

# Chapter 1

## Introduction

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Most lives, injury, displacement, and damage to property resulting from disasters present major challenges for individuals and society at large. These events disrupt and place additional burdens on public and private institutions that provide services. The ability of individuals to cope in the aftermath of a disaster depends largely on their resources and capacities. Problems that an individual faced prior to a disaster, whether psychological or social in nature, can be exacerbated by the chaos following an event.

This chapter addresses the nature of psychological or social problems in the aftermath of disasters and gives an overview of support mechanisms for dealing with these challenges.

### Impact of disasters on the health sector

Disasters resulting from natural and manmade hazards have a twofold impact on health systems: directly, through damage to the infrastructure and health facilities and the consequent interruption of services at a time when they are most needed, and indirectly, by potentially causing an unexpected number of casualties, injuries, and illnesses in affected communities (1).

Caribbean countries are at risk for multiple natural hazards, including seismic activity, hurricanes, and floods, as well as human-caused hazards. The Soufriere Hills volcano in Montserrat is the most active in the region. In 1995, it caused widespread damage, destroying the capital city of Plymouth. The January 2010 earthquake in Haiti was devastating in terms of the number of lives lost, serious injuries, and devastation to housing and infrastructure. In the health sector alone, more than 50 hospitals and health centers collapsed or were left unusable (2).

Hurricanes represent the single most important and recurrent hazard in the region. The direct impact of hurricanes can impede development dramatically. Economic losses from Hurricane Ivan (2004) in Grenada, for example, accounted for more than twice that nation's GDP. The health sector in Saint Lucia was impacted to the tune of EC\$8.3 million by Hurricane Tomas in 2010. A number of hospitals were damaged, particularly Dennery Hospital,

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which accounted for half of the cost of the impact to the health sector when it had to be relocated (3).

Given the proximity of the countries and territories in the Caribbean, it is likely that more than one will be affected by the same hurricane. Due to the small size of the islands, it is equally very possible that an entire country will be affected by any one disaster.

In September 1998, the ten-day journey of Hurricane Georges through the Caribbean left widespread destruction throughout many of the islands. One of the worst affected countries was Saint Kitts and Nevis. The National Disaster Office estimated that 80%–85% of the houses on Saint Kitts were partially or completely destroyed. The Joseph N. France General Hospital in Saint Kitts, a 174-bed facility, and the only hospital on the island serving a population of 33,000, lost 90% of its services.

## Mental health and psychosocial support in disasters

In their *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (4), the U.N. Inter-Agency Standing Committee (IASC) defines mental health as follows: “The composite term mental health and psychosocial support ... describe[s] any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder.” The two terms—mental health and psychosocial support—are highly interconnected, with one or the other having a predominant role during different phases of a disaster.

Significant problems of a predominantly social nature include (5, pg. 2):

- ◆ “Pre-existing (pre-emergency) social problems (e.g., extreme poverty, belonging to a group that is discriminated against or marginalized, and political oppression);
- ◆ “Emergency-induced social problems (e.g., family separation, disruption of social networks, destruction of community structures, resources and trust, increased gender-based violence) or a lack of food and water and shelter;
- ◆ “Humanitarian aid-induced social problems (e.g., undermining of community structures or traditional support mechanisms)”.

Similarly, problems of a predominantly psychological nature include:

- ◆ “Pre-existing problems (e.g., severe mental disorder; alcohol abuse);
- ◆ “Emergency-induced problems (e.g., grief, non-pathological distress, depression, and anxiety disorders, including post-traumatic stress disorder [PTSD]);
- ◆ “Humanitarian aid-related problems (e.g., anxiety due to lack of information about food distribution).”

Thus, mental health and psychosocial problems in emergencies encompass far more than the experience of PTSD or disaster-induced depression. A selective focus on these two problems is inappropriate because it overlooks many other mental health and psychosocial problems in emergencies and ignores people’s traditional resources and support systems.

It is important to note that not all of the population affected by a disaster will encounter psychological problems. In general terms, a study carried out by WHO (6) shows that in emergency situations, there is an increase, on average, of 1% of people with severe mental disorders (e.g., psychosis and severely disabling presentations of mood and anxiety disorders) above an estimated baseline of 2%–3%. Additionally, there is an increase of 5%–10% of people with mild or moderate mental disorders (including mood and anxiety disorders, such as post-traumatic stress disorder) above an estimated baseline of 10%. Most of the persons in this second category will recover naturally, over time. Although these figures are estimates based on available studies, they do offer an idea of what might be expected in a population affected by a disaster.

