

Mental Health and Psychosocial Support Plan for Emergencies

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Why a mental health plan for emergencies?

The importance of addressing mental health and psychosocial issues in disaster situations has become increasingly relevant for governments and humanitarian actors. According to local circumstances, mental health professionals are frequently called upon after an emergency to provide immediate psychosocial support to the victims of an event. This happens after a relatively minor incident, such as a car accident with multiple fatalities, as well as in cases where the disaster is major, as in the case of the 2010 earthquake in Haiti.

Whatever the magnitude of the disaster or emergency, there is increasing awareness of the need to be ready for such events. This is particularly relevant in a region such as the Caribbean, where the risk of hurricanes, earthquakes, and flooding is relatively high.

A mental health component should be part of the national health sector plan for emergencies, which forms part of the national emergency plan. At the same time, mental health plans for emergencies, where they exist, need to be made part of the national mental health plan in order to ensure cohesiveness between the emergency plan and the country's mental health system. An example of one country's integration of mental health care into their disaster planning is provided in Box 3.1.



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Box 3.1**Cuba's experience in the protection of mental health in disaster situations**

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Particularly over the last 20 years, Cuba has developed methodologies and guidelines for mental health care in disaster and emergency situations, which are the country's foundation for planning and action. This process was conducted systematically in all provinces and included the participation of mental health specialists, health workers, and authorities from the National Health System (NHS). Workers from local government and organizations, including the National Civil Defense, first responders and volunteers, were involved in the design and implementation of these methodologies.

In each province, training is carried out by mental health specialists and experts from different organizations such as Ministry of Health and Professional Associations (psychiatry and psychology), under the general supervision and coordination of the Technical Committee of the Latin American Center of Disaster Medicine (CLAMED). The Cuban Ministry of Public Health designated CLAMED as the organization responsible for training and preparing health service personnel for emergency situations and disasters. CLAMED has organized and developed postgraduate courses, training workshops, group discussions, and other approaches to exchange knowledge, experience, and lessons learned in disaster management at local, national and international levels.

In 2008, the Cuban Ministry of Public Health formulated and adopted the Guidelines for Mental Health in Disasters in Cuba. This document provides guidance about general actions to be implemented during each stage of a disaster: prevention, preparedness, response and recovery.

Cuba has trained and prepared a significant number of professionals who have assisted victims of catastrophe in several countries of Latin America, the Caribbean, and other continents, through the Henry Reeve International Brigade.

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The IASC Guidelines (1, pp. 23–24) introduce a Matrix of Interventions to guide basic actions that should be considered in an emergency context to protect and promote mental health and psychosocial support for affected populations. A summary of the areas introduced by the matrix is presented in Table 3.1. For each one of the areas listed, the matrix proposes actions that should take place during emergency preparedness, as a minimum response, and as a comprehensive response. The complete matrix is available online through the link under Reference 1.

Table 3.1 Matrix of interventions in MHPSS in emergency settings

Part A—Common function across domains

- Coordination
- Assessment, monitoring and evaluation
- Protection and human rights standards
- Human resources

Part B—Core mental health and psychosocial support domains

- Community mobilization and support
- Health services
- Education
- Dissemination of information

Part C—Social considerations in sectoral domains

Food security and nutrition
Shelter and site planning
Water and sanitation

Action plan for mental health care and psychosocial support in emergencies

Objective of the plan

The objective of the plan is to introduce and develop the mental health and psychosocial component of health care during emergencies, as well as to offer an appropriate response to the mental and psychosocial needs of the population. Implicit in this central objective are the following goals:

- ◆ To eliminate or reduce the risk of suffering psychosocial injury;
- ◆ To reduce distress among the population;
- ◆ To contribute to prevention and control of the range of social problems arising among the population, especially among those most affected;
- ◆ To prevent, treat, and rehabilitate the mental disorders occurring as a direct or indirect consequence of the disaster or emergency;
- ◆ To provide support and psychosocial care for the members of the response teams;
- ◆ To ensure the psychosocial recovery of the population affected by the disaster after the acute phase.

Principles of the plan

- ◆ Interdisciplinary and multi-sector strategy;
- ◆ Social participation;
- ◆ Comprehensive approach to health, focusing on primary health care;
- ◆ An approach based on: a) vulnerability and risk; b) human rights; c) consideration of ethnic, linguistic, and cultural characteristics; d) gender equity;
- ◆ Flexibility and adjustment to local circumstances.

General recommendations for action (2, 3)

- ◆ The paradigm of mental health care in emergencies should be modified, giving special emphasis to groups and communities. The most frequent institutional responses have been based on individual psychiatric care, which is not effective in emergency situations and can serve only a limited number of people.
- ◆ After a major disaster, it is essential to provide guidance for the insecurity caused by fears of repeated or new disasters.

