



Visit to flood affected north Bangladesh Jigamarighat chor (chor is a small island in the river). Munima aged 25 sitting on the remains of her house which was completely destroyed by the flood.

Photo: Jenny Matthews/British Red Cross

Emergency mental health and psycho-social support

Description

This chapter intends to serve as a guide for setting up mental health and psychosocial programmes for vulnerable populations in developing countries who are or have been exposed to crisis events. It describes the psychological problems of people exposed to violence, disaster or critical incidents and provides guidelines for planning emergency mental health programmes.

Learning objectives

- To discuss the mental and emotional impact of exposure to disasters;
- To define what mental health programmes can contribute to an emergency response effort;
- To design the building blocks of a mental health care programme;
- To recognise the important factors for establishing long-lasting mental health programmes.

Key competencies

- To recognise the mental health problems and psycho-social suffering caused by disasters, displacement, social unrest and violence;
- To apply standard guidelines when designing, implementing or evaluating an emergency mental health programme;
- To recognise the factors that are important for establishing long-lasting mental health programmes.

Overview

There is no universally agreed upon definition of mental health. But people with good mental health have the following qualities in common:

- Being able to understand and respond to the challenges of day-to-day life.
 - Being able to feel and to express a range of emotions.
 - Being able to maintain good relationships among people in families and communities.
- Many factors, which could be biological or environmental, contribute to having good mental health. People are frequently exposed to positive as well as negative factors in their everyday life. Mental health problems occur when the stress from negative factors, such as pressure from work, illness or death in the family, or lack of income, greatly exceeds normal levels, or the exposure to these negative factors lasts for a long period of time. During social unrest, people's entire way of life is torn apart. Living conditions may become intolerable, and even the most basic needs may be lacking. These conditions, along with an uncertain future and a constant state of insecurity, put great stress on families and communities. Prolonged stress can break some people down emotionally and mentally, leading to mental health problems. These problems may exhibit themselves physically (fatigue, headache, back pains), emotionally (fear, anxiety, mood changes), or through major changes in behaviour (domestic violence, alcohol abuse). Many of these problems can be dealt with. If these problems are not treated early, people can suffer long after the emergency is over.

Mental health services are becoming a common part of post-emergency relief efforts. The aim of a mental health programme is to prevent or control the progression of mental health illness among displaced populations. Many lessons have been learnt from past mental health programmes. The key to setting up successful programmes is to link the experiences in treating mental health illness in developed countries with the cultural practices and traditions of the affected community in developing countries.

Introduction

I often have to talk about 'forgotten emergencies' and my responsibility is to alert the world to the emergencies it chooses to neglect. But the mental health crisis is not just neglected; it is also very much a hidden emergency. What we must do is bring it out of the shadows.

Jan Egeland
United Nations Emergency Relief Coordinator 2004

Until recently, problems of psycho-social and mental health during and after humanitarian crises were ignored by health care workers and donors alike. Interest in these problems is now growing as their frequency and impact among trauma-affected populations has become more apparent. Those members of displaced populations or others who stay in disaster affected villages in need of psycho-social and mental health support represent

several overlapping subpopulations of people, including those with:

- Disabling psychiatric illnesses;
- Severe psychological reactions to trauma; and
- Significant problems in individuals who experience temporary psychosocial and/or emotional stress that impairs their ability to function. This subgroup generally represents the majority of the population.

This chapter will discuss assessment, programme design and the general management of psycho-social and mental health issues in these subpopulations of affected populations. However, the reader should recognise that the movement to provide formal methods to assess problems, plan projects and evaluate interventions is quite new. Even now progress continues to be limited by a lack of widely accepted accurate assessment methods and of methods to assess programme impacts. Individuals suffering from psycho-social and mental health problems can often present differently in different environments and require interventions adapted to their situation and cultures. Yet most aid programmes continue to use

assessment instruments developed in western countries for their programmes in other cultures without testing their local accuracy as well as to intervene using interventions developed again in the west without assessing their impact. As a result most interventions currently in use have never been evaluated for their feasibility or effectiveness in the contexts in which they are being used, especially among multicultural populations. Although evidence-based studies are becoming more frequent, where claims of



Psycho-social support programme in the Pakistan earthquake in 2005. Photo: Jakob Dall, Danish Red Cross

effectiveness have been made these have rarely been based on formal evaluation of impact.

Although there is a lack of evidence, programme design has relied heavily on ideological preferences. This has placed the psycho-social approach, which emphasises services to the whole community and avoids ‘medicalisation’ of problems, at odds with the mental illness approach. This last approach emphasises diagnosis and treatment of selected individuals. Lately however, a different kind of thinking has emerged that not only promotes the unification of the psycho-social, mental and public health approaches but equally emphasises community and medically based programmes with traditional multicultural and family centred structures. Whereas this thinking helps clarifying that extreme human-rights abuses and acute or moderate psycho-social reactions that are prevalent in humanitarian crises will no longer be simply medicalised, it forces the appreciation that a broader psycho-social, mental health, and public health services approach is necessary to address the variety of cultural, religious and political factors that threaten well-being among these populations.

Finally, the role of expatriate and local mental health professionals in designing and implementing interventions also needs to be defined. Those with specific skills should be properly identified and vetted to provide the best value-added expertise to a community-based approach. They will, thus, provide care where it is most needed. For example, psychiatric practitioners trained in developed countries can play a critical role in training, providing consultation, supervision and specialised care to the most seriously mentally ill. They will provide assessments and evidence-based investigations preferably through a culturally sensitive partnership with the local population, which might include indigenous healers and caregivers.

The community aid will best serve the population by ensuring that treatment for affected individuals improves the capacity of families to attend to basic survival needs, that there are safe places and clear information available and that directed resources advocate for a community-oriented approach and assist in designing programmes that monitor and evaluate its progress.¹¹

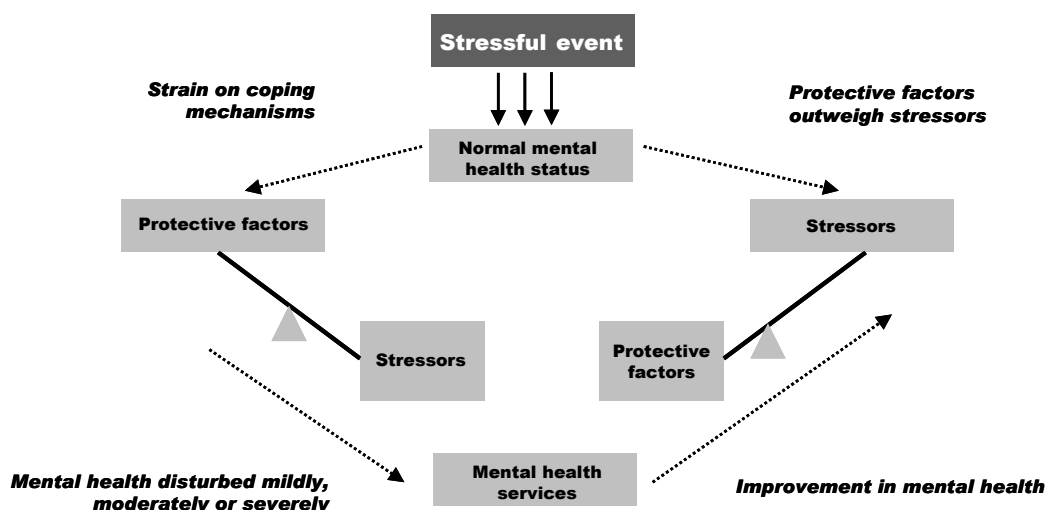
Stressors, protective factors, and mental health disorders in humanitarian emergencies

