencies (e.g., armed conflicts).

Many tools for such evaluation in emergency settings are available, including the *IASC Guidelines on Mental Health and Psychosocial Support in Emergencies* (2007); however, there was an unmet need for a document that included a general approach, including when and how to use each tool.

This publication has its origin in two policy papers: *Mental health and psychosocial support in humanitarian emergencies: What should humanitarian health actors know?*, by the IASC Reference Group (2010), and the mental health guideline of the *Sphere Handbook* (Proyecto Esfera, 2011). It also provides a guideline for selecting tools and shows how these tools tie into the main recommended interventions. Since social conditions contribute to mental health problems and sectors and institutions are linked to psychosocial factors, some tools cover subjects pertinent to various sectors.

The DANA-MH which we presented in 2015 is framed within and based on the DANA-Health produced by PAHO in 2010. Furthermore, it incorporates regional and global experiences from recent years, as well as evidence from the most recent publications, with particular emphasis on *Mental health and psychosocial support in humanitarian emergencies: What should humanitarian health actors know?*, by the IASC Reference Group (2010); the mental health guideline of the *Sphere Handbook* (Proyecto Esfera, 2011); the *Toolkit for humanitarian settings* (WHO/UNHCR, 2015); and the previous regional version of the *DANA-Mental Health* (PAHO, 2006).

III. USE OF DANA-HEALTH FOR MENTAL HEALTH EVALUATION

The first recommendation for mental health teams being trained to act in emergencies is that they become familiar with DANA-Health, use its data and tools, and ensure that the mental health/psychosocial component is duly integrated during evaluations. This, of course, does not exclude that mental health and psychosocial care teams should have and use supplemental tools that allow collection of more specific information in this field.

Some notes on use of DANA-Health (PAHO, 2010) and integration of its mental health/psychosocial component are provided below.

- It is vital that mental health teams be familiar with aspects such as the role of the health sector, preparedness, response, information management, and the situation room.
- The various tools provided in the Annexes of the DANA-Health Handbook contribute useful data for mental health evaluation, and some of them should be used by mental health teams.
- Annex 1: Form for rapid evaluation of the health situation. This includes recording of health services and facilities and their operability in the emergency setting. Mental health services and psychiatric hospitals should be considered.

- Annex 2: Form for rapid evaluation of damage to health care facilities. Provides an overview of the state of the health services network in the affected territory; again, it is important that mental health services and psychiatric hospitals be considered.
- Annex 3: Epidemiological surveillance form. Provides a means of collecting information on cases seen by the health services by symptomatic condition, sex, and age; should ensure that mental, neurological, and substance use disorders are registered by non-specialized professionals (such as mobile medical teams and primary care personnel), as well as by mental health teams.
- Annex 4: Shelter form. Of the utmost importance from a mental health standpoint, as persons in shelters or temporary housing are at serious psychosocial risk. The form summarizes the conditions of the shelters and records the sheltered population with chronic diseases or disabilities, as well as older adults. It also records known or treated cases, and must ensure that people with mental, neurological, and substance use disorders are included.

IV. ASSESSMENT

As far as possible, assessments should be a coordinated effort among the different institutions and organizations involved. Personnel expected to work on assessments should be trained in advance; one of the requirements is that they be prepared to work under pressure. It is also assumed they will be familiar with the core tenets of mental health and psychosocial support and have basic skills in evaluation techniques, conducting and interpreting semi-structured interviews with key informants and group meetings, working with surveys, training interviewers, and managing the logistics of evaluation, among other competencies.

Assessments can be carried out by local and/or outside health workers. Local personnel living in the area can respond immediately and move rapidly; they are usually familiar with the setting prior to the occurrence of the disaster and will thus be better able to judge the true impact of the event. However, emotional ties and personal involvement can compromise the objectivity of their evaluations. As a result, it is important that standardized instruments be available and that specialized outside personnel work jointly and in a coordinated manner with local personnel during the assessment process.