## Coordination of mental health services and psychosocial support

In normal circumstances, providing mental health services and psychosocial support implies working with the health sector as well as other sectors: social, education, justice, and civil society, among others. These sectors play an important role in the direct provision of services, as well as in the development of mental knowledge and tools.

In large-scale emergencies, health sector agencies directly involved in mental health and psychosocial support are limited and in many countries, most of the psychosocial support activities may be conducted by agencies outside the health sector. Therefore, coordination among all the actors/agencies involved becomes a priority. This is particularly relevant in major natural disasters or complex emergencies, where the number of national and international organizations may be very high.

As part of the Humanitarian Reform of the United Nations, in 2005 the Inter-Agency Standing Committee developed a new approach – the cluster approach – as a way of organizing coordination and cooperation among humanitarian actors into sectors. The cluster mechanism was adopted to improve the efficiency and effectiveness of humanitarian response in crisis; to increase predictability and accountability in all main sectors of the international humanitarian response; to ensure that gaps in response do not go unaddressed (7). As stated in the IASC guidelines, while a specific cluster is not assigned to mental health and psychosocial support, the following clusters may be relevant to work in this area: Camp Coordination and Camp Management; Early Recovery; Education; Emergency Shelter; Health; Nutrition; Protection; and Water, Hygiene and Sanitation.

Box 1.1 presents a summary of the recommendations for coordination of mental health and psychosocial support (MHPSS).



**Box 1.1**

**IASC Guidelines for coordination of MHPSS activities in major disasters** (3, pg. 10)

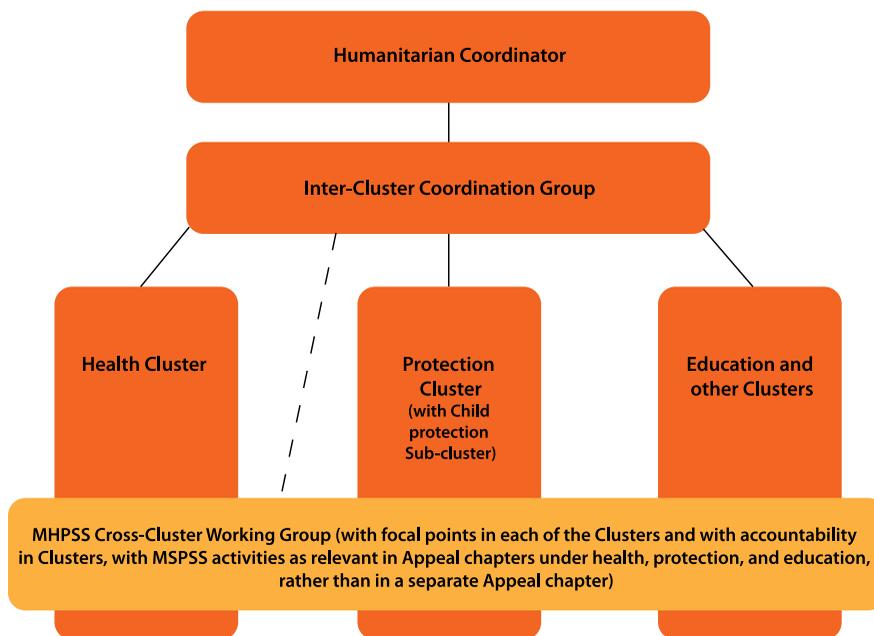
“MHPSS involves activities that need to be discussed and integrated within relevant cluster/sector work plans, as they are core components of core clusters/sectors (e.g. Health, Protection and Education). Accountability for MHPSS activities lies within the relevant Clusters. It is important to include MHPSS projects in relevant chapters (Health, Protection and Education) of Flash or CAP Appeal documents. Such documents should not have a separate MHPSS chapter. MHPSS should not be established as a separate Cluster.

“The IASC Guidelines recommend establishing a single, intersectoral MHPSS coordination group, with terms of references, and in which many MHPSS actors are present. Key inter-cluster operational issues should be addressed by the Inter-Cluster Coordination Group, where it exists. When few MHPSS actors are present, an intersectoral MHPSS coordination group may not be appropriate. In that case, it is important to organize regular meetings among MHPSS actors from different sectors or to establish a system of MHPSS focal points from within the various relevant clusters/sectors, who meet regularly.

“The MHPSS coordination group should work with all relevant clusters/sectors to ensure that their activities are conducted in a way that promotes mental health and psychosocial well being.”

In large-scale or complex emergencies when the inter-cluster coordination mechanism is activated, the model shown in Figure 1.1 is suggested. According to this model, MHPSS should have focal points in each cluster involved that provides MHPSS to report and provide feedback to and from specialized sectors and MHPSS.