Introduction to mental health disorders

Mental health care is concerned with normal as well as abnormal reactions to a given situation. One way of looking at mental health is to see the relationship between stressors, protective factors, and mental health problems, as well as the role of mental health services:

- **Stressors** challenge the ability of people and communities to cope.
- **Protective factors** help people continue to cope even at a time of crisis.
- **Mental health disorders** occur when stressors outweigh protective factors.
- **Mental health services** help people with mental health problems to recover and move forward with their lives.

Understanding the four parts to this relationship is essential for planning mental health programmes.

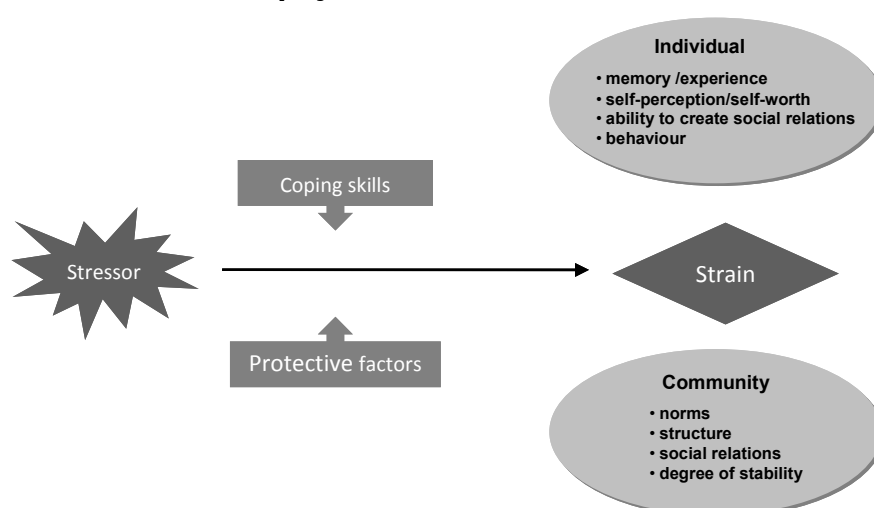


Stressors

Stressors are factors that add to people's stress. Stressors exist in everyday life (e.g., physical injury, a death in the family, or financial problems). They can cause reactions to problems or difficult situations that are positive or negative. Normal and healthy reactions to stress include a temporary dryness of mouth and feelings of fear or worry. The ability to cope with normal stress depends on various factors, including the nature of the stressor, access to social support, and prior level of functioning. If the stressed person is not cared for early or is ignored, it can develop into a serious mental health disorder. This can bring about the break-up of families and entire communities or even suicide.

Stressors in humanitarian emergencies should not be viewed in the same light as stressors in non-emergency situations. Displaced populations experience extreme forms of stressors (particularly in conflict situations). As a result, the behaviour of displaced people can only be partly compared to behaviour of the average non-displaced population. Below is a list of unique stressors that displaced people commonly encounter during a humanitarian emergency:

The psychosocial environment



Displacement

Forced displacement, whether it results from conflict, persecution, violence, or social and political collapse, is one of the most stressful human experiences. Fleeing from war or civil strife is a more common factor in developing countries than displacement due to

natural disasters such as floods or famine. Forced displacement is often associated with multiple and prolonged exposure to three groups of stressors:

- *loss* (of family, homes, possessions, identity),
- *deprivation* (of basic needs, normal life, safety)
- *trauma* (from witnessing or experiencing rape, killing, etc.).

Displaced populations may be at increased risk of illness and deaths. Many deaths can occur due to physical exhaustion after fleeing from danger with only a few resources. Displaced populations may remain in camps for years or may later become refugees in a foreign country. In both situations, people have to adjust to unfamiliar surroundings and to a different way of life. For those who are able to return to their home, the negative changes that may have taken place in their absence (e.g., lost property, different community) can also cause high levels of stress.

Lack of basic needs

War and other major disasters can tear apart a society and deprive people of their means for survival. Farmers are not able to plant their seeds and markets close. People are forced to migrate to places that have little to offer them. Displaced populations in developing countries usually end up in camps or slums that are overcrowded, have poor sanitation, and have limited access to water, food, and health services. As a result, the affected population is exposed to higher risks of malnutrition, disease and death.

The relief response to an emergency situation aims at meeting the basic needs of displaced populations. Once people get the things that sustain life, other needs will appear more important.

It is only after people feel reasonably safe from harm, that belonging to a particular group and gaining self-respect becomes a priority. Some of these needs can only be met after rebuilding the community and resuming a normal life. The following Figure shows:

Maslow's ladder of basic human needs.



Social disruption

Social unrest disrupts the social support network of families and destroys their future hopes. Societies in developing countries are based on relationships within families and communities. People in non-emergency situations help one another to cope with stress. During a humanitarian emergency, chaos often disrupts the everyday rules and social practices of a community. Families can be broken apart by physical separations and by a breakdown in family functioning. Unlike women in refugee camps who retain their role as caretakers of children, men find it difficult to cope when they have no occupation. As a result, spouses may become abusive to one another and children may question moral or cultural values and become more defiant of their parents.

Exposure to violence

The greatest cause of stress is trauma. Forced displacement is often associated with violence, which may be due to political, ethnic or other factors. During social unrest, most people flee when they fear or witness violent acts such as murder, rape, robbery or torture. These experiences may produce long term physical, psychological and social consequences. Some people who are unable to cope may resort to alcohol or other forms of substance abuse. Others may become aggressive and violent. This causes displaced people to look at each other in a less supportive manner. The social order and rules of the community fall apart, and the affected people may continue to sense danger long after they are taken to safety.

Protective factors

Not everyone will respond to a stressful event in the same way. This is as true in extreme situations, such as war, as in everyday life. Protective factors are qualities in a person, or in the surrounding environment that shield a person emotionally and mentally from the full force of a stressful event. The fewer protective factors people have, the more likely they are to develop mental health problems. Knowing what protective factors exist among a displaced population can help agencies select which mental health services should be offered. The first step is to identify those groups or individuals that lack one or more of the following basic protective factors:

Prior level of functioning

People's level of functioning may vary according to their age, sex, personality type, cultural beliefs, etc. Therefore, not everyone comes to a stressful situation with equal abilities to cope mentally and emotionally. People who were having problems functioning before will be especially vulnerable to developing mental health problems during times of widespread violence and social unrest. For example, children who have been living on the streets are easy victims of violence, hunger, and abuse. Identifying such people and helping them cope during the emergency situation should be a priority for any emergency mental health programme.

