

MENTAL HEALTH PROTECTION AND PSYCHOSOCIAL SUPPORT IN EPIDEMIC SETTINGS
Mental Health and Substance Use Unit, Pan American Health Organization (PAHO/WHO),
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I. INTRODUCTION

In September 2005, while the H5N1 flu epidemic ravaged the world, then-WHO Director Dr. Lee Jong-wook warned the Pan American Health Organization (PAHO) Directing Council that “failure to take this threat seriously and prepare appropriately will have catastrophic consequences.” He also stressed that, in a global pandemic, “no government can afford to be caught off guard”, and that every country must also have a communication strategy and be ready and able to inform the public about the pandemic, what is happening, and what to do.

The Ebola outbreak that began in Guinea in March 2014 not only caused more than 27,000 cases and 11,000 deaths in West Africa, but also left behind thousands of survivors, orphans, family members, health personnel, and other support workers who might require mental health care and psychosocial support.

Among the many experiences discussed regarding psychosocial interventions in the event of Ebola outbreaks in Africa, particular attention has been given to: a) the need for involving communities before, during, and after the epidemic; b) investing in the training and supervision of workers to provide psychosocial support and mental health care; c) improving the care of orphans and other children affected; and d) integrating psychosocial and mental health interventions within the framework of public health.

In today’s world, a microbial disaster is no longer a possibility, but a certainty: “As human impact on the earth increases exponentially, the chances for unpleasant surprises from the microbial world will also grow [...] The virus spreads quickly because no one has any significant immunity to the novel strain, and the illness it causes can be unusually severe¹.”

Usually, epidemic preparedness measures have placed emphasis on the development of national plans, epidemiological surveillance, and vaccines and drugs; the improvement of immunization coverage in high-risk groups; and the impact and economic burden of the event. However, psychosocial and mental health aspects are conspicuously absent from such plans.

The behavioral perspective must be stressed and a better understanding of the responses of affected population groups must be achieved. Controlling an epidemic entails effecting changes in behavioral patterns, which, in turn, requires active participation from the community.

Many of the problems that affect people in epidemic situations are rooted in fear in its multiple expressions. Studies have identified that more than 80% of people placed in evident proximity to danger express symptomatic manifestations of stress and even panic.

¹ Peters, C.J. Hurrying Toward Disaster? Perspectives in Health Magazine: the Magazine of the Pan American Health Organization. Special Centennial Edition. Volume 7, Number 2. Washington (DC): 2002.

In 2006, PAHO's Mental Health Unit prepared a technical document for the countries of the Region, designed to guide mental health interventions in epidemic situations. The document we now present is a new version that incorporates the experience obtained since then and contributions from the literature published in the intervening years.

Psychosocial and mental health care in epidemic situations is based on the same common principles that underpin actions in disasters and other humanitarian emergencies. Therefore, this document will only briefly cover aspects that can be found in detail in other publications (which we will cite); instead, we will address in detail some topics that are more specific and relevant to epidemics, such as psychological first aid, risk communication, management of complicated grief disorder, and management of corpses.

PAHO/WHO reiterates its commitment to supporting the countries of the Region in their preparations for a possible future pandemic emergency.

II. PSYCHOSOCIAL IMPACT AND RISK

Epidemics are highly impactful health emergencies, which threaten the lives of many people and can cause significant numbers of casualties and deaths; the situation is made worse by the fear of contagion. Usually, the safety and normal functioning of the community are threatened. Psychosocial impact can exceed the management capacity of the affected population; an increase in the incidence of mental disorders and emotional manifestations is expected, depending on the magnitude of the epidemic and the vulnerability of the population. However, as in other humanitarian emergencies, not all mental conditions that develop can be described as diseases; many will be normal reactions to an abnormal situation.

Psychosocial risk is defined as the likelihood that a traumatic event will exceed a specific level of damage in social and mental health terms. It is the product of the interaction between external conditions (threat) and internal ones (vulnerability). It is also linked to other risks (environmental, health-related, economic, etc.).

The external factor (threat caused by circulating pathogens) is the epidemic, which represents the potential occurrence of the disease in a large number of people. Vulnerability is the internal condition of a subject or group exposed to an epidemic threat, which corresponds to its intrinsic predisposition to sustain damage—e.g., from a biological standpoint, someone's immune status.