- ◆ General measures that help to bring about order and calm should be supported.
- ◆ It is important to take into account the values, traditions, and customs of the population, as well as other features in accordance with age, gender, place of residence, etc.
- ◆ The most vulnerable people should receive specific care. Members of the response teams are an at-risk group who should receive priority attention.
- ◆ Humanitarian assistance, the satisfaction of basic needs for the disaster-affected population, and the establishment of safe environments are the primary and crucial measures of first aid and psychosocial assistance.
- ◆ Placing disaster victims in shelters should be considered the option of last resort since it generates many psychosocial problems.
- ◆ The provision of direct assistance in shelters, schools, and other community spaces makes early identification of psychosocial problems possible and allows proactive treatment.
- ◆ Diagnostic labeling should be avoided when dealing with disaster victims.
- ◆ Hospitalization should be limited to only the absolutely necessary cases and for the shortest possible time. Also, the use of medications should be restricted to the bare minimum.
- ◆ Criteria for psychiatric referral should be defined, for example: 1) persistent or aggravated symptoms that do not resolve with initial treatment, or symptoms that cause great suffering; 2) significant difficulties coping with daily life; 3) the risk of complications, especially suicide; 4) related problems, such as alcoholism; and 5) serious psychiatric disorders, such as psychosis (which rarely develop in these conditions).
- ◆ There should be an emphasis on a return to normalcy as soon as possible, avoiding re-victimization of the population.
- ◆ Companionship in the form of groups at significant moments such as during exhumations or in morgues is an approach that complements clinical interventions and administrative measures.
- ◆ Mourning is expressed differently by different cultures. The execution of farewell rites of loved ones is important for accepting and processing what has occurred.
- ◆ It has been demonstrated that there can be medium- to long-term mental health effects of severe disasters.

Before drawing up the plan, it is desirable to (4, 5):

- ◆ Review the country's regulations and legislation; the national disaster response plans in the ministry of health and other institutions of the health sector; and the national mental health plan;
- ◆ Compile existing documentation on mental health and emergencies;
- ◆ Interview key actors at the national and local levels;
- ◆ Set up a multi-sector working group to draw up the plan which includes:

- The government agency responsible for coordinating disaster and emergency response (the agency name differs depending on the country)
- The ministry of public health
- Other government agencies (education, culture, sport, social protection, labor and economic actors)
- Civil defense
- Red Cross
- Military forces
- Police force and other public security agencies
- Mayors' offices and city authorities
- The fire service
- Universities

Suggested components of the plan (1, 3, 4)

The following ten suggested components of the plan are drawn from different materials produced over the years, both at global level (as in the case of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings) and at regional level (PAHO publications produced as a result of countries' experiences in disasters).

1. **Prior preparedness actions**
These include planning and organization of the response, training of staff, etc.
2. **Rapid preliminary assessment of damage and mental health needs after a disaster**
Territories and/or countries should conduct a Mental Health Situation Analysis. This will provide a basis for a more efficient rapid assessment that is required in the immediate aftermath of the disaster (see Chapter 4 for more details on conducting mental health assessments in disasters). A tool or guide for rapid assessment in disasters or emergencies should be used at the local and country level and include the following:
 - General, social, and demographic assessment of the community;
 - Identification of the mental health needs and psychosocial problems faced by the population;
 - Evaluation of the mental health services and programs;
 - Determination of priorities and target groups for immediate action.
3. **Psychological first aid by unspecialized personnel**
Primary health care workers, volunteers, search and rescue personnel, humanitarian aid workers, and community agents are the "first responders" following a disaster and have direct contact with the population. They can provide psychological first aid immediately after a disaster.

4. Specialized care

Specialized care should be reserved for cases with more complex mental disorders. The mental health services should be linked to primary health care. The following features of a country/territory's mental health system should be taken into consideration when planning for specialized care of the disaster-affected population:

- Assessment of specialized human resources and their distribution, the coverage they provide and the existing support network. The mental health resources available for mobilization during emergencies should also be assessed.
- Provision of direct specialized clinical care for persons with mental disorders, implying the organization of the following services:
 - Psychiatric hospital (it is not the favored option);
 - Psychiatric department of a general hospital;
 - Community and ambulatory mental health services;
 - Mobile teams or teams temporarily assigned to selected sites;
 - Other mental health units or services in governmental and nongovernmental organizations.
 - Definition or updating of mechanisms for referral and counter-referral of cases
- Priority for care of highly vulnerable risk groups. Identification of specific highly vulnerable people or with special needs: deeply affected groups; women; older persons; children and adolescents; displaced persons, especially those living in shelters; persons with pre-existing mental disorders (including those living in institutions). (See Chapter 9 on supporting vulnerable groups in disaster situations);
- Care for members of the first response teams (including self-care).