Social support

The more social support an individual has, the better he or she is able to deal with stress. People separated from their family and community may have a more difficult time coping than people who are surrounded by their family members and community and have immediate access to support following exposure to a stressful event. Not only is being alone stressful, but the events that led to becoming separated from the family and community are often horrific. These people will have an increased risk for developing mental health problems.

Incident 1

A traditional healer said she developed depressive illness after soldiers executed her son and two daughters, leaving her with only one son. She cries all through the night. She is not happy. She is alone with one son, so she (almost) has no one to help her, which makes her unhappy.

Ability to cope

The ability to cope is generally greatest when the first stressful event occurs. As more stressful events occur, the likelihood of developing mental health problems increases. An example is a recovering rape victim. Given proper services, a woman has a reasonable chance of recovering her mental and emotional well being following a rape. However, if a victim is raped a second time, her mental health problems may be far worse than after the first rape. How long a person is exposed to a stressor also affects their ability to cope. For example, the suffering of someone kept in a prisoner of war camp for years may be greater than someone imprisoned for only a few months. In addition, the more intense or

traumatic the stressor is, the worse the emotional and mental health problems will be. Some traumatic events may be more deeply felt and have more long-lasting effects, e.g., torture, watching the slayings of family members, etc.

Emergency mental health services need to identify and reach people who have suffered repeated, prolonged, or extremely stressful events. Among this group could be anyone who has lived for a long time in a war zone.

Moral belief systems

People have an easier time recovering from traumatic events if they believe they are good, loyal members of the community, and if they believe living with their community is still good for them.

But, if they have broken moral codes important to the community, they may be tormented by their actions. Also, people may lose faith in the government if officials betray them or act in violent or immoral ways against its own people. Land may no longer be seen as fit for planting if killings took place there.

Incident 2

A woman told of soldiers throwing her baby into the trees and then telling her to run before they shot her. She ran to save her own life, but several years later, she was still overwhelmed with guilt. She felt that, as a mother, she should not have considered her own life, and told workers she hears her baby crying almost everyday.

Incident 3

A soldier reported being forced to kill a prisoner of war as an act of initiation into a warring group he had been forced to join. Now, he thinks that slitting his own throat would be the only way to rid himself of the guilt he feels.

Moral belief systems are deeply woven into the fabric of daily life. So much so that an outsider can never fully understand it. Local staff will be better able to understand how cultural and religious morals may have been broken. It is only by gaining proper understanding that mental health workers will learn how to help people heal after a breach of their moral belief system.

Return to normalcy

It must be remembered that displaced populations are people whose normal life has been disrupted by an emergency situation. A disruption that seems endless creates additional stress, fear, and lower self esteem. Dependency can develop which destroys the displaced person and his family's natural way of coping and can worsen symptoms of disability, even in extensive emergency health programs. The more quickly an individual is able to return to a structured daily life, the less likely a mental health problem will develop. For people who were forced to leave a community or have lost family members that they never see again, there may be no return to normal routine. The impact of stressors for these people stretch indefinitely into the future.

Mental health programmes should include efforts to help people go back to normal activities as soon as possible. Schools and cultural activities can bring back the feeling of normal life even in a displaced population settlement. Time for play can help children overcome their fears and remember a better time and place, no matter where they are. For women, a chance to talk together can be a comfort and a reminder of an old way of life, even in a prisoner of war camp. Having a chance to farm or work can help a man feel like a husband and father again, even if he is far from home. Repairing a damaged community building or resuming normal activities in a new location can be an external act that leads to healing *inside* a person and a community.

Incident 4

A relief worker who had worked in Uganda told the story of women who had been raped during the fighting. It was seeing their village working again—fields planted, school buildings repaired, homes swept and neat—that gave them the feeling that they would be well again.

Mental health disorders

Surviving a disaster does not necessarily mean that a displaced population can cope with the emergency situation. Whether the negative effects of their experiences subside or become more severe will depend on the availability of psychosocial support. Lack of mental health care for people whose ability to cope with stressors is pushed to its limits, can increase their chances of developing a mental health disorder. Below is a list of the mental health problems commonly seen among displaced populations:

Mild mental disorders in children and adults

Not everyone in an emergency will develop severe mental illness. But the mental and emotional wellbeing of everyone who undergoes sadness and mourning may be affected for varying length of time. Constant feelings of loss or worry may be common, which can lead to depression and anxiety. Mild symptoms of anxiety and depression may be present in a large number of people. Even after the day-to-day life of a village is restored, people will struggle to regain the feelings of trust and safety that once made them feel like a community. These problems can be addressed in many ways, such as community wide programmes like public education, community projects, and cultural rituals and festivals.

Somatisation

Somatisation is present when a person's emotional problems affect how he or she feels physically. For example, anxiety or depression may be expressed as different symptoms, including fatigue, gastrointestinal problems, headache, sexual dysfunction, etc. People with a somatisation disorder believe that a physical illness is causing their health problems. However, the true source of the problem is emotional.

Health workers in Africa report that in conflict zones, patients frequently complain of malaria, headache, and sleeplessness assume there is a physical reason they are not feeling better. They expect medical treatment to cure the problem. However, after taking the patient's history, the health workers note that the symptoms often appeared shortly after the patient had been displaced, exposed to violence, or lost a member of his family. The patient's physical complaints can be stopped without any medical treatment simply by talking to the patient about his ordeal or directing him to an agency that can address other underlying problems and help him function as a member of the community.

Depression

Depression can be defined as intense and prolonged feelings of sadness, tiredness, hopelessness, or lacking interest in normal activities. It may be caused by a feeling of not having control over things that are happening, or by feeling cut off from familiar people and places. Depression is a common reaction in children who are separated from their parents. It is also a common reaction to the loss of family, community, or property.

Depression can also occur in people who are disappointed in themselves for something they have done or not done. Depression sometimes leads to suicide. Some people will take active steps to end their life. Others may take a less obvious approach, such as placing themselves in danger, not taking care of a medical condition, or not eating. It is common to hear stories of people who intentionally provoke a soldier, break curfew, or violate other rules, hoping that someone will kill them. Depression often causes increased irritability and a tendency to lose control more quickly. This seems to be especially true in children. In men and boys, depression may lead to increased aggression. In women, depression may prevent them from caring for themselves or their children.

Behaviour problems in children

When parents lose authority, families can fall apart. Many children will respond to confusion and fright by isolating themselves from others or by misbehaving. Once children have seen their parents lose control over family life, they may no longer be able to trust their parents to take care of them. Problems like bed-wetting, nightmares, clinging, and lack of interest are common among children who are nervous or scared.