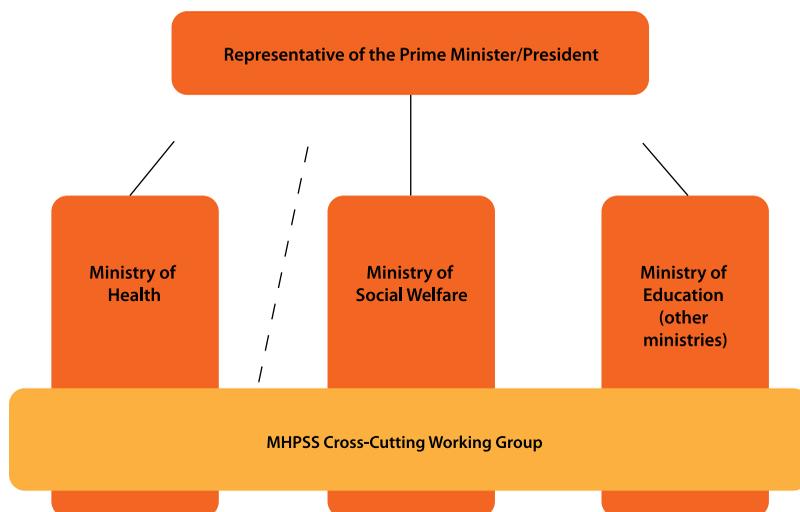
**Figure 1.1. Model for coordinating MHPSS in large-scale disasters**



Source: Adapted with permission from IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know? Geneva, IASC, 2010 (5).

Most disasters in the Caribbean are not considered complex emergencies. However, although fewer actors may be involved, the need for coordination is extremely important. In most countries the ministry of health leads the mental health and psychosocial coordination efforts, involving actors from other ministries (social, education, local government) as well as non-governmental agencies (see Figure 1.2).

**Figure 1.2. Model for coordinating MHPSS in smaller scale disasters**



## Disasters are an opportunity to develop or strengthen mental health systems

Disasters often present windows of opportunity, and in these situations, the attention and support that a country receives can help to develop and/or strengthen existing mental health systems. In order to improve the effectiveness and sustainability of activities, it is important to have a medium- to long-term vision when planning and implementing interventions.

The *IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings* (5, pp. 22-29) offer a detailed list of initiatives that should take place as part of the post-emergency recovery process. The following initiatives are recommended for the health sector:

- ◆ Initiate updating of national mental health policy and legislation, as appropriate.
- ◆ Make mental health care available to a broad range of emergency-related and pre-existing mental disorders through general health care and community-based mental health services.
- ◆ Work to ensure the sustainability of any newly established mental health services.
- ◆ For people in psychiatric institutions, facilitate community-based care and appropriate alternative living arrangements” (5, pg. 17).

Examples exist in which the initiatives aimed at consolidating or strengthening a mental health system, were an outgrowth of activities initiated in the response to a disaster. As described in IASC Guidelines for Humanitarian Actors: “Reports from Albania, China, Indonesia, Jordan, Iraq, Kosovo, Macedonia, the occupied Palestinian territory, Peru, Sri Lanka and Timor-Leste show how an emergency can lead to the long-term development of sustainable mental health care.” The aftermath of the earthquake in Haiti, and the cholera outbreak later in 2010, also demonstrate how the post-disaster period can be right time to plan for change in existing systems. As pointed out by Z. Abaakouk (see Box 1.2), shortly after the earthquake, “the Ministry of Health and key stakeholders discussed the future model of mental health for Haiti. The intention was to use the expertise and funds present in the aftermath of the disaster to build a sustainable mental health system that will remain once international actors leave the country.”

Key interventions that can help to establish or strengthen a sustainable mental health system should be taken into account, starting in the immediate post-disaster phase:

- ◆ Development or updating of the mental health policy and plan to ensure a long-term vision of strengthening the mental health system in the country. While a post-emergency response to mental health and psychosocial needs is being offered, representatives from international organizations that intend to provide support to the country for longer periods of time should meet with officials from the ministry of health and a group of national stakeholders for the elaboration or revision of the policy and plan that considers a human rights perspective.
- ◆ Development of community-based mental health services to include psychiatric units in general hospitals and designating health facilities to be used for community-based mental health day services that would be built or renovated as part of the reconstruction process. It is important to avoid the concentration of efforts and resources (financial and human) for a country’s mental health system in tertiary level institutions (psychiatric hospitals being the most common).
- ◆ Training community-based mental health professionals is particularly relevant in cases where the only or the most significant service has been a psychiatric institution. Professionals that provide mental health and psychosocial support will need updated training and development of skills to facilitate their work in community settings.
- ◆ Ensure inclusion of a mental health component in training programs for primary health care practitioners as part of large training programs being implemented.