5. Training on mental health and psychosocial support, including crisis intervention and psychological first aid

Training must be given to workers with first contact with victims and survivors. Issues for consideration include:

- Availability of support and teaching tools;
- Distribution of publications on mental health and psychosocial support;
- Training for health workers and other agents while circumstances are normal. The most important target groups for training are: primary health-care workers; staff responsible for the management of shelters and refuges; volunteers, first responders and humanitarian assistance staff; teachers; community leaders and health promoters;
- Continuity and follow-up of the training process in the services.

6. Health education for the population

The population should know that many psychosocial manifestations are normal emotional responses to an adverse event, how to identify problems that require assistance, and some simple measures for coping with these situations. Educational strategies for the population should include the following:

- Ensure availability of easily understandable educational material, graded by age group and level of vulnerability;
- Group awareness-raising educational activities during emergencies, involving: groups and families deeply affected by the disaster, evacuees and shelter dwellers, children and adolescents, women's groups, members of initial response teams, and other organized community groups;
- Implement health promotion and education activities with participation of community organizations, focused on children and adolescents in schools.

7. Social communication

A good strategy of information and guidance for the community is essential to promote calm and to reduce fear and suffering (see Box 3.2 “Experiencing fear during an infectious disease outbreak” and Box 3.3 “Communicating with the public during an emergency”). The following actions should form part of that strategy:

- Advise authorities on how to set up a coherent and efficient social communication system;
- Inform key political players about the need for a social communication system and the strategy defined for its establishment;
- Inform and motivate service providers about psychosocial issues;
- Help design messages directed at different population groups;
- Dispel and manage rumors;
- Evaluate the response by the population in order to quickly organize social communication activities;
- Organize, during times of risk, educational/informational campaigns in the community (e.g., during the rainy season or hurricanes).



Box 3.2

Experiencing fear during an infectious disease outbreak

Although fear is common in any disaster, it is even more common in cases when biological or chemical agents are present. Cholera and pandemic influenza are some of the threats that have been present recently in the Caribbean region. Different reasons can be given for this fear:

- The invisibility of the agent. People affected during an earthquake may quickly determine the extent of their losses or injuries, but infection with a disease may not be immediately evident and people may not be able to determine by themselves whether or not they have been infected.
- The contagion factor. The risk of a disease that spreads from person-to-person creates a situation where everyone may be a source of disease: family, friends, and health care providers themselves may transmit illness. Such a situation creates stigma, discrimination, isolation, quarantine, separation from family members, and even evacuation. These experiences increase levels of fear and stress.
- Uncertainty about the level of risk. The consequences of being infected may not be fully known. Lack of clarity among professionals involved during the outbreak and confusing messages and recommendations sent to the general population may increase public anxiety.
- Autonomic arousal. Signs and symptoms that may be normal among frightened persons (muscle tension, palpitations, hyperventilation, vomiting, sweating, tremors and a sense of foreboding) may be incorrectly attributed to a disease and lead to overwhelmed health services.
- Use of protective clothing. Using masks, respirators, or special clothing may provoke some distress due to difficulty in breathing, claustrophobic effects, limited verbal communication, and difficulties in movement.

Dissemination of appropriate information is crucial, and will have an immediate influence in annulling the effect of at least some of the reasons listed above.

Adapted from: World Health Organization, *Mental health of populations exposed to biological and chemical weapons*. Geneva. 2005

Box 3.3.

Communicating with the public during an emergency

During the acute emergency phase, it is important to establish and disseminate an ongoing reliable flow of credible information on:

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

Source: World Health Organization, *Mental Health in Emergencies*, Geneva: WHO, 2003.

8. Intersectoral and inter-institutional coordination

Establishing coordination among sectors and agencies is a critical part of pre-disaster planning. Actions that should be taken include:

1. Identify and strengthen organizations and institutions acting directly and indirectly in the mental health field;
2. Enhance the ministry of health's stewardship role;
3. Conduct joint activities by the national mental health program and institutions responsible for disaster management;
4. Define and enhance cooperation mechanisms and establish networks at different levels;
5. Secure the commitment from organizations to implement and follow up on plans;
6. Convene assessment meetings periodically for different national stakeholders;
7. Exchange and classify experiences.

9. Community organization, social participation, and promotion of self-reliance

It is critical to involve the community at large in pre-disaster planning. Actions to this end include:

- Identify community organizations and leaders;
- Support social participation and self-help by encouraging and organizing the population to help themselves and each other;
- Encourage the population to take part in planning and implementing actions during emergencies.

