

Community-Based and Self-Help Psychosocial Interventions during Different Phases of Disasters

Marc Laporta³³

Claudina Cayetano Elington³⁴

Lorin Young³⁵

Alexandra Baines³⁶

Introduction

Planning for mental health issues in emergencies and disasters has emerged as a fundamental aspect of how communities, families, and individuals prepare for these situations. Yet these considerations often remain implicit and poorly defined. As we shall discuss, behavioral and psychosocial problems are expected to occur, given the context of the many challenges these extreme events cause. One of the most important loci for intervention is at the community level, with families and individuals engaging in relatively non-specialized activities, aimed at reinforcing a return to normal living conditions.

When communities are insufficiently prepared, their capabilities can be overwhelmed. Looking more closely at what makes up effective community-based and self-initiated interventions will enable better planning for the humane, competent, and compassionate care for victims during a disaster and in the aftermath, when recovery is the goal.

This chapter is about the non-medical and non-specialized interventions that hold great potential for preventing adverse mental health outcomes and enhancing healthy adaptation. It will examine some of the people, places, and ways that are likely to provide the best basic community- and self-based interventions in disasters. Of course human, geographical, organizational, and technical resources vary from one place to another, so the interventions discussed need to be framed in the realities of each community and its particular strengths and abilities, while understanding the possible pitfalls.

Recognizing the limits of community-based mental health interventions

While community-based interventions play an important role in preventing and reducing acute mental health reactions, they also help to detect a number of problems requiring

33. Director, Montreal PAHO/WHO Collaborating Centre for Research and Training in Mental Health, Canada.

34. Mental Health Program, Ministry of Health, Belize

35. Consultant, Montreal PAHO/WHO Collaborating Centre for Research and Training in Mental Health, Canada.

36. Consultant, Montreal PAHO/WHO Collaborating Centre for Research and Training in Mental Health, Canada.

intervention. Acquiring the basic ability to be sensitive to and recognize the appearance of more severe symptoms is a definite asset at the community level. It is important to have some notion of when reactions are excessive and may require medical assessment. Throughout this chapter, we will stress this point: the goal is to achieve what is possible, while collaborating with the complete system of health care set in motion by the disaster.

The frequency of mental health problems in emergencies and disasters

Each disaster is a distinct entity, difficult to compare to others. This is because the type and severity of the hazards vary and differences exist in the level of preparedness, the density of the population, the country's ability to deal with the disaster, and numerous other factors (1). Let it be said simply that the severity of mental health problems that arise in the aftermath of any disaster varies from the minimal and transient level to the very severe level of distress (2). In a summary article on the topic, Norris et al. emphasized that youth are often reported to suffer severe or very severe distress (3). They also note that most problems were reported to peak in the first year after the disaster and usually improved over time.

Looking at the types of problems encountered during disasters and emergencies, one will see mainly the following psychosocial problems: fear and distress, psychological disorders or psychiatric illnesses, social disorder, violence, and consumption of addictive substances. Psychiatric problems are not the most prominent of these.

The World Health Organization (WHO) has proposed a rough projection for 12-month prevalence rates of various mental health problems, as shown in Table 12.1 (4). It should be emphasized that observed rates vary with the setting (e.g., time elapsed since the onset, socio-cultural factors in coping, community social support, previous and current disaster exposure) and assessment method, but give an approximate indication of what WHO expects the extent of morbidity and distress to be. Despite limitations, the figures can help form an idea of proportions and types of problems that are likely to occur.



Table 12.1 WHO projections of psychological distress and mental disorders in adult emergency-affected populations

Type of disorder or distress	Before the emergency: 12-month prevalence (median across countries and across level of exposure to adversity) ^a	After exposure to the emergency: 12-month prevalence (median across countries and across level of exposure to adversity)
Severe disorder (e.g., psychosis, severe depression, severely disabling form of anxiety disorder)	2%–3%	3%–4% ^b
Mild or moderate mental disorder (e.g., mild and moderate forms of depression and anxiety disorders, including mild and moderate PTSD)	10%	15%–20% ^c
"Normal" distress/other psychological reactions (no disorder)	No estimate	Large percentage

Source: World Health Organization. Mental health assistance to the populations affected by the tsunami in Asia [Internet] 2005 [cited 1 June 2010]. Available from: <http://tinyurl.com/7fk589>.

Notes: PTSD indicates post-traumatic stress disorder.

a. The assumed baseline rates are the median rates across countries as observed in the World Mental Health Survey 2000.

b. This is a best guess based on the assumption that trauma and loss (a) may exacerbate previous mental illness (e.g., it may turn moderate depression into severe depression), and (b) may cause a severe form of trauma-induced common mental disorder.

c. It is established that trauma and loss increase the risk of common mental disorders (depression and anxiety disorders, including post-traumatic stress disorder).

Expected psychological phases of disasters and emergencies

Just as there are psychological phases in our reactions to many events in life, disasters also take victims through a series of phases largely determined by the specific realities of the disaster. While there is always a risk of aligning expectations too rigidly with a developmental sequence, having an appreciation of the unfolding psychosocial reactions to disaster is valuable in presenting a timeline to follow in the preparation for, the progression of, and the aftermath of a disaster, and in the long-term planning for recovery from it. It also provides insight into when certain psychological interventions may be more or less useful as individuals and the community move through particular phases.

Following is a description by D.J. DeWolfe of the community-related issues that are likely to occur through these phases (5):

“During the week to months following a disaster, formal governmental and volunteer assistance may be readily available. Community bonding occurs as a result of sharing the catastrophic experience and the giving and receiving of community support. Survivors may experience a short-lived sense of optimism that the help they will receive will make them whole again.”