Alcohol and drug abuse

People who feel, that life has become too much to bear commonly use alcohol and drugs as an escape. These substances may also be considered a means for dealing with anxiety, depression, or a number of other problems including sleeplessness. An increase in alcohol and drug abuse is common after widespread social unrest. However, substance abuse does not reduce the stress. Instead, it reduces one's ability to cope. Substance abuse over a long time leads to more problems for the individual, the family, and the community.

Psychosis

Psychosis means losing touch with reality. It can range in severity from mild distortions of reality to hearing or seeing things that are not there. People who become psychotic during a humanitarian emergency may have symptoms related to their experience, for example:

- People displaced and caught in fighting may lose touch with the world around them and become convinced they are safe at home.
- Victims of violence may hear screams and see blood long after they have been taken to safety. People who are severely psychotic may be agitated or aggressive. Full recovery from this condition is possible if it is detected and treated early.

Post traumatic stress disorder (PTSD)

Post-traumatic stress disorder (PTSD) is a mental illness in people who have been exposed to severe violence or abuse. People suffering from PTSD have painful memories about the trauma, even when they try to forget what happened. Because they have difficulty in differentiating the real world from the unreal, they always have a feeling of being on guard, ready to run or fight at a moment's notice. People often avoid things that remind them of the trauma as a way to stop the memories from coming back. The merican author, Annie Dillard, uses metaphors to describe memory as follows:

Dillard describes memory as standing beside a stream and those events that are in the present are right before us. As time passes, the events move further down stream, eventually tumbling over the edge of a waterfall out of view, and out of our everyday awareness.

In her description of traumatic memories, Dillard talks about events as hovering at the edge of the waterfall but never tumbling over and out of view; events we remember often no matter how long ago they happened.

Having unpleasant memories that do not fade is the core of post traumatic stress disorder. Individuals who have experienced a traumatic event often talk about how much they try to "forget" but continue to recall the terrible event and suffer the emotional impact all over again.

Incident 5

A woman talked about being raped by soldiers, along with a group of women. Because it was dark, her most vivid recollection was the sound of cloth being ripped as the dresses were torn from the women's bodies. She said even now, several years after the event, if she hears cloth being ripped, it "all comes back to her."

Incident 6

A child reported having trouble staying in school because there was a boy in her class with the same name as the neighbour who had killed her family. She knows, and tells herself all the time, the boy in her class has nothing to do with the killer, but when she hears the teacher call his name, she remembers watching her family die and feels overwhelmed with fear.

If left untreated, PTSD can become part of a person's personality and can prevent them from functioning normally. Children with untreated PTSD often believe they will not live into adulthood. They also may become much more aggressive if the violence they have seen becomes a part of their play and behaviour. For adults and children alike, PTSD can lead to secondary disorders such as depression.

Conclusion on mental health disorders

Mental health disorders can be recognised as signals of severe and persistent stress. One may even fear that displaced populations would be unable to resume normal physical and psychological function after being settled in a more secure and less traumatising setting. The majority of people affected by humanitarian emergencies do have the capacity and ability to cope, with or without external help, and avoid the long-term effects of their negative experiences. There are also reports of displaced people becoming more mature and active within their community than they might have become under normal circumstances. A solution, however, is necessary for the few displaced people who are at risk of developing or actually have depression or other severe mental health disorders. Community-based mental health care is the best solution.

General measures

This section does not intend to provide or recommend detailed programme design and assessment protocols. Assessments are covered at length in the epidemiology chapter of this book. The Inter Agency Standing Committee Guidelines on Mental Health and Psycho-social Support in Emergency Settings¹² and the Sphere handbook⁶ have comprehensive sections on psychosocial and mental health support. However, common guiding principles and strategies for the aid community in developing interventions for populations exposed to extreme stressors include:

- Contingency planning before the acute emergency;
- Assessment and, if possible, base-line studies before intervention;
- Inclusion of long-term development perspectives;
- Collaboration between agencies;
- Provision of treatment in primary care and community settings;
- Access for all in need to services, including for responders in need;
- Training and supervision; and
- Monitoring indicators including project impact.

Initial considerations for assessment and programme development

Culture can be considered, in part, to be a collection of 'coping mechanisms' or behaviours shared by a group of people. These behaviours are learned ways of navigating the world safely and, having been developed and refined over centuries, these behaviours are often recognised as defining a culture and its strengths. Strengths exist within an individual and the social structure within the community. Disasters, especially those resulting in displacement, involve upheaval to the extent that many of these behaviours are no longer appropriate or possible. To assist with supporting pre-existing coping strategies, psycho-social programming in the immediate period after a crisis should include support for and approaches aimed at making as many of these behaviours as

possible appropriate and possible once more. This consists in re-establishing many of the physical and social structures that existed prior to the disaster, including:

- Reconnecting families;
- Reconnecting communities;
- Re-establishing security; and
- Facilitating community motivation, ownership and control of the emergency response.

The psychosocial and mental health response in the immediate post disaster period often emphasises this type of approach. This can include, but is not limited to, the re-establishment of schools, the development of appropriate employment strategies and the reintroduction of social structures that are important to the local population. In addition, a programme of what is commonly referred to as



‘Psychological First Aid’ can be introduced. It is both an assessment strategy as well as an intervention and entails basic, non-intrusive pragmatic care with a focus on listening but not forcing talk, while assessing needs and ensuring that basic needs are met, encouraging but not forcing company from significant others and protecting the affected population from further harm. With this approach, many of the ‘symptoms’ of mental health disorders might be resolved, increasing the likelihood that those who continue to have symptoms have specific disorders that require specific treatment.

In Palestine, a school-based programme has been implemented by the Palestine Red Crescent Society, supported by the Danish Red Cross, the French Red Cross and the Icelandic Red Cross. The programme’s objectives are to enhance the psychosocial well-being of children and their families, to improve the interaction between children, peers and their teachers as well as the interaction between parents and the schools, and to strengthen the social fabric in the communities. The primary beneficiaries of the programme are children in fifth and sixth grades who attend weekly workshops, facilitated by teachers, which aim at reducing the stress and insecurity experienced by the children in their daily life. The children’s parents are an important secondary target group who are sensitised on the reactions of their children and how they might support a healthy child development.

Three indicators are defined for the programme: playfulness, trust and tolerance. In order to document the effects of the programme, children and parents are given at the outset of the school year a self-reporting questionnaire which provides information on each of the three indicators, asking them to rate a number of statements on a scale. This exercise is repeated at the end of the school year where it is complemented by focus group discussions that explore the same issues and provide qualitative data to complement the statistical information. Throughout the school year continuous monitoring takes place by the teachers who run the workshops for children. These various tools provide an excellent opportunity to follow both the progress of implementation and the qualitative changes that are seen from the programme.