Psychosocial risk assessment introduces a third element: outrage, which is the set of factors that make the population get annoyed, angry, or at least concerned. Experts often fail to pay due attention to what causes outrage in the population; people, on the other hand, often do not understand or do not agree with the information and assessments provided by authorities and experts. As a result, it is not surprising that perceptions and assessments of risk change from one group to another. Numerous outrage-related factors have been defined in the perception of risk. A proper approach to mental health problems entails understanding how risk is perceived by the population and which factors cause anger and outrage.

Differences in vulnerability among different population groups, especially those related to gender, age, and socioeconomic level, must be recognized. The mental health impact of an epidemic is usually more severe in populations who have precarious living conditions, few

resources, and limited access to social and health services. There are also risks of occupational origin, such as among emergency responders (including morgue workers). Generally, the most vulnerable groups are those which sustain the greatest losses and find it most difficult to rebuild their lives and social support networks after an epidemic.

Losses experienced can have different effects on different population groups. For example, men’s emotional response may involve excess alcohol intake or violent behaviors. Women tend to communicate with one another, as well as seek support and understanding for themselves and their families. Older persons may be vulnerable as a result of chronic and disabling diseases, nutritional deficits, and lack of family and social support; usually, they are less physically fit to face an epidemic. Children have a limited understanding of what is happening and limited ability to communicate how they feel. The setting created by an epidemic affects all aspects of child development (physical, mental, and social).

III. PLANNING FOR PSYCHOSOCIAL SUPPORT AND MENTAL HEALTH CARE

Mental health plans for emergency systems cannot be limited to expanding and enhancing the specialized services that are offered directly to those affected; their scope must encompass a much broader area of expertise, including humanitarian aid, counseling for the population and at-risk groups, and risk communication. It has also been recognized that, after large catastrophes, including epidemics, survivors will need prolonged mental health care when facing the task of rebuilding their lives.

From the standpoint of care, it is important to recognize and distinguish three phases (before, during, and after) and four groups of people:

- Patients;
- Those who contracted the disease and survived;
- Those who have not contracted the disease, but may become infected, and have experienced significant losses (infected or deceased relatives, friends, or neighbors); and
- Members of the emergency response teams.

The table below describes the main psychosocial manifestations in an epidemic, broken down by phases and corresponding actions.

Phases/psychosocial manifestations in the population	Mental health actions
<p><u>Before:</u></p> <ul style="list-style-type: none"> - Sense of inevitability, with a high level of tension in the population. - Over- or underestimation (denial) of the possible epidemic. - Maximization of preexisting characteristics (positive and negative). - Anxiety, tension, insecurity, obsessive attention to the symptoms of the disease. 	<ul style="list-style-type: none"> - Communicate risk to the population, with emphasis on vulnerable groups. Build awareness and information on the subject. - Train teams and responders in basic Psychological First Aid techniques. - Locate personnel trained in mental health. - Train mental health teams and PHC workers on the subject. - Establish psychosocial support and counseling groups. - Detect psychosocial risk factors.

	<ul style="list-style-type: none"> - Should preventive measures be imposed in an authoritarian manner if needed? - Encourage collective spirit and support community participation. - Organize mental health services for an adequate emergency response, especially the formation of mobile teams, crisis intervention units, and liaison services in general hospitals. - Interinstitutional coordination. Establishment of working networks.
<p><u>During:</u></p> <ul style="list-style-type: none"> - Feelings of fear, abandonment, and vulnerability. - Need to survive. - Loss of initiative. - Spontaneous leadership arises (may be positive or negative). - Emergence of behaviors that can alternate between: heroic or cruel; violent or passive; selfless or selfish. - Adaptation to changes in the usual patterns of life: restricted movement, wearing masks, reduction in direct physical contact, temporary closure of schools, etc. - Anxiety, depression, grief, peri-traumatic stress, emotional breakdowns, panic attacks, mass agitation, decompensation of preexisting mental disorders, somatic disorders of psychological origin. 	<ul style="list-style-type: none"> - Rapid evaluation of the psychosocial needs of the population in the specific setting in which the epidemic is occurring. - Support the core actions of early detection, reporting, care, and containment. - Mass communication. Information and guidance on: what is happening, what is being done, and what the people should do. Convey messages of: organization, security, authority, morale, calm, support, courage. - Continue in situ training during the emergency. - Provide psychosocial care and support (individual and group-based) for affected people, families, and communities. - Foster self-help and mutual aid mechanisms, including support groups and peer support. Recovery of initiative and improvement of self-esteem. - Contribute to containment of social unrest. - Psychological first aid by non-specialized personnel (health and humanitarian aid workers), especially to grieving families. - Psychiatric care for people with established mental disorders. - Specialized services for pandemic settings: mobile groups to work in the community and PHC, crisis intervention units at selected locations (morgues, large hospitals, etc.), and liaison services in general hospitals.
<p><u>Aftermath (epidemic under control):</u></p> <ul style="list-style-type: none"> - Fear of a new epidemic. - Violence and protests against authorities and institutions. Seditious and/or criminal acts. - Social and mental health consequences: depression, pathological grief, post-traumatic stress, alcohol and drug abuse, violence. 	<ul style="list-style-type: none"> - Maintain a robust mass communication strategy to facilitate recovery. - Continuing in-service training of teams working on recovery. - Implement individual and group-based mental health care for affected persons, families, and communities, as part of a