“As disaster assistance agencies and volunteer groups begin to pull out, survivors may feel abandoned and resentful. The reality of losses and the limits and terms of the available assistance becomes apparent. Survivors calculate the gap between the assistance they have received and what they will require to regain their former living conditions and lifestyle. Stressors abound—family discord, financial losses, bureaucratic hassles, time constraints, home reconstruction, relocation, and lack of recreation or leisure time. Health problems and exacerbations of pre-existing conditions emerge due to ongoing, unremitting stress and fatigue” (5, pg. 23).

Community-based and self-help interventions in different phases of a disaster

A rationale for community-based mental health interventions

The case for mental health interventions in disasters has been made in other chapters. In general clinical practice, early attention to problematic mental health symptoms has been shown to offer some advantages. Whether this is also true for problems arising in the context of a disaster is more complex and continues to stimulate heated debate. Some authorities concur that earlier interventions for mental health problems can speed recovery, prevent long-term problems, and foster resiliency (6). Generally, most will agree that early intervention after a disaster is indicated only if it is of the right kind.

The point is that for the most part, the best interventions will be those that do not unduly pathologize or ‘psychiatrize’ behavioral problems, but rather which adequately foster adaptations that are meaningful and normative for that community and culture, so long as they conform to basic human rights and are aimed at protecting the individuals who are suffering.

In fact, the notions that humanitarian workers will develop about a culture are often based on false representations or interpretations of what they observe, or on general notions about the culture in question. This is why effective community-based interventions help the community itself regain its capacity to offer the kind of help and support that is appropriate to that locality—help which may be quite different from that which the humanitarian worker believes to be right (7). Community-based approaches gain in relevance and power if aid workers are able to enhance the naturally-occurring psychosocial resources within their communities, tapping into the sensitivity and culture-based knowledge that is suited to the needs and circumstances, to the language, to the religious considerations, and to the comfort-level of the disaster survivors. Formal or external counseling or support groups may be unwelcome within communities attempting to regain a sense of connection.

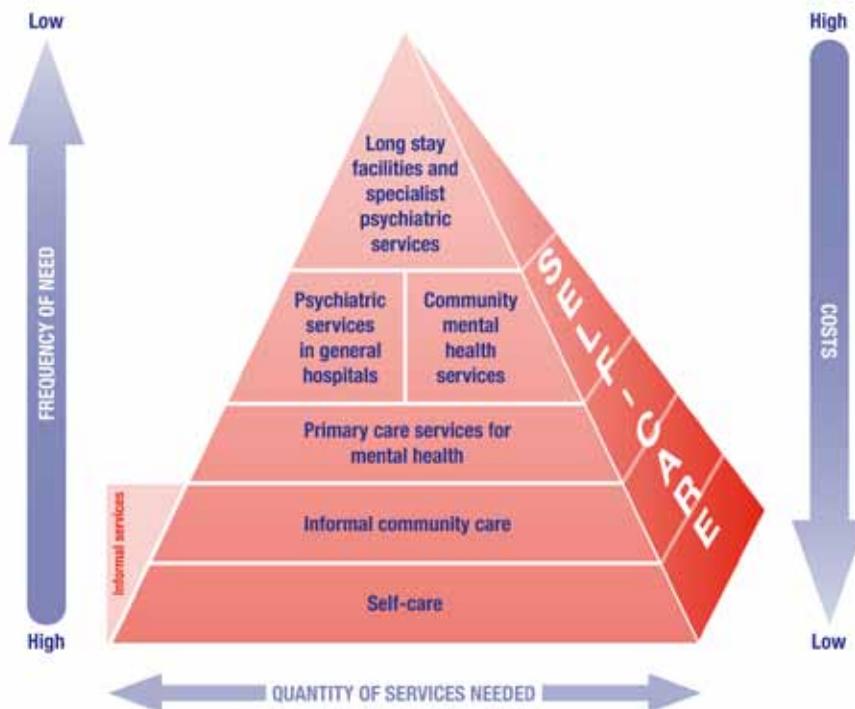
“After the tsunami that hit Aceh in Indonesia on December 26th 2004, community workers from other parts of the country were trained to bring their expertise to Aceh. But even though they were from the same country, they were perceived with mistrust and a sense that they could not understand the particular situation in Aceh, where strong senti-

ment against the central Indonesian government had long existed and had led to recent clashes. It became evident that it was more appropriate and acceptable to train local community workers, or at least to involve them prominently in the training to permit taking into account the specific cultural and political issues in planning interventions” (M.L. personal communication).

Such considerations beg the question of how to make mental health and psychosocial support interventions as widely accessible as possible. Clearly, much psychosocial support accrues from informal channels of help and from non-specialized health care settings, where a more integrative approach is offered. WHO recommends this type of non-specialized, wide-based approach as a general way of organizing mental health services (Figure 12.1). The bottom of the organizational pyramid represents the services most needed, which include the two types of care this chapter discusses (8). A similar pyramid (Figure 12.2) depicts the recommended types of psychosocial interventions that should be available in emergencies and disasters, again with the bottom of the pyramid representing the most important services (9).