Mental health assessment, monitoring and evaluation

The development of a locally and culturally valid, evidence-based intervention programme begins with the assessment of the existing mental health and psycho-social strategies and their capacity and capability to function in a crisis situation. Assessments should use standardised approaches which are discussed in the epidemiology chapter of this book and must be easily applied by relief organisations. The authors begin mental health assessments with a *qualitative* study of the target population in order to understand local perceptions of problems and resources. This information is necessary in order to select which problems to address, to design both accurate assessment tools and feasible interventions. Using qualitative methods in this way increases the likelihood that interventions will be both feasible and effective as well as increasing the accuracy and appropriateness of assessment tools. The qualitative data informs the development and adaptation of indicators for identifying people with psycho-social and mental health problems, indicators for evaluating the effectiveness of programming to address these problems and information for the adaptation of interventions to ensure local appropriateness. From the beginning of the programme's design, its monitoring and evaluation, qualitative data gathered from the community is used specifically to guide a crisis monitoring and evaluation workshop to:

- Train those involved in mental health programmes how to design programmes around goals;
- Train in designing indicators (see programme indicator section below); and
- Use these skills collaboratively to design the project with aid community staff.

Making contacts with the affected community

In developing countries, most people in rural communities associate with people they know well. Observing traditions and customs is highly valued. Bringing in outsiders to create and deliver a mental health programme can create communication barriers between staff members and the people they want to help. Any mental health programme that is introduced to a community as part of emergency relief services needs to first link with the affected community. A top priority of the incoming programme officers should be to identify and consult with community leaders, to seek their advice, and to make sure they participate in decision-making throughout the life of the project.

Measuring need and resources

A multi-sectoral assessment team, which includes members of the displaced population, can be organised to gather the priority information for setting up a mental health program. Carrying out a mental health assessment helps to identify the unmet physical and psychosocial needs as well as to reassure displaced people that they are under caring, concerned and competent emergency service providers. Areas to assess include the ability of the displaced individuals to do what they need to do everyday and to assume an active social role in the community. Efforts should be made to carefully adapt any assessment checklist or survey brought in from the outside to assess the people being served. The following checklist may be used for a mental health assessment only after being adapted to the local situation:

Background on disaster: <ul style="list-style-type: none"> ■ Demographic profile — total population, number of men, women, children, elderly. ■ Disaster experiences — pre-flight, flight, camp, etc. ■ Population characteristics — language, religion, rural or urban culture, level of education. 	Mental health symptoms: <ul style="list-style-type: none"> ■ Physical — fatigue, headache, aches and pains, etc. ■ Emotional — feeling sad, hopeless, anxious, lack of interest ■ Behavioural — alcoholism, drug abuse, aggression ■ Difficulty in recognising real from unreal
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<p>Health status:</p> <ul style="list-style-type: none"> ■ Common causes of deaths (serious injury, disease) ■ Common causes of illness (serious injury, disease) ■ Nutritional status and micro-nutrient deficiencies <p>Trauma events (experienced, witnessed, or heard about):</p> <ul style="list-style-type: none"> ■ Rape or sexual abuse ■ Torture or isolation ■ Unnatural death or murder of family or friend ■ Forced family separations ■ Lost or kidnapped ■ Any other frightening event 	<p>events, frequent, painful memories of past events</p> <p>Resources available:</p> <ul style="list-style-type: none"> ■ Local services: PHC, schools, mental health care ■ Social support network (family, peers, neighbours) ■ Community services: traditional healing, religious or traditional ceremonies ■ Technical resources of mental health and social workers, drugs, and health services ■ National curriculum on mental health training ■ National policy on mental health care
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In addition to the above information, special surveys should be carried out. These surveys are listed and are discussed in detail below.

- Identify local beliefs and customs about mental illness.**
- Screen the general population and identify those with mental health problems.**
- Individual evaluation of anyone identified as having a mental health problem.**

a) Identify local beliefs and customs about mental illness

It is important to identify local terms and traditional beliefs about the causes of mental health problems. This will help identify coping behaviour and the resources available locally for mental health care. The displaced people classified mental illness into two categories — *traditional illnesses* and *illnesses from God*.

Traditional illnesses were defined as those due to evil intent of the living (e.g., witchcraft), bad spirits, or the dead. These illnesses are not recognised by western medicine and cannot be treated by them unlike illnesses from God. In fact, an important way of diagnosing traditional illnesses is for a doctor not to find anything wrong with the patient. Most of what developed countries describe as mental illness falls into the traditional illness category and is, therefore, often ignored by clinics and hospitals.

b) Screen the general population

Because individual screening is not practical for a large displaced population, it will be necessary to first identify people that have the greatest difficulty functioning. There are various ways of collecting this information including carrying out interviews, focus group discussions, surveys. The following sources of information may be approached:

- **Community health workers**—to identify individuals with frequent physical symptoms, e.g., headache, gastrointestinal disorders, respiratory symptoms, etc.
- **Health workers**—to identify cases of attempted suicide or other illness of uncertain cause.
- **Social services workers**—to identify and assist individuals who cannot function, e.g., mothers neglecting their children, families with reported domestic violence, etc.
- **Field officers/Camp officials**—they may have access to a wide range of information about the health and well-being of a displaced population in a settlement.
- **Community leaders/officials**—they are often aware of families and individuals facing more difficulties than others in the community, e.g., substance abuse, malnutrition, etc.
- **Family system**—family members often endure common stressors. Ask parents to identify troubled children and then investigate the whole family.
- **Traditional health care providers**—they may report on those who visit them most frequently or have major health problems.

- **School teachers** (in formal or indigenous schools)—to identify children and adolescents who have problems paying attention or are withdrawn.

c) Individual Evaluation

Every person suspected of having a mental health problem through the general screening should be referred to the health facility for an individual mental health evaluation. This will help identify the nature of the problem and determine the effects of the emergency experiences. Standard evaluation instruments may be used, which allow an individual to disclose more about his/her psychological state and trauma experiences than they might otherwise do.

Programme indicators

Indicators to monitor a programme's process, satisfaction and outcomes should be defined for each objective or activity. The Inter-Agency Standing Committee on Mental Health and Psychosocial support in emergency settings has created guidelines that include sample process indicators for each of a series of activities.² Generally, the key psychological and psychiatric functional indicators based on Sphere standards for interventions are:

- Individuals after experiencing acute mental health distress after exposure to traumatic stressors must have access to psychological first aid at health services facilities and in the community;
- Care for urgent psychiatric complaints must be made available through the primary health care system;
- Individuals with pre-existing psychiatric disorders must continue to receive relevant treatment. Harmful and sudden discontinuation of medications must be avoided. Patients' basic needs in custodial psychiatric hospitals must be addressed; and
- If the crisis becomes protracted, plans must be initiated to provide a more comprehensive range of community-based psychological interventions for the post-crisis phase.

In many situations ethnographically informed quantitative measures will have to be generated for each programme because cultural and context specific issues can vary widely across crises. When possible, indicators should cover macro-level factors (e.g. economic opportunities, social capital and human rights violations), individual-level factors (e.g. mental health symptoms, disabilities and differences in targeted behaviour) and access to and availability of psycho-social and mental health resources. Indicators should encompass data collected at multiple levels of programming and include access to services (culturally-based and those being provided by international NGOs), aspects of programme implementation and daily functioning of beneficiaries.