<p>- A slow, progressive recovery process begins.</p>	<p>medium-term psychosocial recovery plan (6 months at least).</p> <ul style="list-style-type: none"> - Provide mental health care to those who helped (responders and teams). - Rehabilitation means moving on and restoring hope. New life projects should be fostered and encouraged. - Consolidate interinstitutional coordination and the community organization. - Discuss experiences and lessons learned.
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General principles for planning and implementing psychosocial support in epidemic settings:

- Rapid evaluation of psychosocial needs, to inform actions in the initial phase.
- Psychosocial intervention should be early, rapid, and efficient.
- Working methods should be agile, simple, concrete, flexible, and adapted to the ethnic and cultural characteristics of the affected population.
- Care should not be regarded only as a demand for psychiatric clinical care.
- Create safe environments, promote community living, and help families reunite.
- Active adaptation, which involves resuming the daily activities of the community, including work for adults and school activities for children.
- Create opportunities for mutual support in the community.
- Listen to the demands of people in their own social or informal spaces rather than waiting for people to present to the health services.
- Emotional support should be integrated in the daily activities of organized groups within the community.
- Emotional support for grieving people should consider culturally accepted funeral rites.
- Forge partnerships and achieve involvement of the various social stakeholders.
- Actions should be sustainable in the mid- and long-term actions, and strengthening of existing services should be sought as a result of these actions.

IV. PSYCHOSOCIAL SUPPORT AND PSYCHOLOGICAL FIRST AID

Initially, it will be necessary to use brief and effective interventions for those who are not sick, but are experiencing significant emotional reactions; response teams, health workers, and humanitarian aid workers should be trained in basic psychological first aid (PFA) techniques. It is also especially important to have mental health care services with crisis intervention capabilities at the main health centers where patients are being treated and to create provisions for the care of family members and chaperones.

WHO has published guidance on *Psychological first aid during Ebola virus disease outbreaks*, designed for people who can help others who are experiencing an extremely distressing event. This guidance is adapted from a previous publication, *Psychological first aid: Guide for field workers* (WHO, War Trauma Foundation, World Vision International, 2011), which has been modified specifically with a better response to the challenges of Ebola virus disease outbreaks in mind. Ebola poses specific problems for affected people (such as stigmatization, isolation, fear,

and abandonment), as well as for their caregivers and for service providers (such as safety measures and access to up-to-date information).

Psychological first aid has been recommended by several expert groups, including the Inter-Agency Standing Committee on mental health and psychosocial support in humanitarian emergencies and catastrophes and the Sphere Project. In 2009, a WHO working group evaluated the available evidence on psychological first aid and psychological debriefing, concluding that the former, rather than the latter, should be offered to people after a recent and severe exposure to a traumatic event.

Backed by many international organizations, the psychological first aid field guide reflects current scientific evidence and international consensus on how to support people immediately after highly stressful events.

Psychological first aid

Psychological first aid (PFA) describes a humane, supportive response to a person who is suffering and may need support. Providing PFA responsibly means: 1) Respecting people's safety, dignity and rights. 2) Adapting what you do to take into account the person's culture. 3) Being aware of other emergency response measures. 4) Looking after yourself.

During an Ebola virus disease outbreak, PFA providers should: a) ensure people know their rights (such as the right to treatment) as well as their responsibilities in the Ebola disease outbreak (such as following the guidance of local health authorities); and b) look after their own physical and mental well-being. Helpers may also be affected by the Ebola outbreak or have family, friends, and colleagues who are affected.

PFA providers should be prepared to:

- Learn about Ebola virus disease.
- Learn about available services and supports.
- Learn safety rules.
- Know their limits and get help when necessary from others who can provide more skilled mental health care or specialized medical care.

Basic principles of PFA: Look, Listen, and Link.

Look:

- Check for safety.
- Check for people with urgent basic needs and attend to them first.
- Check for people with serious distress reactions.