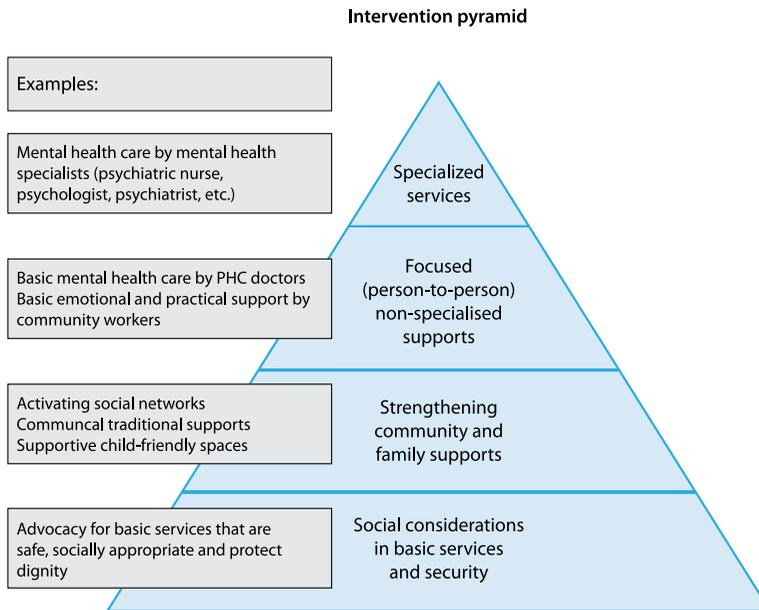
Strengthening community and family support, usually an informal and implicit form of care, constitutes a basic level of care. WHO recommends taking a comprehensive approach to health, integrating informal and community-based care with more formal primary health

Figure 12.1 Self-care pyramid: WHO model of organization for an optimal mix of mental health services



Source: WHO, Integrating mental health into primary care: A global perspective, 2008. p. 16.

Figure 12.1 Self-care pyramid: WHO model of organization for an optimal mix of mental health services



Source: Inter-Agency Standing Committee (IASC). IASC guidelines on mental health and psychosocial support in emergency settings: what should humanitarian health actors know? Geneva: IASC, 2010; pg. 3.

care services, and including promotion of mental health and ad-hoc preventive measures (8). Of course, specialized care also comes into the picture, but only for a small proportion of problems, and in a focused manner, as the resources are usually not available and often not necessary.

In community-based work, methodologies relying on group work are recommended in the interest of making interventions available to as many people as possible. In approaching children, the use of child-child and child-adult strategies (using games, sports, and other forms of expression) are seen as fundamental tools for the rehabilitation and ongoing development of children and adolescents.

Paradoxically, disasters may have the effect of reducing the stigma and invisible barriers that would otherwise exist to accessing mental health services. This is probably true because people feel justified in using such services when the suffering is so evident and widespread. This was the case in the aftermath of the 2010 Haiti earthquake. However, most people do not see their needs as related to ‘mental health problems’ and often do not consult mental health services (10). Indeed, others may be averse to seeking mental health services.

The question of “at-risk groups”

Chapter 9 discusses groups that are at high-risk for developing mental health difficulties in disasters. However, it is important to remember that the hardest hit populations often are

among the poorest and are already more vulnerable even before a disaster strikes. Poverty has been identified as being predictive of a worse outcome in cases of natural disasters. Of the more than 6,000 natural disasters recorded between 1970 and 2002, a reported three-fourths of the events and 99% of the people affected were in developing countries (11). On average, more than 2% of the population is affected each year and disasters cause more than one-half of 1% of GDP in damage. Both figures are about 10 times greater than in advanced economies. Unfortunately, it is also true that in these countries, the burden of illness from mental health problems is very high, as is the mental health care gap (12). But even within populations hit by a natural disaster, certain subgroups at relatively greater risk may require specially adapted interventions.

Ideally, all groups would be equally and fully prepared for a disaster, and would not require a distinct approach. However, it is advised to plan and prepare appropriately to avoid that all, even the most vulnerable, suffer the negative outcomes that are associated with a disaster.

In reality, those who were already marginalized before the onset of a crisis receive scant attention, as they are less visible, often less vocal and frequently remain unsupported both during and after the crisis. Humanitarian aid workers must advocate within the community and beyond on behalf of marginalized and at-risk persons and approach their work by linking it to social justice principles. Among the groups who are likely to be at higher risk for mental health complications in disasters and emergencies, are the following: the young, older and frail persons, pregnant women, single mothers, cultural and ethnic minority groups, persons lacking caregivers or local social support, low socioeconomic status groups, people living in group facilities, people with serious or persistent mental illness or with other disabilities (intellectual disabilities, cognitive impairment, sensory impairments, poor physical health, complex medical illness), and human service and disaster relief workers (1). We will introduce some community-based and self-help approaches more specifically indicated for vulnerable groups; interventions for these groups are also covered in Chapter 9.

Interventions through the phases of a disaster

Following is a discussion of three phases of a disaster: preparedness, response and recovery. The ISDR glossary of Terminology on disaster risk reduction defines each phase as follows:

- ◆ Preparedness action aims to build the capacities needed to efficiently manage all types of emergencies and achieve orderly transitions from response through to sustained recovery. Preparedness is based on a sound analysis of disaster risks and good linkages with early warning systems, and includes such activities as contingency planning, stockpiling of equipment and supplies, the development of arrangements for coordination, evacuation and public information, and associated training and field exercises. These must be supported by formal institutional, legal and budgetary capacities. The related term ‘readiness’ describes the ability to quickly and appropriately respond when required.

- ◆ The response phase includes the provision of emergency services and public assistance during or immediately after a disaster in order to save lives, reduce health impacts, ensure public safety and meet the basic subsistence needs of the people affected. It is predominantly focused on immediate and short-term needs and is sometimes called ‘disaster relief.’ The division between this response stage and the subsequent recovery stage is not clear-cut. Some response actions, such as the supply of temporary housing and water supplies, may extend well into the recovery stage.
- ◆ The recovery task of rehabilitation and reconstruction begins soon after the emergency phase has ended, and should be based on pre-existing strategies and policies that facilitate clear institutional responsibilities for recovery action and enable public participation. Recovery programmes, coupled with the heightened public awareness and engagement after a disaster, afford a valuable opportunity to develop and implement disaster risk reduction measures and to apply the ‘build back better’ principle.

1. Interventions through the phases of a disaster—Preparedness

Some actions will help buttress people’s sense of mastery in chaotic situations and promote recovery. Preparing for disaster, educating the population about normal responses to such events, providing training on what to do to help psychological recovery, setting up information centers and offering ongoing information feedback to affected communities all help people’s mastery and recovery. For these reasons, WHO recommendations prominently include community-based and primary health care-based interventions in the preparedness phase, as well as during and after the disaster (1).