Programme monitoring and evaluation

Programme monitoring is focused on implementing and analysing programme process indicators which assess whether the programme is implemented as planned and identify if it can maintain its *quality*. On the other hand, programme evaluation should focus on the programme's impact including its goals. While this approach is important, it has its limitations because it does not consider the potential for the programme's unexpected positive and negative effects. A brief qualitative study conducted after a programme is completed will be useful to identify the unexpected outcomes from the perspective of the programme's participants. This process can be used further in progress reports and briefings where comparison data, based on questions asked at baseline and after the intervention is complete, provide a measure of change from pre- to post-intervention.

Evaluating the programme after it has begun can help ensure that the programme stays on course and that objectives are being met. The following table highlights information that may be useful for evaluating a mental health programme.

1. What were the objectives of the programme? To what extent were they achieved?
2. Was the strategy valid, appropriate, and adequate?
3. How was the programme started, organised, and run? Was the organisation and decision-making favourable for achieving the objectives?
4. Did the programme help the growth of new links and networks between different communities and with concerned agencies?
5. What were the benefits of the programme? Who was supposed to benefit and who actually did benefit?
6. What effect did the programme have on the affected community's coping mechanisms for their situation?
7. Did the programme foster or damage these coping mechanisms? Was dependency created?
8. What effect did the programme have on the social processes in terms of how things got done in the affected community?
9. What effect did the programme have on the ways in which the affected community interact?
10. What effect did the programme have on the ways in which groups of the community participate in public life?

Risk factors and intervention strategies

This section presents information about risk factors that not only increase the likelihood of individuals and populations developing psycho-social and mental health problems but also compound the problems for those with pre-existing problems. Intervention strategies will be presented that focus on the three important subpopulations mentioned at the beginning of the chapter.

Risk factors

Various factors increase the risk of developing new and also compounding both new and old problems that already exist among populations exposed to severe stress. These factors include, but are not limited to:

- Poor health and nutrition;
- Suboptimum prenatal care and increased risk of birth injuries;
- Separation from family and caregivers;
- Neglect and under-stimulation of children;
- Exposure to chronic communicable diseases that affect the brain;
- Risk of traumatic epilepsy; and
- Exposure to extreme and repeated stress.

Furthermore, conditions provoked by disasters, conflict, displacement or prolonged vulnerabilities often place those with pre-existing problems at greater risk of:

- Abuse, including gross dereliction, stigma, ostracism, sexual violence;
- Child abduction, youth violence and death;
- Family separation and displacement;
- Neglect or abandonment by family and caretakers;

- Exploitation;
- Destruction of supportive institutions and services including psychiatric facilities and medications;
- Life threatening physical illnesses and suicide;
- Conditions that foment hatred and revenge; and
- Unremitting conditions that lead to worsening disability and premature death, especially among the elderly.



The behaviour of neglected and abused mentally ill people in an emergency or post-disaster setting can lead to an erosive impact on displaced communities' already fragile social fabric.

Interventions

Immediate psycho-social interventions should focus on supporting public health activities to reduce mortality and morbidity, to mitigate the community's burden from having to manage the seriously mentally ill who need specialised psychiatric care and to help mobilise community-based resiliency and adaptation to new circumstances that affect people in an emergency. Initial research indicates that these immediate interventions might mitigate more serious mental illness in a large proportion of the affected population.

In Pakistan, following the earthquake in October 2005, a massive humanitarian intervention was launched aiming to reduce the immense suffering experienced by the population. With over 80,000 dead and several hundred thousand people displaced, this was an immense challenge, bearing in mind that the area in which the earthquake hit was remote and mountainous, making access a crucial issue. In order to ensure a coordinated approach to addressing both physical and emotional wounds that were evident, a unified approach was set in motion, in which the International Federation, the French and Danish Red Cross collaborated to organise outreach medical teams that could cover a large geographical area as well as provide a comprehensive response in terms of targeting needs in the areas of physical and mental health, water and sanitation and community-based first aid. Such emergency interventions pave the way for a sustainable and long-lasting return to normal life by addressing the needs in the local settings in which people live.

Photo: International Federation

Disabling psychiatric illnesses

Pre-existing psychoses and severe mood disorders which include the DSM-IV defined diagnoses of major depression and bipolar disease cause considerable disability in every culture worldwide. How these disorders are conceptualised, recognised and managed across cultures and in a conflict or post-conflict situation might differ considerably. While it may be possible to diagnose pre-existing psychotic disorders after a crisis event, providing sustained and effective treatment can be difficult. This places considerable stress on families whose members have severe illness and might exacerbate the present stress on the camp population especially if there is any disruptive behaviour within the camp. For pre-existing anxiety and mood disorders, it is often impossible to distinguish the symptoms of these disorders from normal responses to an overwhelming crisis event.

While emergency health services usually do not have many mental health personnel at all including psychiatrists, there is some promise in programmes that have used local

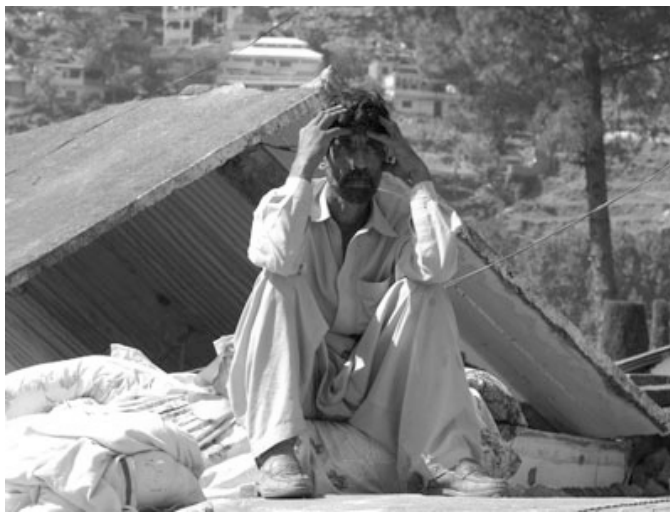
psychiatric nurses and community volunteers to provide services. Whenever possible, psychiatric interventions should be included as part of the established primary healthcare system, but even these resources might be severely lacking.

For the severely mentally ill, the impact of treatment is often dramatic with the reintroduction of antipsychotic medications and supportive community follow-up which can also include rehabilitation within traditional family structures. In camps, community volunteers can provide outreach services, family education, support and links to other agencies that can assist with rehabilitation.

It must be acknowledged that newer psychotropic medications, particularly those that are often familiar to foreign aid workers with experience in psychiatric treatment, are both scarce and prohibitively expensive. Aid workers, however, must advocate for what is best for the populations they are working with and co-ordinate all requirements with the ability of local healthcare workers to sustain any medications from outside resources.