10. System for registering information, indicators, and follow-up

It is important to establish a system for recording all relevant demographic and contextual information, people's experiences in the emergency, mental health and psychosocial problems, existing resources to deal with those problems, etc.

Evaluation and indicators

The follow-up and evaluation of a plan depend, to a large extent, on the use of reliable indicators and the determination of a baseline, which makes it possible to monitor progress.

Indicators that are of interest tend to relate to the structure of mental health services (for instance, the availability and conditions of existing services and resources) and processes (for instance, utilization of those services), which are important during both normal times and in emergencies. A valuable foundation on which to develop indicators for mental health during emergencies would be the existence of a reliable surveillance and data collection system that functions during normal times. Unfortunately, it is common for health systems to have no satisfactory mental health information systems, which makes it more difficult to set them up or strengthen them during emergencies.

This is further compounded by a dearth of readily available information during the emergency situation, since the information available from hospitals tends to be of little value for mental health services, as it relates mainly to physical morbidity and the increase in caseload. They usually do not reflect the true scale of psychosocial problems besetting the affected population.

Therefore, a large part of the information available during emergencies is qualitative, obtained through rapid interviews with key informants or community meetings. The information concerns not only current morbidity, but also the whole range of psychosocial problems affecting people at such times and which affect their very survival.

Regardless of the aforementioned limitations, the impact of interventions implemented as a result of the emergency should be evaluated in the long- and medium-term and will be aided by ad hoc research or specially-designed studies.

Sustainability

The sustainability of actions or strategies put in place by the emergency plan requires ongoing evaluation. The following questions will assist in measuring the success of actions taken.

- ◆ How many of the services and processes instituted during the emergency plan are sustainable? Which have proved impossible to maintain, despite their being useful and necessary?
- ◆ Have primary health care and mental health services been enhanced at the local level and have their levels of coverage increased? Are specialized professionals (psychiatrists and psychologists) with specific training available? Are health workers motivated by and sensitive to the issues raised by disasters? Have they been trained in basic mental health and psychosocial issues?
- ◆ Are there education professionals with a background in mental health and disasters? Have universities shown an interest in contributing to the training process?
- ◆ Have inter-institutional agreements been established regarding mental health and psychosocial support during emergencies? Will it be possible to maintain these agreements?

Final remarks

1. Throughout their history, many Caribbean countries have been beset by major events such as natural disasters, against a background of deep social and economic adversity. There has been enormous loss of life and property. This makes it imperative to address the psychosocial and mental health problems as a matter of State policy within the framework of a comprehensive health plan.
2. A mental health action plan in disaster situations should be founded in pragmatic, flexible, and broadly accepted principles. There are types of mental health and psy-

chological interventions that have been validated through experience and are agreed on by nearly all experts.

3. The psychosocial problems in disasters or emergencies are not solely a problem for the health sector; they also involve other players, including government agencies, NGOs, local authorities, and the community itself. The main priority of mental health work is to reintegrate persons back into their normal lives.
4. In natural disasters emergencies, the frequency of mental disorders increases, as do many other emotional manifestations that can be considered “normal responses to abnormal situations.” There is also evidence of other problems such as excessive alcohol consumption and violent behavior. The small group of persons who need specific support or specialized treatment must be identified early on.
5. There are not enough mental health specialists in Caribbean countries to provide care for all those affected by disasters. However, it is neither necessary nor desirable to rely solely on professional or specialized staff to provide all mental health care needed.
6. The mental health component must be integrated into the primary health care network. Under normal circumstances and before disasters strike, the mental health care model should be reinforced on a community basis. Frequently, the structure of mental health services does not match the needs that arise during emergencies.
7. At present, the classic concept of post-traumatic stress disorder is facing criticism. It does not apply to developing countries; most commonly, isolated symptoms of post-traumatic stress may be observed, but not the syndrome in its entirety. Specialized services that are vertical and centered on trauma treatment are not recommended. Indiscriminate psychological support activities, carried out by foreign teams or by a variety of groups simultaneously, are counterproductive.
8. The recovery work should begin immediately after the critical phase of the emergency. The psychosocial impact of a disaster is the outcome of several factors which need to be dealt with appropriately; they include the nature of the event, the extent to which an individual is affected, and the nature of the losses. It will also be necessary to ensure continual monitoring to determine the medium- and long-term repercussions.
9. Humanitarian and social assistance is an important part of the work to improve mental health of populations affected by disasters, but should be complemented with other specific interventions.
10. There is a clear relationship between human rights and mental health in disaster situations.

References

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