National disaster preparedness plans must be drawn up well ahead of emergencies and involve not only a system of coordination between focal points within relevant agencies, but also, and prominently, a detailed plan for adequate social and mental health response within communities (see Chapter 3 on this topic). In this way, most mental health and psychosocial care and interventions will take place not only within primary health care settings, but also and especially within communities themselves, enhancing the care afforded by families and by available resources. As is the case with disaster preparedness plans, preparing community resources to be available in emergencies should be undertaken beforehand.

2. Interventions through the phases of a disaster—Response

Public education and information messages can play a central role in minimizing psychosocial complications in the victims. However, much of this information will need to be taken up and adapted within each community. Information about the disaster, helping victims orient themselves as to what to expect and where to find water, food, shelter, safety, and medical attention, and about where to locate family and community members are most urgently needed in the early response phase. Messages are most meaningful if they respond to specific community needs—such as where to find shelter and water.

Only after the response phase will it become useful to inform people about the psychological reactions they can expect and provide information about ways to handle the stress with which they are dealing. Public information about normal reactions, education about

ways to handle them, and early attention to symptoms that are problematic can speed recovery and prevent long-term problems (9). Sources of information on the topic include IASC, WHO, and SAMHSA documents (9, 12, 13, 14).

The Response Phase—types of mental health assistance

In the immediate aftermath of a disaster, practical assistance and interventions that are commensurate with people's immediate needs can easily become part of 'psychosocial' interventions, as they constitute supportive responses that are targeted at diminishing worsening psychological distress (5).

"An aid worker was helping someone look for lost belongings among the debris of her collapsed home after a strong hurricane. The victim spontaneously spoke of being concerned about her older parents who lived in a distant province and she had not been able to call since the events. The aid worker immediately arranged for her to use the phone of her aid organization. There was great relief in the parents when they heard the victim's voice, as they thought she might have died in the storm" (M.L. personal communication).

In parallel to these practical considerations, relief from stress, the ability to talk about the experience even informally, and the passage of time usually lead to the reestablishment of psychological equilibrium (10). Of course, this does not exclude the fact that the types of mental health and psychosocial support that will be required will run the full gamut of needs and interventions, and will occur at different times during and after the disaster.

The Inter-Agency Standing Committee Guidelines (13) highlight the importance of facilitating conditions for community mobilization, ownership, and control of emergency response in all sectors, community self-help and social support, and appropriate communal, cultural, spiritual and religious healing practices. The guidelines underscore the principles of preventing separation and facilitating support for young children (0–8 years) and their caregivers, and strengthening access to safe and supportive education. Interestingly, for persons who are unable to return to their own communities, it is recommended that social considerations such as safe, dignified, culturally and socially appropriate assistance in site planning and shelter provision, and in the provision of water and sanitation are taken into account.

The response phase—locus of assistance

Primary health care and emergency care settings

A person's behavioral problems can fail to improve even with appropriate help from the community's resources, and it is very important for community-based agents to identify when this is the case. In these circumstances, part of the community's role is to facilitate a person's access to medical care. Of course, the ubiquity, centrality, and sometimes preponderance of mental health issues in disaster situations can quickly overwhelm medical systems and emergency departments, so accessing the medical system should be practiced with circumspection.

General primary health care (PHC) settings offer the first point of contact for most surgical and medical problems. Because physical and mental health problems frequently co-

occur, especially among survivors of emergencies, persons with behavioral, psychosocial, and mental health problems may be recognized here. Indeed emergency medical settings should endeavor to properly identify mental health needs and make judicious use of adequately identified resources, including community-based resources. It is highly recommended that at least one member of each primary health care team have some capacity to deal with psychological issues and understand the available resources in the community, while maintaining a useful level of contact with these resources. The same intense overlap between physical and mental issues is encountered in treating the health consequences of human rights violations such as torture and rape.

During the response phase, community workers can provide effective mental health assistance, even while helping survivors with concrete tasks. For example, a community health worker can use skilled but unobtrusive interviewing techniques to help a survivor in sorting out demands and setting priorities while they are sifting through rubble together (10). Some forms of psychological support (i.e., very basic psychological first aid) for people in acute psychological distress do not require advanced knowledge and can easily be taught to workers who have no previous training in mental health, whether they are working in communities or within a PHC setting (see Chapter 11 on PFA).

The way in which health care is provided in these settings often affects the psychosocial well-being of people living through an emergency. Compassionate, emotionally supportive care, in keeping with the cultural norms, protects the well being of survivors; disrespectful treatment or poor communication threatens dignity, deters people from seeking health care, and undermines adherence to treatment regimes.

Ideally, mental health care should be available in most, if not all settings. However, optimal use should be made of non-specialized community resources, and when referral is necessary, PHC services should be the first line. From there, specialized mental health services can be accessed if necessary. Heavily solicited PHC and first-line health services and personnel must be able to recognize the severity of presenting problems and have clear lines of referral to easily accessed, specialized psychiatric services. However, in most cases, PHC services will do well to coordinate their work closely with community-based resources having less of a focus on acute care, thus alleviating less severe mental health problems arising in the early phases of the disaster. From this perspective, PHC becomes a coordinator of care for both less and more specialized services, and must be able to differentiate the needs of persons presenting for help.

Humanitarian aid workers can relieve help-seekers by assisting them to navigate the bureaucracy of humanitarian organizations, directing them to appropriate resources, working as liaisons between individuals and aid agencies, and advocating for appropriate services (15, 16).

Specialized medical (non-PHC) settings

Of course, things do not always happen as described above, so all health and community workers should have at least a basic understanding of mental health and psychosocial needs during and after disasters.