Listen:

- Approach people who may need support.
- Ask about people's needs and concerns.
- Listen to people and help them feel calm.
- Even if you must communicate from a distance because of safety precautions, you can still give the person your full attention and show that you are listening with care.

Link:

- Help people address basic needs and facilitate access to services.
- Help people cope with problems.
- Give information.
- Connect people with their loved ones and with social support networks.

Ethical “do’s and don’ts” are offered as guidance to avoid causing further harm to the person receiving PFA, to provide the best care possible, and to act only in their best interests.

Do’s:

- Be honest and trustworthy.
- Respect people’s right to make their own well- informed decisions.
- Be aware of and set aside your own biases and prejudices.
- Make it clear to people that even if they refuse help now, they can still access help in the future.
- Respect privacy and keep personal details of the person’s story confidential.
- Behave appropriately by considering the person’s culture, age and gender.

Don’ts:

- Don’t exploit your relationship as a helper.
- Don’t ask the person for any money or favor for helping them.
- Don’t make false promises or give false information.
- Don’t exaggerate your skills.
- Don’t force help onto people, and don’t be intrusive or pushy.
- Don’t pressure people to tell you their story.
- Don’t share personal details of the person’s story with others.
- Don’t judge the person for their actions or feelings.

Source: Adapted from *Psychological first aid during Ebola virus disease outbreaks* (WHO, 2014)

Some psychosocial support recommendations for survivors of an epidemic and those who have suffered significant losses include:

- Don’t medicalize care or treat people as mentally ill.
- Support and show concern for the people’s health condition and recovery process.
- Make sure their basic needs are covered.
- Ensure privacy and confidentiality in communication.
- Helpers who provide psychological care should develop a sense of responsible, careful, and patient listening. They also should explore their own attitudes and concerns toward the disease and should not impose their vision on those they are helping.
- People need to think about what happened and on how to face the future. Guidance should be very practical: provide as much information as possible and contribute to channeling problems.
- Facilitate a return to everyday life as soon as possible.
- Avoid intrusions from the press or other groups.
- Spiritual or religious support is usually a valuable instrument.

Special recommendations for surviving children:

- View school, community, and family as essential therapeutic spaces.
- Teachers, community workers, women's groups, and youth groups become agents for working with children and adolescents.
- Strengthen training, care, and motivation among personnel who work with children.
- Group-based play techniques and recreational activities are essential for children's psychosocial recovery.
- Facilitate a return to normal life, including school attendance, as soon as possible.
- Take advantage of traditions and customs as they apply to care of affected children.

V. CARING FOR PEOPLE WITH MENTAL DISORDERS

A crisis is defined as a situation precipitated by an external life event that surpasses someone's emotional capacity to respond. In other words, the person's coping mechanisms turn out to be insufficient; this is followed by a psychological imbalance and failure to adapt.

Certain feelings and reactions are common in response to a highly emotionally significant situation, such as the serious illness and/or death of a loved one. However, although some mental manifestations correspond to an understandable, transient response to the traumatic experience, they can also be red flags of progression to a pathological condition. Assessment should be conducted within the context of the event, to determine whether responses can be considered "normal" or "expected" or, conversely, are manifestations of psychopathology that require professional help.

Criteria for determining that an emotional reaction is becoming symptomatic are:

- Prolonged duration.
- Intense suffering.
- Associated complications (e.g., suicidal behavior).
- Significant impairment of social and routine functioning.

The most frequent immediate mental disorders in survivors are depressive episodes and transient acute stress reactions. Occasionally, an increase in violent behaviors and excess alcohol consumption have been observed in emergencies.

Late effects that have been reported include pathological grief, depression, adjustment disorders, manifestations of post-traumatic stress, harmful use of alcohol and other addictive substances, and psychosomatic disorders. Prolonged distress patterns can also manifest as somatized sadness, generalized fear, and anxiety—symptoms that often become severe and long-lasting.

Grief is expected after the death of one or more loved ones. The term "grieving period" implies that the person will progressively assimilate what has happened, understand it, overcome it, and rebuild their life. This is a normal process; it should not be hurried or discouraged, nor should it be regarded as an illness.

All societies have their own rites, standards, and forms of expressing grief. Performing the rituals of one's culture and community is an integral part of the recovery process for survivors.