Severe psychological reactions to trauma

Researchers talk of the 'power of displacement,' the cultural shock of which can cause cognitive and emotional disorganisation in a population. This is often catalysed by a degree of 'experienced brutality,' which, because of the fear of possible reprisal and stigma, might not be easily or readily recognised by healthcare workers. Beyond the physical suffering that occurs, displaced people are deprived of their



livelihoods and often suffer a loss of identity, purpose and community. Displacement camps are frequently overcrowded, poorly designed and poorly serviced. When war and conflict damage traditional ways of life, cultural and individual bereavement can be key determinants of psycho-logical distress. It is common for a population after experiencing success in ethnically relevant community programmes aimed at the severely mentally ill to see the same programmes have a sudden increase in people presenting themselves with acute trauma related symptoms. This suggests that the initial barriers of stigma and suspicion tend to decrease with time.

Options for programming include both community-based interventions and more conventional 'western-oriented' one-to-one therapies. Identifying the local population's problems and needs will assist the decision about which direction to focus on. Mental health problems common to populations without a history of pre-existing mental illness but with a history of trauma exposure and problems particularly experienced by children and adolescents include several of the psychiatric diagnoses defined in the DSM-IV:

- Situational depression and major depressive disorder;
- Drug and alcohol abuse;
- Somatisation;
- Anxiety;
- Post-traumatic Stress Disorder (PTSD); and
- Co-morbidity of depression and post-traumatic stress disorder.

Historically, researchers and health care providers have assumed that, given the experience of trauma, high rates of post-traumatic stress disorder in the population would naturally be present. The claims of large populations experiencing post-traumatic stress disorder have only limited evidence: research is showing that only a minority of those exposed to mass violence suffer from this disorder; numbers vary from 4% to 20%. A

*A survivor from Balakot sits on a collapsed roof looking at the destruction around him.
Photo: Till Mayer / International Federation*

purely medical model of intervention that focuses on post-traumatic stress disorder to the exclusion of other diagnoses is, therefore, problematic because it might fail to address other problems present in the population. Epidemiological evidence, however, indicates that symptoms commonly associated with both post-traumatic stress disorder and depression have been identified in most cultures that have been investigated. Ethnographic assessments have determined that just having a language for relevant symptoms helps communities be able to identify individuals suffering from these disorders.

Temporary psychosocial and/or behavioural problems

There is a natural overlap of those with temporary psychosocial and behavioural problems and those who have severe psychological reactions to trauma. However the complaints presenting in those suffering from only temporary psychosocial problems generally differ in degree and often demonstrate a greater ability to cope and adapt. For this population, when culture and community cohesiveness determines, generally, how war, trauma and displacement are experienced and coped with, programmatic emphasis can be placed on community-based programmes which focus on ‘strengthening family and kinship ties, promoting indigenous healing methods, facilitating community participation in decision-making, fostering leadership structures, and re-establishing spiritual, religious, social, and cultural institutions and practices that restore a framework of cohesion and purpose for the whole community.’⁴ The goal of programmes for this population is to encourage and strengthen the population’s pre-existing coping and adaptive capacities. Strategies could also be developed that reduce stress and encourage normal activities and active participation of those who have been displaced. Examples are:

- Establishing cultural and religious events, including funeral ceremonies and grieving rituals that involve spiritual and religious practitioners;
- Restarting formal or informal schooling and recreational activities;
- Promoting adult and adolescent participation in relief activities, especially those that facilitate the inclusion of social networks of people without families;
- Organising community-based self-help support groups that are especially focused on problem-sharing, brainstorming for solutions, effective ways of coping, mutual emotional support and community-level initiatives; and
- Economic redevelopment initiatives such as micro credit or income-generating activities.

3. Setting goals and objectives

It is important to set goals and objectives of an emergency mental health programme to provide a basis for all activities as well as for evaluating the program’s success. Below are examples of **goals** that may be appropriate:

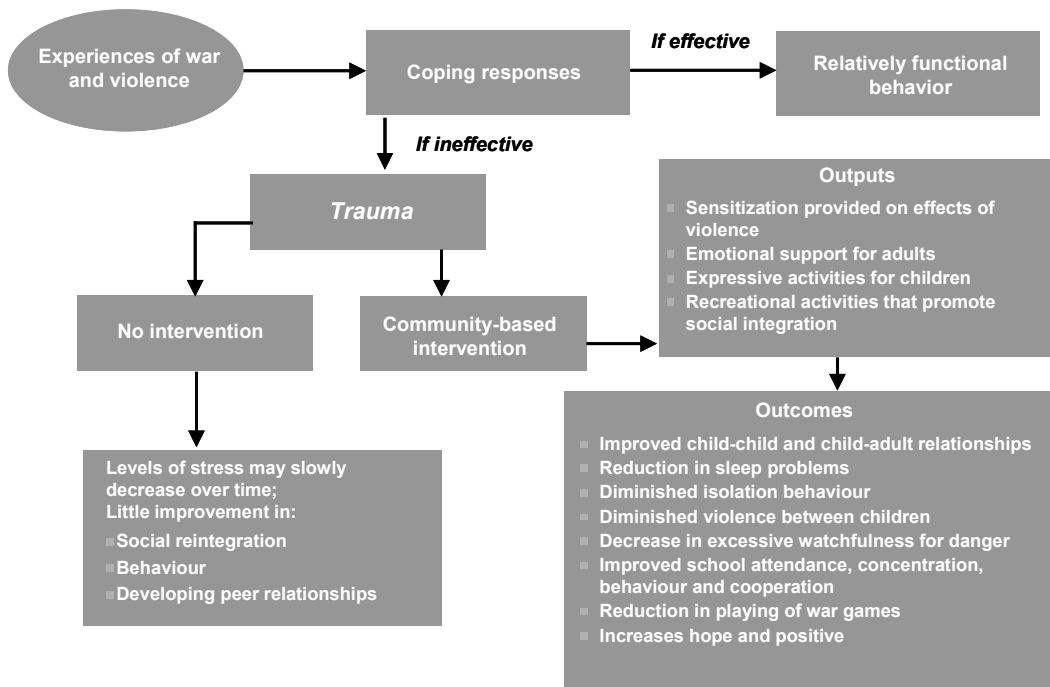
- to restore normal functioning among the affected population,
- to relieve and alleviate stress and psychological suffering resulting from the emergency situation,
- Immediate and long-term **objectives** should be defined that can help achieve the goals that have been set. Objectives are useful for monitoring the effectiveness of the program.

Below is a list of possible objectives:

- to help the people in the affected community understand the current situation and their options,
- to increase awareness about normal and abnormal reactions to stress,
- to mobilise social support within the community,
- to reinforce normal coping mechanisms,
- to identify those individuals who are unable to cope,
- to offer support to those who cannot cope with the current situation,

- to effectively prevent milder mental health problems from becoming long-lasting mental health disorders,
- to reduce the need for medical treatment in somatisation disorders.

Psychosocial responses and action



4. Developing the right approach

Emergency mental health programmes differ from traditional mental health care systems in terms of who benefits and how services are provided.