“In Port-au-Prince, after the 2010 earthquake, many of the PHC settings were not functioning, and specialized surgical team members or post-op teams often identified people in need of mental health interventions. One surgical unit in the neighboring Dominican Republic encountered strong emotional reactions to their operations or to being distanced from their loved ones, or still to the harrowing experience of phantom limb symptoms.

“The coordinator of one post-operative-care setting in Fond Parisien was quick to observe that survivors’ complex emotional and psychological reactions were playing a major role in delaying the discharge of patients otherwise stabilized. Many were afraid to go home to the expected devastation that had hit their families” (M.L. personal communication).

It is very important to keep in mind those people with mental health conditions prior to the disaster who needed specialized care (see Chapter 9). It is true that there are examples of persons who were successfully discharged from specialized psychiatric institutional settings following a disaster, or of persons who had received regular out-patient care prior to a disaster and were able to adopt a more community-based approach after the disaster. However, many people with mental health conditions will require continued—and sometimes increased—care after a disaster.

During disasters, it may be necessary to return persons with mental illness to their communities. Ensuring follow-up in these situations requires creative solutions and cooperation. Families, community members, and community-based emergency workers are often called upon to help follow through with the therapeutic interventions recommended by the treating teams or to ensure continued treatment with medications in order to maximize clinical stability and follow-up.

“A mental health institution was considered structurally unsafe after an earthquake. The overcrowded hospital had to be emptied, and so concerned families who came to see their hospitalized family members were asked to take their ill family member back home, and to periodically help them back for follow-up appointments. This method was effective in maintaining the stability of some otherwise quite unstable persons until more regular services could be ensured again” (M.L. personal communication).

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3. Recovery phase

From the long-term perspective, the bulk of the mental health and psychosocial work takes place in the recovery phase, following exposure to severe stressors. Recovery and the return to a level of normalcy in living circumstances will become the main focus of the majority of the affected population. In this phase, the medium- and long-term development of community-based services and social interventions will need to be deployed to its full potential.

As acute medical and surgical interventions gradually recede, community organizing can take on a longer-term role, with the goal of ensuring the long-term psychosocial well being of its members. Having stated this, readers will find that most of the approaches described below can apply in response as well as recovery phases if they can be organized.

Community organization

This is the process of bringing together community members to help them define and work toward solving their own problems (17, 18). Issues may run the gamut from practical relocation to social policy for disaster preparedness and reconstruction at the neighborhood level, to other issues of neighborhood concern.

Approaches to effective community organization

People will generally find it difficult, if not impossible, to heal from the effects of individual distress while the community around them remains in shreds and a supportive community setting does not exist (19). Thus, mental health interventions such as outreach, case finding, support groups, job groups, or advocacy groups, must be re-established in a more or less formal manner in order to assist in re-establishing linkages between individuals and groups (10, 20). These activities are described in more detail below.

This section emphasizes what can be done when communities are not able to quickly and effectively reorganize after a disaster. Many factors may contribute to this difficulty, including, the physical loss of established meeting places or respected community leaders. In these circumstances, it is essential that aid workers help to re-establish the fabric of the community they are working in, using a variety of means.

Key informants

Humanitarian workers aiming to strengthen local resources in communities they are serving will want to identify social groups or mechanisms that functioned prior to the emer-

gency and that can be revived to help meet immediate needs. These may include collective work groups, self-help groups, rotating savings and credit groups, burial societies, and youth and women's groups. Community members who are familiar with community needs can serve as 'key informants.' These informants may part of key agencies and groups in affected neighborhoods (health, social services, churches, schools, day-care providers, community groups, police, fire department, etc.), in places where people congregate (restaurants or coffee shops, bars, grocery or liquor stores, etc.), in services familiar with the neighborhood (mail delivery personnel, public utility workers, building inspectors), or in businesses or offices that survivors frequent during their recovery (thrift shops, lumber yards, hardware stores, building permit departments).

Aid workers will almost always gain from requesting an interview with key informants to ask about their perception of the type and intensity of difficulties and ways of coping in their neighborhood. They should listen to whether there are specific concerns about practical issues, specific individuals or certain families.

Identifying human resources in the local community is another important step. These resources may be found among significant elders, community leaders (including local government leaders), traditional healers, religious leaders/groups, teachers, health and mental health workers, social workers, youth and women's groups, neighborhood groups, union leaders and business leaders, political leaders, volunteer mental health practitioners, primary health personnel (such as nurses, doctors), social workers, occupational therapists, pharmacists, and those previously receiving care.

Mapping local resources

Similarly, the IASC Guidelines call for mapping local resources by asking community members about the people they turn to for support at times of crisis (13; see action sheet 2.1). Particular names or groups of people are likely to be reported repeatedly, indicating potential helpers within the affected population.

Social network analysis

A more formal analysis of the social network examines the inter-relationships of individuals and groups in a community concerning exchange of resources, information, social obligations, economic resources, and kinship ties. A thorough assessment of community needs and resource can be conducted to gain an understanding of the extent to which existing social networks fulfill these needs, and what is required to fill the gaps.



This analysis will identify problem areas and vulnerable high-risk groups, as well as permit the creation of a directory of available and appropriate resources and services. For example, social network analysis may show that a neighborhood or social group attends church frequently. In this case, mental health staff could use the clergy, church social groups, and church bulletins for distributing information about common reactions to disaster and about mental health resources.

Volunteer community support

Where local support systems are incomplete or too weak to achieve particular goals, it becomes useful and necessary to train not only community workers but also volunteers to perform tasks such as identifying and responding to the special needs of community members, developing support in a culturally appropriate way, and providing basic support (for example psychological first aid) where needed (13, action sheet 6.1).