It bears stressing that: a) There is no one-size-fits-all methodology for evaluation; b) the proposed guidelines are not dogmatic or prescriptive, but rather provide guidance, and should be adapted to each specific setting; and c) the suggested tools can be selected as needs dictate.

Objectives of assessment

1. Describe the human impact of the event, considering the sociocultural context and forms of organization of the affected population.
2. Identify mental health and psychosocial problems, including hazards, morbidity, and mortality, in addition to the needs of the affected population.
3. Evaluate existing resources, as well as the capacities and modes of response of institutions and of the population.
4. Establish recommendations and priorities for action.

Stages of assessment

The common language of the international humanitarian response system divides assessment into a series of phases. Although imperfect, this consensus is useful for communication between stakeholders and for collaborative planning and action.

The phases and their time frame are as follows: phase 0 (before the sudden-onset crisis); phase 1 (the first 72 hours of a sudden-onset crisis); phase 2 (the first two weeks); phase 3 (weeks 3 and 4); and phase 4 (the remaining time). However, there is no complete agreement on these suggested time frames, which only apply to sudden-onset emergencies. When the onset of a crisis is slow, so too will each phase last longer. Furthermore, phase 3 can last much longer (for example, until the end of the third month if the emergency is severe or when access to services is limited).

For the purpose of this document, the first 30 days after onset of the event will be used as the reference period (the remaining time after the first month will not be taken into account), and two phases will be defined:

1. Critical period (phase 1): 72 hours after the event;
2. First month (phases 2 and 3): the first 4 weeks.

Initial assessment is community-based: The community plays a decisive role in first response. The initial assessment should be carried out by community organizations, rescue teams, relief and humanitarian assistance organizations, as well as by frontline health workers who have first contact with the population (primary care level). This first assessment should serve as the basis for later analysis and specialized intervention.

Assessment in the first 72 hours is community-based, qualitative, and very simple; its purpose is rapid identification of psychosocial problems. It is important that this assessment disclose which factors can influence the mental health of the population positively or negatively, the degree to which basic needs are being addressed, and the resources available.

Later assessments are specialist-led: This entails participation of mental health workers, who should expand on and supplement the initial community assessment. These later assessments should be qualitative and quantitative, and seek to define with greater precision the existing situation and record which actions have been taken.

Before an event

When preparing for disaster response (i.e., before a disaster), it is highly advisable to conduct an up-to-date diagnosis or analysis of the mental health situation; this will facilitate assessment once an event has occurred. This analysis should include a map of psychosocial risks and mental health resources. The mental health component should be incorporated into all situation rooms.

Suggested content:

1. Description of the population, with emphasis on sociocultural aspects:

- Demographic data.
- Ethnic makeup and social structure.

- Historical background on the community. Relationships among its different groups.
- Most common traditions. Spiritual and religious aspects.
- Existing community organization and psychosocial support structures. Functionality of mechanisms for cohesion and solidarity.
- Community structures for emergencies. Experience from previous disasters.
- Situation of educational facilities (schools).
- Availability and operability of social protection programs.
- Formal and informal leadership. Traditional authorities.
- Channels for conflict resolution/forms of mediation.

2. General considerations on the local economy.

3. Existing mental health resources, services, and programs:

- Institutions and organizations (both governmental and nongovernmental) that provide mental health services in the area, and the population coverage they achieve.
- Network of primary health care and hospital-based services.
- Personnel with mental health training available, both institutional and community-based.
- Specialized mental health care providers available and which of these have been trained to work in emergency settings.
- Mobile mental health teams that can be deployed and their places of origin.
- Referral and counter-referral mechanisms.
- Population coverage by the mental health services.
- First response teams and which of these teams have mental health training.
- Whether traditional healers exist and, if so, their role in the community.

4. Brief analysis of the existing psychosocial situation prior to the traumatic event:

- Data on mental health-related morbidity and mortality.
- Population knowledge, attitudes, and practices toward mental health problems.
- Psychosocial risk and protective factors.

Having a community-based mental health services network with an appropriate information system strengthens the institutional response capacity of the health sector in emergencies.