During the *acute emergency stage*, most relief agencies focus on providing basic needs such as food, water, sanitation, health care and shelter. Because most of the survivors appear to cope, establishing an emergency mental health programme may not be a priority at this stage. However, mental health needs, can still be addressed in a general way, to prevent long-term consequences. The following measures may be adequate:

- Reinforcing normal everyday routines, such as fetching water and cooking.
- Encouraging the population to form communities.
- Linking vulnerable groups such as children, women, or the elderly to existing services and resources.

During the *post-emergency stage*, some degree of social order and daily routine may have become established among the affected population. Having adequate family support under these circumstances can help most displaced people to recover over time, without need for emergency mental health services. However, certain people, because of their individual characteristics or exposure to more stressors, may experience persisting mental health problems. These individuals should be evaluated to determine the appropriate level of mental health services they need to help them achieve the reconstruction phase.

5. Working toward a sustainable programme

Ways of sustaining a programme should be determined at every step of programme planning. Displaced people may suffer from mental health problems for years after the emergency is over. Many people continue to suffer long after the relief agencies pull out from the program, and the effects can be felt well into future generations. Even though there is much sympathy for these problems, resources for promoting mental health care

for displaced populations are extremely limited. Therefore, the design of the programme should not be too ambitious and planners should develop cost-effective ways of complementing the program, which focus mainly on local resources and volunteers. From the start, relief agencies must decide how long they are going to support mental health services.

Well-established mental health services may not be suitable for relief programmes that are supported for two years or less. Programmes that intend to go on longer should have a well-developed plan in place that shows how the programme will continue both financially and administratively.

It is important to gain the support of the local health system, locally-based relief groups, and any NGOs. Externally supported mental health programmes often bring resources that local health care systems lack, such as transportation, and technical and financial support. Below is a list of the benefits from mental health programmes that link with local health care systems:

- . gaining the co-operation of all health care providers,
- . increasing likelihood of being able to educate general health care providers about mental health. This increases the network of individuals who can provide services.
- . more easily overcoming misgivings and misunderstandings the local community may have about mental health services.

6. Train the trainers model

A word of caution may be in order for programmes that are considering a “train the trainers” model. This model is built on the idea that the number of service providers can be greatly expanded when each newly trained and third generation of trainees. The quality of the overall programme deteriorate worker trains a new group of workers, and so on. While this model sounds good in theory, in practice there is often no quality control over the secos rapidly.

Selecting mental health services

A basic building block of any mental health programme is choosing the types of services to be provided. The best choice depends on the needs and traditions of the people being served, and the resources available. The following services have been included in existing mental health programmes:

General measures

Most of the mental health problems (e.g., somatisation, mild mental health disorders, behaviour problems) can be managed through simple, measures that target the entire displaced community, for example:

1. Aiding people to resume normal cultural practices

Every individual, family, and group has some social practices or rituals they engage in to heal themselves. For some, it is prayer. For others, it may be getting together with others to eat, dance, or sing. Sometimes healing for the society as a whole can begin through national holidays, the media, or installing leaders who will bring peace.

In humanitarian emergency situations, individuals, families, and communities may lose touch with the rituals they rely on to cope with hardship and tragedy of everyday life. Displaced people should have the freedom and opportunity to practice their customs, beliefs, and traditions according to their culture. Mental health programmes working through cultural leaders can build on the strengths of a community by taking active steps to reintroduce cultural practices into everyday life. For many affected people, this type of support may be enough to help them cope with any mental or emotional problems they are having.

2. Educating the community

When people are educated about health and disease they are able to take better care of themselves. So, by making people aware of mental health problems, they are able to tolerate their negative reactions to the emergency situation and cope better. In addition, the stigma of seeking mental health care will be overcome and they will be more willing to accept services. Programmes can spread information in several ways:

- through the media, by putting educational programmes on the radio or in the newspapers
- by making leaders from the affected community aware of common mental health problems
- by giving additional training on mental health to health workers and social workers
- by training local staff about mental health problems so that they can educate other support groups

3. Linking people with other services

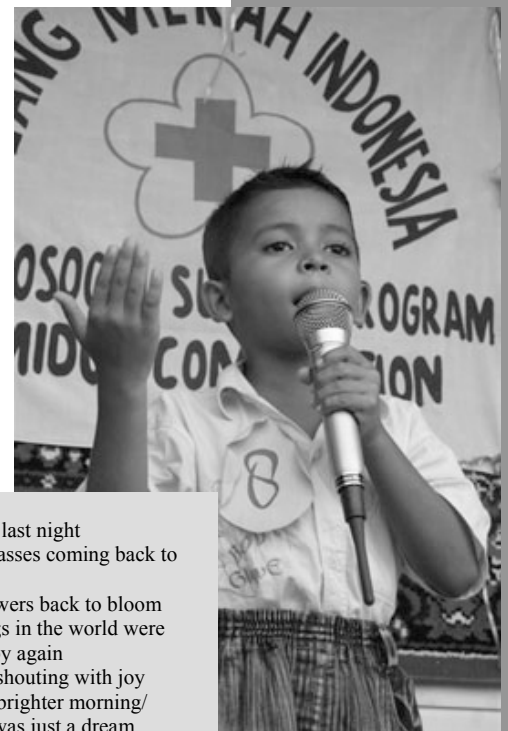
Displaced people often need food, shelter, and health care, as well as non-emergency social services. For the affected population to fully benefit from a mental health program, relief workers must pay attention to the people's material needs as well as their emotional needs. Linking people with other essential services can help them take the first steps toward regaining their health and normal routines.

In addition, relief agencies and the host community should help the affected people find opportunities for meaningful work. This includes involving the displaced people in delivering relief services as much as possible.

The following table identifies some of the needs of displaced people. Even though some needs may be of a non-emergency nature, meeting these non-emergency needs will help them cope better with their situation.

Summary

This chapter is aimed at providing guidance to the community supplying aid to address the psycho-social and mental health needs of populations exposed to crisis events. The humanitarian community's challenge is supporting the community within the displacement camp or damaged areas and shouldering the burden of reintegration and eventual reconciliation. The humanitarian agencies and organisations usually have limited resources and are faced with disaster affected populations whose needs are overwhelming. Unfortunately, many of the psychosocial and mental health interventions promoted over the last three decades are not based on sound scientific evidence or best practices. This is partly a result of the lack of appropriate assessment tools for evaluating the impact of these programmes as well as a result of a lack of evaluation standards. What is emerging however is that psycho-social and mental health services need to be provided through both primary health care and community settings. It is encouraging that more evidence-based studies are emerging that can direct programme design, monitoring and evaluation and that can serve as future templates with which psychosocial and mental health indices can be developed and tested.



"I had a dream last night
I saw all the grasses coming back to green
And all the flowers back to bloom
All living things in the world were becoming happy again
Everyone was shouting with joy
To welcome a brighter morning/
But all of this was just a dream
That will never come true
All the disasters,
The earthquake and tsunami
They have destroyed my dreams
Will my dreams ever come true again?"

One of hundreds of great singers who have performed in Pelang Merah Indonesia.