Complicated grief is defined as a grieving or bereavement process that does not progress "naturally", and instead becomes pathological, usually leading to depressive disorder. Confronting loss and processing grief adequately are related to the following factors:

- The personality of the survivor and the strength of their coping mechanisms.
- The relationship with the deceased.
- The circumstances in which the event occurred.
- The social support network (family, friends, and community).
- In major epidemics, it is common for survivors to have to cope with many losses simultaneously, and grief and mourning take on a broader, community-based sense.

Survivors' experiences, fears, and feelings in epidemics and other mass fatality situations have been described as follows²:

- Grief and distress because of the loss of family members and friends which, sometimes, coincide with material losses. There are also more subtle and sometimes intangible losses, such as loss of faith in God.
- Practical fears: having to assume new roles that are imposed after the disappearance of a family member (for example, the widowed wife who becomes the head of the household, or the widowed father who must take charge of the children).
- Recurrent fears that something can occur again or that death will befall other members of the family or community.
- Personal fear of dying.
- Feelings of solitude and abandonment: it is common for survivors to feel that family members and friends have abandoned them at a difficult time.
- Fear of forgetting or being forgotten.
- Anger toward the deceased, which is taken out on family members or close friends.
- Guilt: Some measure of guilt for someone's death; sometimes, what takes place after the death of a loved one increases this guilt.

The criteria for referral to a specialist (psychologist or psychiatrist) are limited and specific:

- Persistent or aggravated symptoms that have not been relieved using initial measures.
- Major difficulties in family, work, or social life.
- Risk of complications, especially suicide.
- Coexistent problems such as alcoholism or other addictions.
- Major depression, psychosis, and post-traumatic stress disorder, which are serious psychiatric conditions that require specialized care.

Medicines should be used only when strictly necessary and prescribed by a physician. Indiscriminate and prolonged use of psychoactive drugs should be avoided; in particular, benzodiazepines have major side effects and create dependency.

² PAHO/WHO. Management of Dead Bodies in Disaster Situations. PAHO/WHO: Washington (DC); 2002.

The vast majority of cases can and should be treated on an ambulatory basis, in the family and community context. Hospitalization is usually not necessary. Everyday life is the critical space in which psychosocial recovery occurs after a major traumatic event.

mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical Management of Mental, Neurological, and Substance Use Conditions in Humanitarian Emergencies

People who have been affected by emergencies can experience a substantial and diverse range of mental, neurological, and substance use problems.

The mhGAP-HIG contains first-line management recommendations for MNS conditions for non-specialist healthcare providers in humanitarian emergencies, where access to specialists and treatment options is limited. It is a simple, practical tool that aims to support general health facilities in areas affected by humanitarian emergencies in assessing and managing conditions including acute stress, pain, depression, post-traumatic stress disorder, psychosis, epilepsy, intellectual impairment, hazardous substance use, and risk of suicide.

This tool is adapted from WHO's mhGAP Intervention Guide, a widely used, evidence-based manual for the management of mental, neurological, and substance use conditions in non-specialized health settings.

Source: *mhGAP Humanitarian Intervention Guide (mhGAP-HIG). Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies* (WHO/UNHCR, 2015).

Organization of services

The organization of mental health services should be adapted to the needs of an outbreak situation. At the primary level, PHC teams should have sufficient basic training in mental health to allow them to provide emotional support; provisions should also be made for psychosocial support and counseling services, as well as outpatient mental health clinics to support PHC.

At the secondary level, it is important to provide crisis intervention units at selected locations (such as emergency rooms and morgues) and mental health services in general hospitals with a large number of hospitalized patients.

VI. MANAGEMENT OF DEAD BODIES

The presence of a great number of corpses after a catastrophe or epidemic creates fear in the population due to inaccurate information about the danger the bodies of the dead represent. There is also tension and a widespread feeling of grief; the reigning chaos and emotional climate can lead to difficult-to-control behaviors.

The belief that corpses are dangerous and should be burned or buried rapidly is a myth. It is essential that reliable information be disseminated on the real hazards that dead bodies (of those who died as a consequence of the epidemic) pose to the health of survivors.

Regardless of the power of the authorities in charge of managing the emergency and of epidemiological reasons that may hasten the disposition of human remains, any measures adopted should respect and consider the customs of the population, avoiding situations such as burial in mass graves or cremation, which are usually forbidden by law and a violation of fundamental human rights.

The management and disposition of dead bodies has serious psychological implications for families and survivors, in addition to other sociocultural and health considerations.