First 72 hours (see Annex 1)

This assessment should provide preliminary knowledge of the impact of the disaster and seek to identify the most immediate needs. Data should be collected from key informants in the community (mayors, teachers, community leaders, etc.) and through direct observation.

Since mental health teams (save in exceptional circumstances) will not be at the site of the event when it occurs, it falls to primary care personnel to collect the necessary data and translate it into an assessment of possible psychosocial impact. In this first phase, the mental health services should prepare for deployment of specialized personnel and enlist available mechanisms for more detailed data collection.

We suggest a simple rapid assessment tool (Annex 1) that can be used to carry out a general qualitative appraisal in very little time. It consists of a list of risk factors to which the affected community is exposed, the protective factors the community has at its disposal, a survey of resources, and the degree to which basic, psychosocial, and institutional needs are being met. It consists of a checklist of assertions that are checked against the perception of the frontline (i.e., primary-level) health workers who have first contact with the population immediately after the traumatic event.

The tool also provides for an appraisal of the information that is being provided to the population and other pertinent observations by means of a simple, preliminary analysis. This rapid assessment of the psychosocial component should be part of general DANA-Health.
It is anticipated that, during the first 72 hours after an event, collection of quantitative data on mental health-related morbidity will be practically impossible.

Contents of the rapid assessment tool (see Annex 1):

1. Preliminary appraisal of the human/psychosocial impact of the traumatic event (qualitative analysis based on first impressions)
2. List of psychosocial risk factors.
3. List of protective factors.
4. Identification and *a priori* qualitative analysis of: a) basic needs (housing, food, safety) and b) psychosocial needs (guidance, contact with family members, emotional support, social and institutional support, education for children, leadership, cultural and religious factors).
5. Information on response:
    a. Preliminary list of facilities and resources available for the immediate response. Appraisal of infrastructural damages.
    b. Preliminary list of human resources trained in mental health and available in the area (psychologists, psychiatrists, physicians, nursing personnel, social workers, occupational therapists, and even university students or vocational students with mental health training).
    c. Institutional needs to strengthen the response: deployment of specialized personnel, training, opening of new mental health facilities, logistical resources.
6. Communication: First assessment of the information that is being provided to the population, both by the media and informally.
7. Other observations, which can include high-risk geographic areas and location of the most psychosocially vulnerable population groups; manners in which the population is expressing emotions and available coping mechanisms; how the population is coping with deaths and losses; ways of mourning; who is requesting psychological assistance or support and how.
8. Conclusions and recommendations for the next 30 days.

From 72 hours to 30 days (see Annex 2)

Assessment of the first 4 weeks should continue the situation monitoring described for the initial or critical assessment, but is a systematic and more detailed process of data collection that helps develop an intervention plan for this time period. It analyzes the context, basic and psychosocial needs, and MH-PHC situation as a consequence of the disaster, as well as the response that is being mounted. Weekly periodicity is recommended, thus allowing interventions to be defined, adjusted, or reoriented in the most timely way possible.

During this phase, specialized mental health personnel intervene jointly with the primary health care team.

The essential points of assessment in this phase are as follows:

1. Assess existing mental health plans, services, and resources and their operability during the emergency. Determine the need for external assistance according to the existing situation and the needs of the organizations participating in the response.
2. Infrastructural damages to mental health services.
3. Quantitative and qualitative assessment of the MH-PHC situation and its progress during the first month, based on the initial analysis, with emphasis on psychosocial risk factors and protective factors, as well as the degree to which basic and psychosocial needs are being met.

