EMERGENCY MENTAL HEALTH CARE

Description

This chapter is intended to serve as a guide for setting up mental health programs for displaced populations in developing countries. It describes the psychological problems of people exposed to violence and provides guidelines for planning emergency mental health programs.

Learning Objectives

- To discuss the mental and emotional impact of exposure to violence.
- To define what mental health programs can contribute to an emergency response effort.
- To design the building blocks of a mental health care program.
- To recognise the factors that are important for establishing long-lasting mental health programs.

Key Competencies

- To recognise the mental health problems caused by social unrest.
- To apply standard guidelines when designing, implementing, or evaluating an emergency mental health program.

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Overview

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

- Being able to understand and respond to the challenges of day-to-day life.
- Being able to feel and to express a range of emotions.
- Being able to maintain good relationships among people in families and communities.

Many factors, which could be biological or environmental, contribute to having good mental health. People are frequently exposed to positive as well as negative factors in their everyday life. Mental health problems occur when the stress from negative factors, such as pressure from work, illness or death in the family, or lack of income, greatly exceeds normal levels, or the exposure to these negative factors lasts for a long period of time.

During social unrest, people's entire way of life is torn apart. Living conditions may become intolerable, and even the most basic needs may be lacking. These conditions, along with an uncertain future and a constant state of insecurity, put great stress on families and communities. Prolonged stress can break some people down emotionally and mentally, leading to mental health problems. These problems may exhibit themselves physically (fatigue, headache, back pains), emotionally (fear, anxiety, mood changes), or through major changes in behaviour (domestic violence, alcohol abuse). Many of these problems can be dealt with. If these problems are not treated early, people can suffer long after the emergency is over.

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

STRESSORS, PROTECTIVE FACTORS, AND MENTAL HEALTH DISORDERS IN HUMANITARIAN EMERGENCIES

Introduction to Mental Health Disorders

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

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

Understanding the four parts to this relationship is essential for planning mental health programs (see Figure 12-1 below).