Recruiting volunteers from the community should take certain characteristics and processes into consideration. Considerations of who recruit will yield better results by asking who the important community members are. Community workers should develop a clear notion of what they do in order to be able to train volunteers in specific tasks for limited periods of time and to offer ongoing supervision and support.

Volunteers will likely require a brief training (less than one day) to understand normal and abnormal reactions to disasters and emergencies, how to perform active listening, and how to refer to more specialized services when there is concern about someone. Humanitarian workers should have ongoing meetings for supervision and support of volunteers.

Specific community-based and self-help approaches

Community outreach

As the term suggests, community outreach actively reaches persons in need of help and support who may not otherwise seek out help within their natural community setting.

The goals of this outreach are to provide ongoing, detailed information on available resources, to reassure community members that most stress reactions are normal, and to make people aware of ways to cope with the stress they are experiencing. They also need to know whether what they are experiencing is normal and what help may be available if required. Mental health information, education, consultation, and even clinical interventions are usually well received when presented as ‘normal’ events that are familiar and non-threatening to the community.

Making use of information media is an effective strategy to reach out to the community. These may include radio and television announcements, articles in newspapers and community newsletters, public announcements at local events or community fairs, Internet websites, or through video programs for training and education. Posters, brochures and fliers, books, and booths can also be effective.

For community workers, knowledge of where community members gather can provide a direct means of hearing about expressed needs and helping people to access to appropriate

care. However, the worker will require strong cultural competencies to do this adequately (see Chapter 6 on this topic). Making regular visits to places where survivors may congregate, such as senior centers, recreation halls, food kitchens, or a favorite pub are good ways to meet survivors, and to inform and hear about resources and needs. The frequency of such visits must be gauged depending on an understanding of the situation and of the needs.

Outreach staff will be most effective if they are comfortable working in community-based, non-institutional roles. They must be able to adapt to changing situations, make independent decisions, and work without close supervision (20). They should be action-oriented and able to do what will be needed. Staff should be comfortable working being outside and in the elements. Workers must be comfortable and adept at striking up conversations with people they have not met before and have not come to them seeking help. It is helpful if workers live in the community, as they will have common knowledge, concerns, and topics of conversation. They must project interest and empathy. It is helpful if workers wear comfortable clothes that blend into the community. In a farming area, for example, boots and jeans might be the appropriate attire. Clothing should be appropriate to the weather, to the hazards, and to the job to be done.

An understanding of ways to help relieve stress, a level of comfort with resolving specific problems, knowledge of ‘psychological first aid,’ the ability to talk about the experience if needed, and the ability to refrain from intervention when it is not required, are all useful attributes.

Community meetings

While the topic of community meetings need not be directly related to mental health issues, the process should be tailored to help disaster recovery in several ways:

- ◆ Help people deal with concrete problems of concern to them.
- ◆ Re-establish feelings of control, competence, self-confidence, and effectiveness that were weakened by the disaster.
- ◆ Establish, re-establish, or strengthen social bonds and support networks that may have been fragmented by disaster.

As stated in the IASC Guidelines (13), “all communities contain effective, naturally occurring psychosocial supports and sources of coping and resilience. Nearly all groups of people affected by an emergency include helpers to whom people turn for psychosocial support in times of need. In families and communities, steps should be taken at the earliest opportunity to activate and strengthen local supports and to encourage a spirit of community self-help.”

As such, a community-based self-help approach is vital, because having a measure of control over some aspects of their lives promotes people’s mental health and psychosocial well being following overwhelming experiences. Affected groups of people typically have formal and informal structures through which they organize themselves to meet collective needs. Even if these structures have been disrupted, they can be reactivated and supported as part of the process of enabling an effective emergency response. Strengthening and building on exist-

ing local support systems and structures will enable locally owned, sustainable, and culturally appropriate community responses.

In this type of approach, the role of outside agencies is less to provide direct services than to facilitate psychosocial support that builds the capacities of locally-available resources. Facilitating community social support and self-help requires sensitivity and critical thinking. Communities often include diverse and competing sub-groups with different agendas and levels of power. It is essential to avoid strengthening one particular sub-group while marginalizing another, and to promote the inclusion of people who are usually invisible or left out of group activities.

Community organization can also profit from a wider approach at a macro level of outreach. For example, communities can organize and bring together local residents to deal with problems of recovery specific to the locality, increasing the community's sense of resolving its problems and helping to establish or repair social bonds and support networks among affected citizens.

The IASC Action sheet 5.2 entitled "Facilitate community self-help and social support" gives a series of recommendations for such interventions (13).

Activity groups

Group activities offer many advantages in disaster situations. Besides the obvious efficiency of having many persons participate in activities at once, there are also therapeutic advantages. One of the goals of group-based community interventions is to break isolation. Another is to experience, through others, a wider range of ways to solve problems. Yet another is the possibility that through group activities, communities can be revived or new communities can be built. Furthermore, groups can be organized and run by specialized personnel, but they can also very efficiently be run by non-specialized persons or by the affected members themselves.

Most commonly, a community organization exercise will result in a series of activities and support groups. Activities typically include recreation, singing, exercise, and large-muscle activities appropriate to age and health. These exercises can help to reduce stress and improve the spirit in the community and reestablish a sense of control and purpose. Particularly in temporary shelters, involving residents in shelter tasks (serving meals, reading to children and telling them stories, serving coffee, providing language translation, putting together a skit for entertainment, etc.) is usually more helpful than expected. Residents may help with practical activities that provide concrete help as well as opening the door to informal 'therapeutic' conversations.

Support groups

Support groups can serve useful functions in a shelter. Survivors who attend these groups find reassurance that their problems are not unique, and more importantly, that their experiences are not idiosyncratic and isolating. Hearing others' experiences and tribulations can provide useful practical ideas and resolution to particular problems. Groups provide a place

to which health staff may refer people who could benefit from some regular contact with their community.