Data registry mechanisms should be established to compile information on ongoing actions:

1. Cases of mental, neurological, and substance use disorders seen (according to sex, age, and diagnosis)
2. Morbidity: classification of cases by diagnosis. The use of broad diagnostic categories is advised, as it can be very difficult to obtain specific ICD-10 diagnoses in a complex emergency setting. As reference, we recommend using the conditions listed in WHO's *mhGAP Humanitarian Intervention Guide*:
    - Depressive disorder
    - Psychosis
    - Epilepsy/Seizures
    - Intellectual disability
    - Conduct disorders
    - Dementias
    - Harmful use of alcohol
    - Harmful use of drugs
    - Self-inflicted injury/Suicide
3. Disaggregation by site of care delivery (primary health centers, hospitals, or other community spaces):
    - Cases seen by specialized personnel
    - Cases seen by non-specialized personnel
4. Number of referrals to psychologists, psychiatrists, or other available mental health professionals.
5. Mortality from causes related directly and indirectly to mental health:
    - Violent deaths (suicides, homicides, family violence, accidents).
    - Deaths related to alcohol or drug use.
6. Group activities:
    - Psychoeducation or emotional support: number of sessions and participants.
    - Treatments offered by specialized personnel: number of sessions and participants.
7. Care for the pediatric population through group activities (with parents and children or teacher-led): number of sessions and participants.
8. Care of responders by specialized personnel: cases served individually and in group activities.

Other essential points of assessment:

9. Training: target audience, number of sessions, participants, where held, and topics addressed.
10. Identification and stratification of high-risk groups and/or groups requiring priority care.
11. Identification of institutional and human-resources problems and needs, as well as the degree to which they are being met.
12. Care of displaced persons and refugees.
13. Analysis of the information being provided to the population through different channels.
14. Considerations on the population's attitudes and practices, coping mechanisms, mourning experiences, conflict resolution mechanisms, and strengths and weaknesses of the community.

Annex 2 provides a list of key points for assessment in the first month after a disaster, which can be adapted to national and local contexts.

Assessment at the end of the first month after the traumatic event

This assessment allows analysis of the mental health situation during the first month after the event. It should offer an integrating, strategic vision that proposes lines of action and priorities to facilitate the subsequent recovery phase. The report should be distributed to and discussed with the relevant authorities.

Key points to consider:

- Analysis of the sustainability of mental health actions deployed to date.
- How the disaster can be used as an opportunity to strengthen mental health programs and services and advance toward a sustainable, community-based mental health model.
- Which shelters or refuges remain operational after the first 30 days.
- Interinstitutional coordination established and forecasts for its consolidation.
- The conclusions of the assessment should identify the key problems and needs detected at the end of this stage, and provide recommendations and aspects to prioritize during the recovery period that will follow.

A quick guide to identifying tools

The following table lists the tools available in the online WHO assessment guide, which can be selected in accordance with the specific needs and interests of each setting.

#	Tool	Method	Why use this tool
For coordination and advocacy			
1	Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support	Interviews with agency program managers.	For coordination, through mapping what mental health and psychosocial supports are available.
2	WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings (WASSS).	Part of a community household survey (representative sample).	For advocacy, by showing the prevalence of mental health problems in the community.
3	Humanitarian Emergency Setting Perceived Needs Scale (HESPER)	Part of a community household survey (representative sample)	For informing response, through collecting data on the frequency of physical, social, and psychological

		OR, exceptionally (in major emergencies), as a convenience sample.	perceived needs in the community.
For MHPSS through health services			
4	Checklist for site visits at institutions in humanitarian settings.	Site visits and interviews with staff and patients.	For protection and care of people with mental or neurological disabilities in institutions.
5	Checklist for integrating mental health in primary health care (PHC).	Site visits and interviews with primary health care program managers.	For planning a mental health response in PHC.
6	Neuropsychiatric component of the Health Information System (HIS).	Clinical epidemiology using the HIS.	For advocacy and for planning and monitoring a mental health response in PHC.
7	Template to assess mental health system formal resources.	Review of documents and interviews with managers of services.	For planning of (early) recovery and reconstruction, through knowledge of the formal resources in the regional/national mental health system.
For MHPSS through different sectors, including through community support			
8	Checklist on obtaining general information (non-MHPSS specific) information from sector leads.	Review of available documents.	For summarizing general information already known about the emergency (to avoid collecting data on issues that are already known).
9	Template for desk review of preexisting information relevant to MHPSS in the region/country.	Literature review.	For summarizing MHPSS information about the region/country that was already known before the emergency (to avoid collecting data on issues that are already known).
10	Participatory assessment: perceptions by general community members.	Interviews with general community members (free listing with further questions).	For learning about local perspectives on problems and coping, to develop an appropriate MHPSS response.
11	Participatory assessment: perceptions by community members with in-depth knowledge of the community.	Interviews with key informants or groups.	
12	Participatory assessment: perceptions by severely affected people.	Interviews with severely affected people (free listing with further questions).	