Figure 12-1

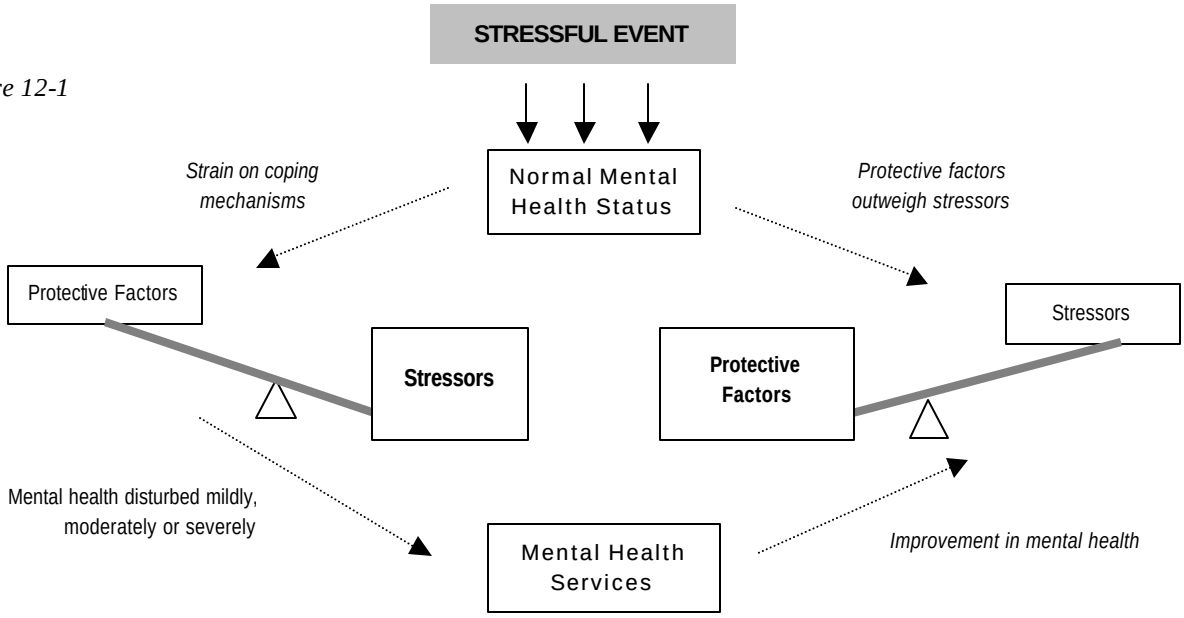


Table 12-1: Terms and Definitions

Anxiety	Intense and prolonged fear or worry, which can lead to mental distress or panic.
Cope	Behaviour that protects a person from internal or external stress; it may be healthy or unhealthy as follows: • Examples of healthy coping behaviour: reaching out to others for help, actively working to find a solution or resolving the source of stress. • Examples of unhealthy coping behaviour: a voiding the source of the threat, ignoring the threat or denying the effect in order to function normally
Counselling	Guiding a person or groups of people through discussion about traumatising events to help them integrate their memories in a healthy way.
Depression	Intense and prolonged feelings of sadness, tiredness, hopelessness, or lacking interest in normal activities.
Empathy	Identifying with and understanding another person's situation and feelings.
Grief	An emotional reaction to the death of a loved one; it may be expressed in two ways: • Healthy grief: feelings of sadness which diminish over time; missing the loved one but being able to return to normal activities after a reasonable length of time. • Unhealthy grief: feelings of extreme loneliness, overwhelmed by sadness; being unable to resume normal activities even after a reasonable period of time.
Normalcy	The state or fact of being normal.
Protective factors	Qualities in a person or the world around them that shield him/her from the full force of a stressor.
Psychosis	Losing touch with reality. It can range in severity from mild distortions of reality to hearing or seeing things that are not there
Post Traumatic Stress Disorder (PTSD)	Mental illness affecting people who have been exposed to severe violence or abuse. Affected people frequently remember their painful experiences and feel tormented by them. They have difficulty defining real from unreal events.
Social Support	A network of people that one trusts and seeks help from. Includes family and extended family members, neighbours, friends, religious leaders, teachers, etc.
Somatisation	When a person's emotional status affects how he/she feels physically. Anxiety or depression may be expressed as follows: fatigue, gastrointestinal complaints, headache, cardiac symptoms, diffuse aches and pains, muscular and joint problems, or sexual dysfunction.
Stressor	A factor that adds to people's stress, e.g., loss of family or home, lack of food, etc.
Trauma	Extreme level of stress reached when a person has lost control and can no longer handle a situation, e.g. exposure to violence such as torture, rape, etc.

Stressors

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

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

1. Displacement

Forced displacement, whether it results from conflict, persecution, violence, or social and political collapse, is one of the most stressful human experiences. Fleeing from war or civil strife is a more common factor in developing countries than displacement due to natural disasters such as floods or famine. Forced displacement is often associated with multiple and prolonged exposure to three groups of stressors:

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

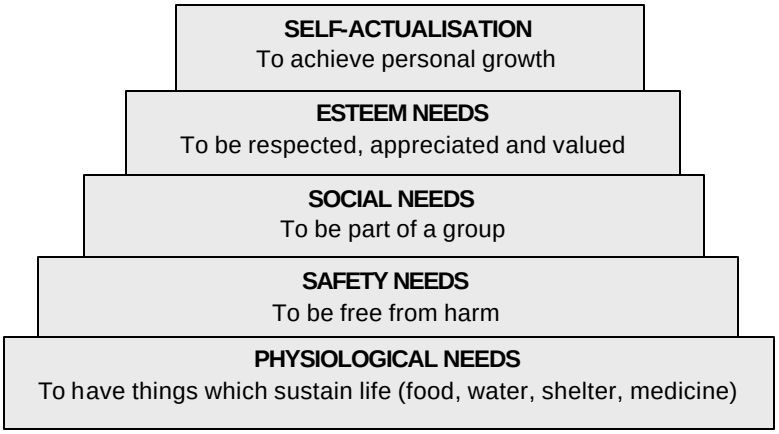
Displaced populations may be at increased risk of illness and deaths. Many deaths can occur due to physical exhaustion after fleeing from danger with only a few resources. Displaced populations may remain in camps for years or may later become refugees in a foreign country. In both situations, people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

2. Lack of Basic Needs

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

The relief response to an emergency situation aims at meeting the basic needs of displaced populations. Once people get the things that sustain life, other needs will appear more important. It is only after people feel reasonably safe from harm, that belonging to a particular group and gaining self-respect becomes a priority. Some of these needs can only be met after rebuilding the community and resuming a normal life. The following Figure shows Maslow's ladder of basic human needs.

Figure 12-2: Maslow's Ladder of Basic Human Needs



3. Social Disruption

Social unrest disrupts the social support network of families and destroys their future hopes. Societies in developing countries are based on relationships within families and communities. People in non-emergency situations help one another to cope with stress. During a humanitarian emergency, chaos often disrupts the everyday rules and social practices of a community. Families can be broken apart by physical separations and by a breakdown in family functioning. Unlike women in refugee camps

who retain their role as caretakers of children, men find it difficult to cope when they have no occupation. As a result, spouses may become abusive to one another and children may question moral or cultural values and become more defiant of their parents.