The creation of self-help support networks consists of citizens gathering in a series of neighborhood meetings to focus on issues such as communal healing practices (see 13, action sheet 5.3), activities that promote non-violent handling of conflict (for example, discussions, drama and songs, joint activities). Other roles that groups can tackle include organizing access to information about what is happening, services, missing persons, security, etc. (see 13, action sheet 8.1), or organizing access to shelter and basic services (see 13, action sheets 9.1, 10.1, and 11.1).



Importantly, community structures and actions can be expected to be useful in the longer-term, well after the immediacy of the disaster has passed. Discussing a longer-term vision, the IASC guidelines recommend facilitating the process of community identification of priority actions through participatory appraisal and other methods (13). This can sometimes be complicated by a disaster that has disrupted known social networks and coping mechanisms, as was the case in Haiti in 2010 in the areas around Port-au-Prince. This exercise requires promoting a collective process of reflection about people's past, present, and future, thereby enabling planning. By taking stock of supports that were present in the past, but which have been disrupted in the emergency, people can choose to reactivate or recreate useful means of supports. By reflecting on where they want to be in several years' time, they can envision their future and take steps to achieve this vision.

Constructive approaches revolve around supporting community initiatives, actively encouraging those that promote family and community support for all emergency-affected community members, including people at greatest risk, determining what members of the affected population are already doing to help themselves and each other, and looking for ways to reinforce their efforts. For example, if local people are organizing educational activities but need basic resources such as paper and writing instruments, one may support their activities by providing these materials (while recognizing the possible problem of creating dependency). Ask regularly what can be done to support local efforts.

Topics of discussion for community groups may also include the following: helping at-risk groups needing protection and support (see 13, action sheet 2.1); setting up community child protection committees to identify at-risk children and to monitor risks, intervene when possible, and refer cases to protection authorities or community services (13, action sheet 3.2). It may be relevant, for example, to organize structured and monitored foster care for separated children (13, action sheet 3.2).

Beyond this, community-constituted groups become potentially powerful agents of change through advocacy. Mental health issues in particular are often difficult for individuals or even families to bring up, as in many communities, the stigma remains of being identified with mental health issues.

Safe spaces: child-friendly spaces

The term ‘safe spaces’ is understood as a means of providing people of all ages with a place and time to regain a sense of security and predictability and where activities can be organized for various community-based functions. Such safe spaces are of particular importance for children and families, and can be set up to respond to their routines, short-term, and longer-term needs, including educational ones (see 13, action sheets 5.1 and 7.1).

In these spaces, activities can be organized according to a child’s age/stage of development: 0–12/18 months (pre-verbal, not ambulatory); 12/18 months to three years; and 3–6 years (include an area for caregiver/child play and interaction in all services for younger children, such as therapeutic feeding programs, hospitals, and clinics, as well as in areas for distribution of food and non-food items); and more education-oriented activities for the 6–8-year-olds.

Support groups can be organized for parents/mothers to talk about their own issues. It is important to organize meetings at which caregivers of young children can discuss the past, present and future, share problem-solving ideas, and support one another in caring effectively for their children. During small group activities for families and their young children, parents also can learn from the interactions of others with their children. For example, after a disaster, many parents are afraid to leave a child alone or have other fears they may be unable to acknowledge. At the same time, parents are often more able to seek help on their children’s behalf or may, in fact, use their children’s problems as a way of asking for help for themselves and other family members.

It becomes possible, in safe settings, to envisage training parents, siblings, grandparents, and youth to work with available staff, and also to take learning home to their families about the healthy development of young children. Consider engaging trusted older women and female youth as volunteers in safe spaces. Include children with special needs in such activities, games, and supportive environments. (For more detailed information on child-friendly spaces see reference 21.)

Schools

In an effort to reestablish as many routine activities as possible, schools may be reopened or reactivated in specially conceived shelters. Teachers play a central role in helping children integrate the disaster and go on with their normal lives, sometimes through art and play activities, or even by encouraging group discussions in the classroom and informational presentations about the disaster. Consulting with specialists on how to best help in the classroom may be indicated. Detecting problematic behavior will often happen in this setting, so teachers also must have some understanding of mental health issues.

“In Aceh, Indonesia, where a major tsunami struck in 2004, many religious groups trusted by their communities and NGOs were able to establish schools for children with local volunteer persons ensuring the maintenance of these normalizing activities. Children felt less alone, were involved in useful activity, and families had some extra time to attend to issues relating to their own post-disaster losses and needs” (M.L. personal communication).

Self-initiated and self-help interventions

In this section, comments are limited to issues relating specifically to community and self-help interventions for vulnerable groups. See Chapter 9 for more detailed discussion on these topics.

Families: parents, caregivers and children

Disaster workers within communities can help to educate families about age-appropriate responses to disaster and help parents understand unusual behaviors that may arise in their children (for example, a child may cling more, have nightmares, or an adolescent may become more argumentative). It can have a soothing effect and improve parent-child relations if one explains that behavior, such as heightened fear of others and withdrawal, or increased fighting with other children, are common reactions to stress and reflect no failure on the caregiver’s part.

But most importantly, family units should meet—and can be helped to do so—in order to decide what to do in case of future disasters and how to protect themselves. It is also vitally important to be honest with children about what happened and the process of recovery.

Surprisingly, families and communities often do not realize the importance of empowering children, particularly adolescents, to participate in the recovery process and to help with clean up and rebuilding. For example, after the 2010 earthquake in Haiti, the ‘cash-for-work’ program gave teens opportunities to become involved while earning income for their families and for themselves. It also provided a way for them to participate and take ownership of the effort to rebuild their communities (28).