Source: *Assessing mental health and psychosocial needs and resources: toolkit for humanitarian settings* (pg. 7) (WHO/UNHCR, 2015).

V. SCREENING CRITERIA

Surveys or screens to detect cases after a traumatic event can be useful if certain conditions for their implementation are met. One of the advantages of these methods is that they shed light on unidentified patients, who can then receive timely treatment, preventing disease progression and further morbidity. Many authors insist there should be no intrinsic objections to conducting such screening routinely in population groups that have been exposed to major trauma or which are expected to have a high prevalence of psychological disorders. However, the debate continues, and questions remain before a definitive conclusion can be drawn on the practical utility of these procedures.

Cost and feasibility can pose obstacles to screening, especially when it is meant to be conducted routinely in major population groups. However, these factors would be less of a problem if screening were restricted to very strictly selected at-risk groups (e.g., responders).

Failure to conduct screening carries the limitation that a significant proportion of people who need care will not be identified early.

Recommendations:

- Screening can be useful to detect problems such as: high and sustained levels of stress which can be indicative of future complications; depression; harmful alcohol or drug use; and marked dysfunction in everyday life.
- In emergency settings, screening should not be carried out before the first 4 weeks, as the possibility of spontaneous recovery is very high in this phase; in this context, screening could overestimate the scale of mental health problems.
- Screening should be restricted to very strictly selected at-risk groups who have undergone major trauma or are expected to have a high prevalence of psychological disorders.

An appropriate damage assessment and analysis of mental health and psychosocial care needs and resources will strengthen health information systems and serve to inform monitoring of the post-disaster recovery process. Follow-up and monitoring largely depend on the use of reliable indicators and on the construction of a baseline to evaluate progress. An important basis would be the availability of a preexisting surveillance system. In many cases, unfortunately, health systems do not have good information mechanisms in the field of mental health, which hinders their establishment or strengthening in emergency settings.

Given the setting in which emergency care is delivered, the majority of indicators will be structure and process indicators. Impact indicators will be assessable in the medium and long-term, and, in some cases, will be obtained through specific research.

Some indicators can be obtained through continuous registries, although the majority will be collected through qualitative analysis, specific research, or sentinel sites. The recommended data collection scheme (Annexes 1 and 2) provides guidance to this effect.

VII. MOST COMMON OBSTACLES AND PROBLEMS

- There is no reliable diagnosis or previous information available.
- The collected information may be irrelevant, unreliable, or influenced by political opinions, private interest, or press reports.
- At times, information can be imprecise (deliberately or otherwise).
- The media can be sensationalistic or tend to generalize situations having major human impact.
- It is sometimes difficult to separate rumors from objective facts.
- Some personal factors favor bias: the personal history of assessors, their emotional conditions, and their intellectual ability at the time the work is carried out.
- Different information sources have not been cross-checked.
- Key informants are unavailable.
- Assessment is being performed too late.
- Insufficient resources or logistical problems hinder data collection.
- The assessment team is ill-prepared; work is poorly distributed or responsibilities are poorly defined.