4. Exposure to Violence

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

Protective Factors

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

1. Prior Level of Functioning

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

2. Social Support

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

> **Incident 1**
>
> A traditional healer said she developed depressive illness after soldiers executed her son and two daughters, leaving her with only one son. She cries all through the night. She is not happy. She is alone with one son, so she (almost) has no one to help her, which makes her unhappy.

3. Ability to Cope

The ability to cope is generally greatest when the first stressful event occurs. As more stressful events occur, the likelihood of developing mental health problems increases. An example is a recovering rape victim. Given proper services, a woman has a reasonable chance of recovering her mental and emotional well being following a rape. However, if a victim is raped a second time, her mental health problems may be far worse than after the first rape.[1]

How long a person is exposed to a stressor also affects their ability to cope. For example, the suffering of someone kept in a prisoner of war camp for years may be greater than someone imprisoned for only a few months. In addition, the more intense or traumatic the stressor is, the worse the emotional and mental health problems will be. Some traumatic events may be more deeply felt and have more long-lasting effects, e.g., torture, watching the slayings of family members, etc.

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

4. Moral Belief Systems

People have an easier time recovering from traumatic events if they believe they are good, loyal members of the community, and if they believe living with their community is still good for them. But, if they have broken moral codes important to the community, they may be tormented by their actions. Also, people may lose faith in the government if officials betray them or act in violent or immoral ways against its own people. Land may no longer be seen as fit for planting if killings took place there.

Incident 2

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

Incident 3

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

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

5. Return to Normalcy

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

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

Incident 4

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

Mental Health Disorders

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

1. Mild Mental Disorders in Children and Adults

Not everyone in an emergency will develop severe mental illness. But the mental and emotional well-being of everyone who undergoes sadness and mourning may be affected for varying length of time. Constant feelings of loss or worry may be common, which can lead to depression and anxiety. Mild symptoms of anxiety and depression may be present in a large number of people. Even after the day-to-day life of a village is restored, people will struggle to regain the feelings of trust and safety that once made them feel like a community.

These problems can be addressed in many ways, such as community wide programs like public education, community projects, and cultural rituals and festivals.

2. Somatisation

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

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

3. Depression

Depression can be defined as intense and prolonged feelings of sadness, tiredness, hopelessness, or lacking interest in normal activities. It may be caused by a feeling of not having control over things that are happening, or by feeling cut off from familiar people and places. Depression is a common reaction in children who are separated from their parents. It is also a common reaction to the loss of family, community, or property.[2] Depression can also occur in people who are disappointed in themselves for something they have done or not done.

Depression sometimes leads to suicide. Some people will take active steps to end their life. Others may take a less obvious approach, such as placing themselves in danger, not taking care of a medical condition, or not eating. It is common to hear stories of people who intentionally provoke a soldier, break curfew, or violate other rules, hoping that someone will kill them.

Depression often causes increased irritability and a tendency to lose control more quickly. This seems to be especially true in children. In men and boys, depression may lead to increased aggression. In women, depression may prevent them from caring for themselves or their children.

4. Behaviour Problems in Children

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

Note: *Please refer to the* Needs of Children and Adolescents *chapter for more details about mental health problems of displaced children and adolescents.*

5. Alcohol and Drug Abuse

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

6. Psychosis

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

- People displaced and caught in fighting may lose touch with the world around them and become convinced they are safe at home.
- Victims of violence may hear screams and see blood long after they have been taken to safety.

People who are severely psychotic may be agitated or aggressive. Full recovery from this condition is possible if it is detected and treated early.

7. Post Traumatic Stress Disorder (PTSD)

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

The American author, Annie Dillard, uses metaphors to describe memory as follows:

> *Dillard describes memory as standing beside a stream and those events that are in the present are right before us. As time passes, the events move further down stream, eventually tumbling over the edge of a waterfall out of view, and out of our everyday awareness.*
>
> *In her description of traumatic memories, Dillard talks about events as hovering at the edge of the waterfall but never tumbling over and out of view; events we remember often no matter how long ago they happened.*

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

Incident 5

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

Incident 6

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

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

Conclusion on Mental Health Disorders

Mental health disorders can be recognised as signals of severe and persistent stress. One may even fear that displaced populations would be unable to resume normal physical and psychological function after being settled in a more secure and less traumatising setting.

The majority of people affected by humanitarian emergencies do have the capacity and ability to cope, with or without external help, and avoid the long-term effects of their negative experiences. There are also reports of displaced people becoming more mature and active within their community than they might have become under normal circumstances. A solution, however, is necessary for the few displaced people who are at risk of developing or actually have depression or other severe mental health disorders. Community-based mental health care is the best solution.