Notification of death can take place in the home, in a health center, in a morgue, or in another setting. It is a critical moment and is difficult to handle since it can result in strong reactions. Following are some useful recommendations:

- Compile as much information as possible about the deceased and the event (progression of the illness, complications, etc.) before making the notification.
- Obtain information about the people who are going to be notified.
- Make sure that the most appropriate adult family member is the first to receive the news.
- Make the notification in a direct and personal manner.
- Where possible, two people should make the notification.
- Observe common rules of courtesy and respect.
- Do not take personal objects of the deceased to the interview.
- Invite family members to be seated. The people making the notification should do the same.
- Observe the surroundings carefully in order to prevent any hazards, and be prepared to attend to children or others.
- The message should be direct and simple. Most people will realize from the setting that something terrible has happened, and their agony or anxiety should not be prolonged.
- Be prepared to answer questions.
- Help the family members to notify others, if the family so requests.
- Listen and serve the immediate needs of the family members, as well as reminding them of their rights.

Notification of death should always be done individually (case by case). Giving information of this nature to a group should be avoided. Where necessary, several teams or pairs should divide up the work.

The people (at times, adolescents) who are forced to face the difficult task of receiving the notification of death and identifying a family member or loved one are exposed to a traumatic situation. Family members who are going to identify the remains of their loved ones can manifest this trauma through expressions of despair, frustration, and, occasionally, protest or disagreement with the way the deceased has been treated or the procedures being used, etc.

Medical care and psychosocial support services should be as close as possible to the morgue to provide physical and emotional assistance to family members.

Usually the family members demand to see the corpse as soon as possible. The following is recommended:

- The relatives should decide among themselves who will see the corpse.

- Do not allow family members to enter the viewing area unaccompanied. It is preferable for skilled personnel to escort them and provide some emotional support.
- Offer privacy and respect so that the family can say goodbye.
- Respect any type of reaction that the family members might have at that moment.
- It is almost always necessary to transport family members to the location of the corpse, and to ensure their return after viewing the body.
- Provide comfortable conditions and guarantee compassionate treatment at the site where the bodies are viewed.

An important element in handling grief is to expedite mortuary transactions and to obtain free or affordable funerals for low-income people. The delay in delivery of the corpses and uncertainty about how payment can be made for funeral services increases anguish and suffering for the families of victims.

VII. PSYCHOSOCIAL SUPPORT FOR RESPONDERS

Members of the first response teams who worked in the epidemic and those responsible for handling corpses are an especially vulnerable group. Also vulnerable are those responsible for conducting autopsies; they feel overwhelmed and overextended with the work load when mass fatality situations occur.

Not all professionals and volunteers are suitable for these tasks; their suitability depends on a variety of factors such as age, personality, previous experience, beliefs about death, etc. They should be well informed about the tasks they will be asked to do. Persons under the age of 21 should avoid participating in or carrying out emotionally taxing activities.

Certain factors increase the probability that a responder will suffer psychological disorders:

- Prolonged exposure to very traumatic experiences.
- Ethical conflicts.
- Simultaneous exposure to other traumas or recent stressful situations.
- History of physical or psychological disorders.
- Unfavorable living conditions.
- A lenient selection process for professional staff.

Members of response teams are likely to experience some difficulties when returning to their daily lives after the emergency tasks are completed. These should not necessarily be regarded as symptomatic of illness, and require, above all, family and social companionship and support.

There is no type of training or prior preparation that can completely eliminate the possibility that a person working with seriously ill victims and the dead in epidemic situations will be affected by post-traumatic stress or other psychological disorders. If major symptoms of psychopathology do appear, these cases should be referred for specialized treatment.

Some general recommendations for the care of members of response teams are:

- Consider the characteristics and the specific behavior patterns of the team. Generally, they feel satisfied about what they have accomplished and develop an altruistic spirit.
- Keeping the team active is positive: it relieves stress and strengthens self-esteem.

- Promote work rotation and organize working hours appropriately.
- Encourage self-care and periodic rest.
- Personnel who offer emotional support should listen conscientiously, as well as guarantee the confidentiality and ethical handling of personal situations and those of the organization.
- Enlist the family's help in care processes.
- Assess underlying emotional conditions and stress-causing factors before, during, and after the emergency.
- Encourage response team members to express mutual support, solidarity, recognition, and esteem.
- Psychosocial support should be available to all personnel involved in the response to the epidemic, during and after the emergency.

When reintegrating into everyday life, personnel who worked in the emergency should:

- Return to their routine as soon as possible.
- Do physical exercises and relaxation exercises.
- Seek contact with nature.
- Get enough rest and sleep.
- Eat balanced and regular meals.
- Not try to lessen the suffering by using alcohol or drugs.
- Seek company and speak with other people.
- Participate in family and social activities.
- Observe and analyze their own feelings and thinking. Reflect on what they have experienced and its meaning in life.