VIII. FINAL REMARKS

1. Damage assessment and needs analysis for mental health and psychosocial support in disaster situations is essential for determining which interventions need to be carried out and for setting priorities. This assessment is an integral part of DANA-Health and should be the product of cooperation among various organizations and individuals.
2. Assessment should be guided and facilitated by standardized tools.
3. Assessors should remain neutral and compare different standpoints in order to come as close as possible to objective reality. Key informants must be selected judiciously, and different sources of information ensured. Snap generalizations based on personal first impressions must be avoided.
4. In the field of mental health and psychosocial care, the basic information comes from frontline health teams in contact with the affected population. Data obtained from psychiatric hospitals essentially measure the increase in cases seen as emergencies and in morbidity addressed at that level of care, but do not reflect the true psychosocial issues affecting the population.
5. Much of the information on psychosocial variables that is obtained in emergency settings is qualitative, obtained through direct observations in the field, interviews with key informants, or community meetings.
6. Health information systems must compile the minimum essential data for assessment.
7. People or groups with high psychosocial risk are often not the most visible at first glance. The needs of patients with known or longstanding mental illness should be separated from psychosocial problems caused directly by the traumatic event.
8. Periodic situation analysis reports—often requested by authorities—should be concrete, specific, brief, and practical, setting priorities and how to address them.
9. Assessment should separate recommendations for immediate action and strategic recommendations for the medium- and long-term outlook. At the end of the first month, recommended actions for, at least, the next 6 to 12 months should be defined.

10. Identifying and promoting the OPPORTUNITIES created by the emergency is crucial.

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ANNEX 1

Mental Health in Emergencies - Rapid assessment tool
Within72 hrs: Crisis

Specific information on MH and psychosocial aspects. Disaster effects on the MH of the population
1. Describe relevant mental health issues affecting the population prior to the disaster: Take into account existing epidemiological studies conducted in the country on mental disorders, risk/protective factors and suicide rates
2. State MH of vulnerable groups and institutionalized people after the disaster (orphans, displaced population, people with severe mental disorders and/or disabilities)[2]
3. State signs of psychological and social distress caused by the disaster, including behavioral and emotional problems
4. State human rights violations, if pertinent
5. Mention any peculiarities regarding mental health or psychosocial problems that you may have encountered

Information on the response
1. Did a MH contingency plan exist prior to the disaster? If it existed, is it comprehensive? Mention domains. Is it being implemented? How?
2. Is there any mechanism for coordination of the interventions in place? Describe
3. Communication: describe ways and means of communication among different actors involved in the response, ways and means of communications with those who are affected, ways and means of communication to public in general
4. Access to information (describe if information is accessible, what are the sources, quality and reliability of the information)
5. Psychological First Aid. First responders. Role of humanitarian agencies
6. Social solidarity and support. Ways in which people help themselves and others
7. Ways in which the population may previously have dealt with adversity or similar emergencies
8. Mental Health resources available in the field (Health services, public and private; PHC services, MH services, hospitals, local and international NGOs, religious institutions, community organizations, psychosocial support programs in education and social services). Quantitative and qualitative description. Functional aspects[3]
9. Impact of the emergency on local Mental Health and other Health or Social Services
10. Describe other means/modalities/alternatives for response, if any
11. Describe specific relevant issues in terms of response that may have not been listed above

Risk and Protective factors identified: Checklist			
Risk factors		**Protective factors**	
Large number of injured		Community organization prior to the disaster	
Large number of fatalities		Citizen groups who participate actively in the solution of problems caused by the disaster	
Social disorder (arguments, fights)		Access to reliable and organized information	
Ethnic, political, religious or other confrontations		Members of the community trained in mental health	
Violent, criminal, or destructive groups		Social services available	
Domestic violence		Mental health services available	
Sexual assaults		Functional external humanitarian assistance programs	
Kidnappings		Governmental assistance	
Missing persons (as a consequence of the disaster)		Others	
Displaced population/groups			
People in shelters			
Families separated			
Individuals suffering from grief, fear or other emotional reactions as a result of the event			
Consumption or abuse of alcohol, drugs, or both			
Individuals with evident mental disorder			
Disintegration of community organizations			
Community disapproval of humanitarian assistance activities			
Refusal of population to cooperate			
Insufficient or unreliable information			
Existence of rumors or gossips			
Response teams affected			
Others			

ANNEX 2

Mental Health in Emergencies - Rapid assessment tool[1]
Within 1 month: Crisis and Post-Crisis

Relevant demographic, community and contextual information[1]