Facilitating play, nurturing care and social support for at-risk groups is not always simple to organize. Much of what has been said about community-based interventions can be applied to children and teens. Among the activities that should be privileged are parent education, home visits, shared child care and communal play groups, ‘safe spaces,’ toy libraries, and informal parent gatherings in safe spaces (see reference 13, action sheet 5.1). These may help to mitigate the negative psychosocial impact of crisis situations.

To minimize their distress, children require a sense of routine and participation in normalizing activities, which should reflect their usual daily activities.

Older persons

Findings vary in terms of the vulnerability of older persons in disasters compared with other age groups (22, 23, 24). But this should not distract from the obvious: persons who

are less mobile, more medically unstable, and more isolated are likely to be at higher risk for complications after a disaster. This is reason enough to take steps to prepare this group for the possibility of a disaster (25). Of course, any characteristics compatible with increased resilience (e.g., self-perceptions of health, etc.) will be an asset, especially in the recovery phases (24). Just as is true for other groups, older persons will have an advantage by participating as actively as they can in community events and by integrating into the available resources. Families are advised to remain involved with their older members in general, but the rewards for preventing suffering after a disaster are invaluable. Conversely, older persons who have experienced disasters in the past may have developed resiliency, which can be helpful to their families (19). See Chapter 9 for more discussion on the vulnerability of older persons in disaster situations.

The poor and persons with a lower socio-economic status

Low-income individuals generally have fewer resources or greater pre-existing vulnerabilities, realities that complicate their ability to reestablish a healthy lifestyle after a disaster. In this group, the extra stressors of losing one's work or home can lead to a profound change in the precarious balance they may have maintained prior to the disaster.

Participation in job groups and involvement in community rebuilding may afford these families a renewed place in their communities and help turn adversity into an opportunity for change in their lives. After the acute phase of a disaster, advocacy for better social conditions and better job stability can have a salutary effect.

Affluent and middle- to upper-middle class persons are not immune to suffering profound consequences after a disaster. People who may have been used to planning and controlling their lives can experience an increased sense of shock, anger, or self-blame after the disaster.

Displaced populations

Persons displaced because of a disaster will be much more disoriented in their new settings and will feel isolated from the host community unless the community can adapt its support and encourage them to take part in integration.

There are central aspects to building a supportive environment for this group and providing them with a sense of stability and safety. Among these are: taking an active role in helping the community understand the cultural and educational background of displaced persons; being proactive in understanding where they came from and why; and gathering information about the status of their families and indigenous communities.

Persons with previous mental illness

Evidence suggesting that people with prior mental illnesses perform worse during a disaster is weak. However, depending on the symptoms, different types of assistance may be needed. If they require medication, it is essential that access to a continued supply is secured in a reasonable timeframe.

Here again, assistance should be largely practical in nature with additional emphasis on helping individuals to link with appropriate mental health services, hospitals, pharmacies, or other centers distributing medications during the emergency to maintain continuity of care. These individuals can benefit from the same supportive interventions described in the section on individual interventions. See Chapter 9 for more information.

Humanitarian workers: self care

The reader of this manual is likely to be a person working in some aspect of the field of disaster preparedness, response or management. Despite an understanding of many aspects of disasters, these professionals (including yourself) are considered to be at risk for mental health problems. This is because they are more likely to be overworked, fatigued, driven to help even if they are exhausted, and spending less time with their own families. They often worry and think about the tasks at hand more than they notice their own psychological strain. They can be emotionally affected by the plight of the victims and also prone to feeling guilty for being better off than some victims they are helping.

As a group, they (and you) are more likely to have prepared for a disaster. This preparation can alleviate much unneeded stress and worry. Steps include the following:

1. Develop a plan, including an evacuation plan for your family, up date family contacts, and become familiar with organizational structure/procedures and policies in order to understand your role prior to deployment.
2. During the disaster, manage your work and rest time (consider 12 hour shifts with 12 hours off, with a full 24 hours off every 7–10 days if possible; regular breaks every 2–4 hours; try to rotate high and low-stress job activities).
3. Use time off to eat, sleep, exercise, spend time with family/friends, and engage in usual leisure/spiritual activities.
4. During the crisis, avoid alcohol, drugs, excess caffeine, and cigarettes.
5. Consider implementing a “buddy system” (formally or informally), pairing inexperienced and experienced field workers for assignments or to provide back-up replacement if needed (for example, due to sudden illness, too large a caseload, or simply a need for rest).

Humanitarian workers: supportive interventions

The same principles used for community interventions can apply, in a general way, to this at-risk population. Some ways of identifying difficulties include informal ‘roaming’ through workplaces, chatting with people and taking the ‘emotional’ pulse of a place. It is important to follow-up with individuals by making an appointment for a quick break, a cup of coffee, or a game of cards.

The ‘over-a-cup-of-coffee’ style of intervention may be vital. It is quick and is usually a comfortable way of meeting. Stress management staff should simply interact in a supportive and therapeutic manner with personnel. It has been shown repeatedly that emergency-orient-

ed staff responds best to an informal structure, engaging in interactions with stress management or mental health staff.

Interventions will usually focus on the immediate, and may include the following (10, 26, 27):

1. Ask about what is happening now and what could help right now.
2. Listen to the person's feelings and reassure him/her that these are normal under the circumstances.
3. Inform the worker that a break will help them return to work soon by providing needed rest.
4. Stress management strategies may be appropriate including: deep breathing, progressive relaxation, gentle muscle stretching exercises or 'self-talk.'
5. Diversionary activities such as playing cards or reading a magazine for a short while may help.
6. Food and beverages should be suggested if the worker has not eaten for a while.
7. After a chat, the mental health worker should allow him/her some 'breathing space.' When checking back, it can probably be determined more easily whether the worker is ready and able to return to work.
8. If the worker seems particularly tired or overwhelmed, it is appropriate to offer practical assistance in finding a replacement, obtaining transportation home, directing the worker to a rest area, or helping coordinate support (family, friends or follow-up if needed).

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