VIII. MASS COMMUNICATION STRATEGIES: RISK COMMUNICATION

The availability of truthful, transparent, appropriate, and timely information is vital for the emotional restraint of family members and for keeping the general population calm. Authorities and community leaders should be prepared to provide information directly either to individual or groups, as well as to respond to questions and be ready to find answers to these questions.

The communications media have a dual nature: on one hand they are profit-driven enterprises, and on the other, they have an enormous social responsibility for the public service they provide. Information on disasters such as epidemics can be exploited to emphasize and even manipulate certain morbid interests of the public. However, it is necessary to insist that the media contribute responsibly to keeping the population calm by providing truthful and balanced news that guides people in the right direction.

A frequent problem is the number of people who go to morgues, hospitals, health centers, or other places in search of relatives (alive or dead). This creates problems of congestion and disorganization. Solutions should be found that are adequate, humane, and respectful to these people.

The health sector should coordinate with law enforcement and humanitarian aid workers for crowd control. In the majority of the cases, the public is not aggressive, but because of their sheer numbers, it is essential to organize it to ensure that adequate information is provided. Entry to health care facilities should also be controlled.

For communication tasks, it is important to seek the timely support of neighbors and community organizations that have, in addition to human talent, extensive knowledge about the population and its customs.

It is advisable for authorities and public institutions to have spokespersons who are specifically responsible for managing information, and who can support the emotional restraint of the population. It is advisable to have regularly scheduled briefings and to make use of official bulletins, avoiding any ambiguity.

Risk communication

Risk communication is essential for protecting the mental health of people and creating a climate of mutual trust among the community, authorities, and communicators. Informing the public of the possibility of facing an epidemic is not an option, but it is a measure that should always be adopted, especially when there is a real threat. The reasons are clear: a) the community can cooperate with official efforts by the government and other institutions; and b) once the epidemic begins, well-informed people can act more appropriately and better protect themselves and their families.

The objective of communication before an epidemic is to achieve a balance in which it is possible to report correctly on existing dangers and hazards, creating an appropriate level of fear and awareness, while offering assistance in facing problems. The purpose must be to stay away from extremes—neither reporting that fails to make the population overcome its apathy, nor alarmist fearmongering that can cause panic.

Recommendations for risk communication:³

1. Start where the audience starts. You can't simply tell people they're wrong. You must start where they are and find a logical explanation they can understand.
2. Don't be afraid to frighten people, within reason. Over-reassurance is a terrible strategy for risk communication. Evidence has shown the effectiveness of imparting a logical amount of fear, which motivates precautionary thinking and action, although people don't stay frightened for long. There is one exception to this rule, which is when people are already terrified or panicking. But if the alternative is considered, which is worse: being accused of unduly frightening people or of failing to warn them?
3. Acknowledge uncertainty. During epidemics, there are doubts and uncertainties that even experts cannot completely clarify; problems concerning prognosis of the situation can and should be recognized and shared with the population.
4. Share dilemmas. Governments face many dilemmas before and after an outbreak. Effective risk communication needs to share these dilemmas and let the public help make decisions.
5. Give people things to do. Representatives of communities and organized groups should be part of the decision-making process. Messages should include clear information on what the public can do to protect itself.
6. Speculate responsibly. Propose different scenarios and recognize mistakes.

³ Sandman, P.M., Lanard, J. Bird Flu: Communicating the Risk. Perspectives in Health, the Magazine of the Pan American Health Organization. Volume 10, Number 2, 2005.

7. Don't get caught in the numbers game. Battles over statistics are useless: what matters is recognizing the problem and its severity.
8. Stress magnitude, not probability. Following from the previous recommendation, what matters is calling attention to the magnitude of the situation.
9. Guide the adjustment reaction. Once people overcome their apathy and start taking risk seriously, their normal response is fear; this is called the adjustment reaction. This is the best time to guide, educate, and inform the population.
10. Inform the public early and aim for total candor and transparency. Although this seems clear and simple, it is sometimes one of the hardest recommendations for governments to adopt, as they are often led by political considerations.

IX. FINAL CONSIDERATIONS

Coping with an epidemic emergency, which causes a great number of casualties and fatalities, is not the health sector's problem alone; other government actors, nongovernment stakeholders, local authorities, and the community itself must be involved.