1. Provide a brief description of the kind and magnitude of the disaster

2. Determine the existence of ongoing hazards, the overall security situation

3. State the existence of refugees or displaced populations(size, age and sex breakdown) and their conditions of life

4. Identify groups at increased risk, e.g. women, children, older people, persons with disabilities. Socially vulnerable or marginalized groups(size, age and sex breakdown)

5. Describe social, political, religious and economic aspects, structures and dynamics

6. State basic ethnographic information on cultural resources, norms, roles and attitudes. Interactions between different social groups (for example, ethnic and religious)

7. Describe gender and family aspects (for example, organization of family life, traditional gender roles, etc.)

8. Describe local power structures (for example local hierarchies based on kinship, age, gender, knowledge of the supernatural)

9. Describe the nature of and quantify problems caused by the disaster on the population (death, mortality rates, threats of mortality,wounds, material losses, structural losses)

10. Describe livelihood activities and daily community life and ways in which the disaster may have changed them[2]

11. Quote local people's experiences of the emergency (perceptions of events and their importance, perceived causes, expected consequences)[3]. Describe ways in which the population may previously have dealt with adversity or similar emergencies

12. State human rights violations, if pertinent

13. Displaced population. Quantify discriminating ages, gender, location, general, social, and health

14. Any other relevant information not listed above

Specific information on MH and PS status of the population prior and after the emergency. Disaster effects and ways to cope with

15. Describe and quantify relevant mental health issues affecting the population prior to the disaster: Take into account existing epidemiological studies conducted in the country on mental disorders, risk/protective factors and suicide rates

16. Describe major sources of distress (for example poverty and unemployment rates, child abuse, trafficking, political reasons, etc.)

17. Describe local expressions (idioms) for distress and folk diagnoses, local concepts of trauma and loss[3]

18. State explanatory models for mental and psychosocial problems[3]

19. Quote concepts of the self/ person (for example relations between body, soul, spirit)[3]

20. Describe the MH state of vulnerable groups and institutionalized people before and after the disaster (orphans, displaced population, people with severe mental disorders and/or disabilities)[4]

21. State signs of psychological and social distress caused by the disaster, including behavioral and emotional problems and signs of impaired daily functioning[5]

22. Make a quick estimate on the prevalence of mental disorders[6]

23. Identify disruption of social solidarity and support mechanisms

24. Describe and quantify the mental conditions of displaced persons. Discriminate mental distress from mental disorders, age, gender, provenience.

25. Mention any peculiarities that you may have encountered

Information on the response

26. Are there a Mental Health Policy and a Legislative framework in place? Describe.

27. Did a MHPSS contingency plan exist prior to the disaster? If it existed, is it comprehensive? Mention domains. Is it being implemented? How?

28. Describe the relative roles of government, private sector, NGOs, and traditional healers in providing mental health care[4]

29. Leadership. Identify key actors and their role leading different aspects of the response

30. Is there any mechanism for coordination of the interventions in place? Role of the Public Health Sector. Describe the history of humanitarian emergencies in the country. Experiences with past humanitarian aid involving mental health and psychosocial support[4]

31. Communication: describe ways and means of communication among different actors involved in the response, ways and means of communications with those who are affected, ways and means of communication to public in general

32. Access to information (describe if information is accessible, what are the sources, quality and reliability of the information)

33. Psychological First Aid. Who were the first responders?

34. Describe qualitatively and quote (quantitatively) the role of different agencies in the first response: GO, local NGO, international NGO, religious organizations, others

35. Describe strategies adopted to face the first response, and its consequences at present

36. Map emergency MHPSS programmes. Quantify human and material resources in place[8] MHPSS resources: location of health, social, NGO and other resources

37. Map potential MHPSS partners

38. Quote the role of the formal and informal educational sector in psychosocial support[3]

39. Are there institutionalized teams for psychosocial support at schools? Quantify out of them, human resources who are actively involved in emergency support: psychologists, social workers, others

40. Identify and quantify alternative, non-formal educational settings. Describe and quantify human resources that are or can be available to provide support to affected population