## Caribbean mental health systems

Between 2006 and 2009, 16 Caribbean countries and territories implemented the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS). For the first time, this comprehensive assessment offered the possibility to gather detailed information about how each country or territory is organized, which resources are involved, and what are the strengths and weaknesses of their respective mental health systems.

Each country or territory has produced a report presenting results from the assessment. These reports, which are available for consultation (8), offer a unique resource that humanitarian actors could use at the time of an emergency to gain knowledge on existing facilities and resources, their distribution, and modalities of functioning. A report reviewing the situation of the 16 Caribbean countries and territories (9) is available as well for consultation. MHPSS disaster managers are encouraged to have a copy of this report readily available in their 'kit' of disaster preparedness material.

To briefly summarize these findings, it can be said that Caribbean countries and territories are undergoing continual change, moving from a centralized system—in general led by a psychiatric hospital—to a decentralized system, which offers community-based mental health service. In many cases, mental health is being integrated into primary health care and psychiatric nurses are playing a significant role in providing services.

However, despite the advances, the decentralization process must continue, particularly considering the limited number of mental health human resources that are available in most countries. Updating mental health policies, plans, and legislation is crucial for the development of a sustainable system.



Following is a brief summary of the mental health system in Haiti, in the context of the catastrophic earthquake of January 2010. The complete text can be accessed through the link at the end of the box.

### Box 1.2

#### **Brief summary of mental health in Haiti in 2010: a public health need, an added value within the health sector, and a cornerstone for reconstruction**

*Zohra Abaakouk, PAHO/WHO Mental Health Advisor, Haiti*

Haiti's existing institutional model of mental health care is poorly developed. There are no regulations and/or legislation related to mental health issues, nor does the country have a national mental health policy and plan.

- Public mental health services are restricted to the tertiary care level, centralized and concentrated in two main facilities
- Mental health services have not been integrated into the public health system. Instead, all ambulatory mental health services as well as community-based services rely on national and international nongovernmental organizations (NGOs).
- Within the public system, the resources (human and material) are very limited. According to the Ministry of Health, the budget allocated to mental health services amounts to 1% of the public health sector budget.

#### **Mental health and psychosocial interventions: the situation in 2010**

Following the 2010 earthquake in Haiti, mental health needs were overwhelming and the Ministry of Health was not able to respond to this important demand. Immediately after the earthquake, the Cross-Cluster Working Group on Mental Health and Psychosocial Support (MHPPS) was created, as it was estimated that at one point more than 110 different organizations were providing mental health and/or psychosocial services, or conducting training to health and mental health professionals (5).

#### **MHPPS activities during response to the cholera outbreak**

The mental health component of the cholera outbreak was not taken into consideration by national authorities and major NGOs, underestimating the importance of a comprehensive public health approach. Due to lack of information and knowledge about cholera, the first reaction of the population was based on fear and hostility (see Box 3.2 on "Experiencing fear during an infectious disease outbreak" in Chapter 3). Interventions by the Ministry of Health played a crucial role in building a bridge between health units and communities, managing fear, and fighting stigmatization of patients, their relatives, communities, and health workers. Through psychosocial group activities it has been possible to gain better clarity about common Haitian representations and perceptions related to cholera (6, 7, and 8).

#### **Mental health issues as part of the Haitian reconstruction process**

One of the first priorities of this cooperation was to conduct an assessment of the existing mental health system through the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) (9). Another priority has been to strengthen existing mental health care services, an area widely excluded from the social perspective. A big effort is being made to support the psychiatric hospitals where living conditions remain poor, there is a shortage of human resources and key supplies, and basic psychosocial needs as well as training needs are still unaddressed.

A draft national mental health policy has been produced to decentralize resources, incorporate mental health services into primary health care and general hospitals, and train primary health care workers on mental health issues.

Click here or go to <http://tinyurl.com/89ud2nd> to read the full article of the mental health system in Haiti, prior to and in the aftermath of the earthquake, which includes links to important references.

## References\*

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\* **Please note** that in some cases, the original web address (URL) of these references has been adapted to make it easier for you to access the information. When you use these shortened URLs in your browser, you will be automatically directed to the resources on the each organization's website. If you are reading this chapter online, you can click on the link. If you have downloaded the chapter or are reading a printed copy, you can cut and paste the shortened URL into your browser.