A public health approach is needed to address the psychosocial and mental health consequences of an epidemic or outbreak. Most problems seen in these settings are similar to those seen in other emergencies; however, fear and social stigma are particularly likely in epidemic emergencies. The response often disrupts local standards, customs, and social support systems by creating physical distance among people.

In summary, the following 10 considerations are important:

1. Ensure a coordinated, orderly response by the government and by other stakeholders, with emphasis on interinstitutional cooperation and community involvement.
2. Ensure that psychosocial support and mental health services are integrated into the general health services that provide care to the population.
3. Identify groups at high psychosocial risk in the context of the epidemic and intervene appropriately and with priority.
4. Implement psychological first aid (PFA), delivered by emergency response teams, for patients and their relatives.
5. Plan for an increase in the number of people with manifestations of complicated grief or mental disorders and facilitate their appropriate care.
6. Ensure that dead bodies are handled carefully and ethically.
7. Training health workers and humanitarian aid workers, as well as educating the general population, are essential lines of action.
8. An adequate risk communication strategy is essential to helping establish a calm, orderly climate.
9. Mental health plans cannot be limited to improving specialized services and increasing their accessibility; the scope of expertise must be expanded to tackle the population's whole range of psychosocial problems and needs.
10. The late (medium- and long-term) effects common in epidemic situations should be taken into account when designing intervention strategies. An emergency provides a good opportunity for definitive improvement of mental health services, especially at the primary care and general hospital levels.

FURTHER READING

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, 2010.

http://www.who.int/mental_health/emergencies/what_humanitarian_health_actors_should_know.pdf

IASC. Mental health and psychosocial support in Ebola virus disease outbreaks. A guide for public health programme planners. Geneva, 2015.

http://www.who.int/mental_health/emergencies/ebola_programme_planners/en/

WHO. WHO global influenza preparedness plan. WHO: Geneva; 2005.

http://www.who.int/csr/resources/publications/influenza/WHO_CDS_CSR_GIP_2005_5.pdf

WHO. Building back better: Sustainable mental health care after emergencies. WHO: Geneva; 2013. http://www.who.int/iris/bitstream/10665/85377/1/9789241564571_eng.pdf?ua=1

WHO. Psychological first aid: Guide for Field Workers. WHO/War Trauma Foundation/Vision Global Internacional: Geneva; 2012.

http://apps.who.int/iris/bitstream/10665/44615/1/9789241548205_eng.pdf

PAHO. Mental Health and Psychosocial Support in Disaster Situations in the Caribbean. PAHO: Washington (DC); 2012.

http://www.paho.org/disasters/index.php?option=com_content&view=article&id=1649:mental-health-and-psychosocial-support-in-disaster-situations-in-the-caribbean&Itemid=807&lang=en

PAHO. Management of Dead Bodies in Disaster Situations. PAHO: Washington (DC); 2002.

http://www.who.int/hac/techguidance/management_of_dead_bodies.pdf

PAHO/WHO. Press Release / News and Public Information. Lee Jong-wook (WHO). "Influenza Pandemic a Brewing Storm, WHO Director-General Says". Washington (DC): 27 September 2005.

PAHO. Strategic and Operational Plan for Responding to Pandemic Influenza. Draft. 2 September 2005.

Peters, C.J. Hurrying Toward Disaster? Perspectives in Health Magazine: the Magazine of the Pan American Health Organization. Special Centennial Edition. Volume 7, Number 2. Washington (DC): 2002.

Rodriguez J et al. (eds.). Guía práctica de salud mental en situaciones de desastres (Serie Manuales y Guías sobre Desastres). PAHO: Washington (DC); 2006.

http://www.who.int/mental_health/paho_guia_practicade_salud_mental.pdf

The Sphere Project. Humanitarian Charter and Minimum Standards in Humanitarian Response; third edition, UK, 2011. <http://www.ifrc.org/PageFiles/95530/The-Sphere-Project-Handbook-20111.pdf>

World Health Organization & United Nations High Commissioner for Refugees. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Settings. Geneva: WHO, 2012. http://apps.who.int/iris/bitstream/10665/76796/1/9789241548533_eng.pdf

WHO/UNHCR. mhGAP Humanitarian Intervention Guide (mhGAP-HIG). Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies. WHO: Geneva; 2015. http://www.who.int/mental_health/publications/mhgap_hig/en/

WHO. Psychological First Aid during Ebola virus Disease Outbreaks. WHO-MBC-World Vision-UNICEF: Geneva; 2014. http://www.who.int/mental_health/emergencies/psychological_first_aid Ebola_manual/en/