41. Quote the role of the formal social protection sector (for example, social services) in psychosocial support[3]

42. Quote the role of the informal social protection sector (for example, community protection systems, neighborhood systems, other community resources) in psychosocial support. Social solidarity and support. Ways in which people help themselves and others[4]

43. Describe the role of the complementary and alternative medicine health system (including traditional health system) in mental health and psychosocial support[4]

44. Describe help-seeking patterns (where people go for help and for what problems)[3]

45. Hospital, Residential or Sheltered pre-existing facilities: number, kind (protected residences, asylums, psychiatric hospitals, children institutions, elderly institutions), location, beds, human resources allocated, living conditions

46. Sheltered facilities after disaster. Number, location, number of beds, number of different professional profiles allocated,supplies, conditions, number of persons sheltered discriminated by age, gender, social and health conditions.

47. Number of heltered displaced persons, discriminated by age, gender, social and health conditions, location

48. Quote Mental Health resources available in public PHC services: Number of generalists, nurses, psychologists, social workers, promoters, other. Does the team deal with mental health related issues? [8]

49. Other PHC or community services (not public). Idem [8]

50. MH services (ambulatory). Public and private. (Outpatient services, Community MH Centers, day hospitals, mobile teams, others.). Number of facilities; number of professional and non professional human resources. Supplies. Availability and their involvement in the emergency. Describe modalities of work and people´s general perception of these institutions.

51. MH services in hospitals. Public and private. Psychiatric hospital and MH services in General Hospitals. Number of hospitals by categories. Number of professional and non professional human resources at hospitals. Number of beds. Turn-over. Supplies- Availability and their involvement in the emergency. Describe modalities of work and people´s general perception of these institutions[9]

52. 24 hr. MH emergency services. How many are available, number human resources and beds available, turn-over, supplies and state where are they located[8]

53. Training: PHC workers who have received training on MH previous to disaster. Kind and hours of MH training of each professional within teams and at all levels. When did they receive the last training?

54. Use of the mhGAP IG: is it known, used, are copies available for easy use?

55. Quantitative and qualitative description, including functional aspects of local, national and international NGOs, religious institutions, community organizations; are they providing any kind of psychosocial support program or education and social service. Make special focus on specific mental health and psychosocial training projects, by quantifying number of people trained discriminating professional profiles, age, gender, curricula and hours of trainings. [9]

56. Determine the availability of standardized protocols on MHPSS for non-specialized setting (public and private or NGO)[8]

57. Determine the availability of essential medicines at different levels of the Health System (public and private/NGO; PHC, MH services, Hospitals, NGO, etc). Specify drugs included at each level[8]

58. Describe referral and counter-referral systems

59. Describe supplies and logistic systems at each level

60. Health Information System (HIS). Describe what kind of information is available. You may suggest introducing items to a pre-existing HIS[19]

61. Describe the impact of the disaster on local Mental Health and other Health or Social Services

62. Describe other means for response, if any

63. Describe specific relevant issues that may have not been listed above

Risk and Protective factors identified: Checklist[10]

Risk factors		Protective factors	
Large number of injured		Community organization prior to the disaster	
Large number of fatalities		Citizen groups who participate actively in the solution of problems caused by the disaster	
Social disorder (arguments, fights)			
Ethnic, political, religious or other confrontations		Access to reliable and organized information	
Violent, criminal, or destructive groups		Members of the community trained in mental health	
Domestic violence		Social services available	
Sexual assaults		Mental health services available	
Kidnappings		Functional external humanitarian assistance programs	
Missing persons (as a consequence of the disaster)		Governmental assistance	
Displaced population/groups		Others	
People in shelters			
Families separated			
Individuals suffering from grief, fear or other emotional reactions as a result of the event			
Consumption or abuse of alcohol, drugs, or both			
Individuals with evident mental disorder			
Disintegration of community organizations			
Community disapproval of humanitarian assistance activities			
Refusal of population to cooperate			

Insufficient or unreliable information	
Existence of rumors or gossips	
Response teams affected	
Others	