EMERGENCY MENTAL HEALTH PROGRAMS

Successful mental health programs are those that consider past lessons, the local environment, and resources. The following steps may be useful for setting up a program. Each is discussed in detail below.

1. **Lessons Learned** — review evaluations of past or current emergency mental health programs to avoid repeating mistakes.
2. **Program Planning and Administration** — create the program in a step-by-step manner (e.g., using the planning cycle). Be sure to consider the critical issues that may affect the success of the program.
3. **Selecting Mental Health Services** — consider treatments used in developed countries but do so against the cultural background and resources of the affected population in developing countries.
4. **Selecting Staff** — select staff from the affected population who are well respected and chosen by their community.
5. **Evaluating Mental Health Programs** — plan the evaluation in advance and identify suitable indicators for measuring how effective the program is in achieving its objectives.

Lessons Learned

In stable developing countries, traditional networks of family and community are available to help people cope with crisis. There are formal structures of associations, community leaders, churches, and traditional healers, as well as informal networks of extended family and ethnic identity. When a society is torn apart, support from these networks is no longer available.

In wealthier, developed countries, the resources people rely on for help are often less personal. People are more likely to go to mental health professionals even for their most personal concerns. Turning to a complete stranger in time of need is more common in Europe than in Africa.

The common factor in the two cultures described above is that, in time of need, people turn to others for help. When people are upset, distressed, grief stricken, or overwhelmed, the help often found is in the form of talking, listening, and giving advice.

Existing emergency mental health programs try to train local people in developing countries to work somewhat like qualified therapists in developed countries. While the role of listening and giving advice is well known in developing countries, confiding in strangers (even from the same country or ethnic group) is new and may be difficult to fit in with the local culture.

1. Barriers to Successful Mental Health Programs

Because so many relief agencies are heavily funded and staffed by people from developed countries, many programs have a combination of local and developed country mental health systems. However, most of these programs have failed to take root. There are many reasons why externally supported mental health programs in developing countries in Africa fail:

a. Poor fit between the program design and the needs of the local people.
   Too often even the expatriate staff with the best intentions fails to understand the local lifestyle and culture. As a result, they set up programs that resemble the mental health programs in developed countries. This makes it difficult to make good decisions about how the local population can best be helped using the resources available.

b. Bringing local people in too late in the planning process.
   The program is about to be implemented. To create a program that can endure and fits the local culture, local groups and leaders should be involved from the earliest stages and encouraged to give their input throughout the planning process.

c. Cultural differences between developing and developed countries.
   People from developing countries do not give criticism directly even when they strongly disagree with something. This may be in contrast to people from some developed countries who prefer to openly tell one another their opinions. If time and effort is put into understanding the cultural differences in approaches, it is likely that everyone involved will benefit. With a more culturally-appropriate approach, a program can be created that will be relevant and sustainable to the local community.

2. Guidelines for Setting Up Mental Health Programs

Bringing together two cultures is crucial to the success of a relief program. Below are the keys to successfully blending systems from both developed countries and developing countries:

a. Do not set up a developed country's mental health system.
   Instead, use the lessons about treating mental health disorders from developed countries to educate and support developing countries interested in creating their own mental health programs.

b. Involve the affected community in decision-making from the beginning.
   Representatives of the community should be made equal partners in program planning and implementation. Their full involvement from the start increases the chances that programs will be planned and implemented to best serve the people with the greatest need.

c. Integrate externally supported mental health programs with the local health care system.
   Many issues that will be faced by an agency trying to provide mental health services may have already been resolved by the existing health care system.

d. Link mental health services with other resources within the community to help rebuild the daily structure, family unit, and communities.
   It is easier for affected individuals to also regain their mental health and get back to their normal routines as families and communities heal.

Program Planning and Administration

Planning and running a successful mental health program involves a wide range of issues. Program planners should begin by recognising that the displaced population is made up of normal people who have been exposed to abnormally stressful experiences. Many of those affected may be temporarily unable to cope with the emergency situation.

Displaced people may be expected to go through the following phases in their recovery (with some differences due to age and maturity):[4]

Table 12-2: Phases of Recovery for Disaster Victims[1]

Phase	Duration	Normal Reaction of Disaster-Affected People
Heroic Phase	Begins prior to the impact and lasts up to a week afterwards	Affected people struggle to prevent loss of lives and minimise damage to property.
Honeymoon Phase	Lasts two weeks to two months	Massive relief efforts lift the spirits of survivors and hopes of quick recovery run high, but the optimism is often short-lived.
Disillusionment Phase (sometimes called the Second Disaster)	Lasts from several months to a year or more	There is delay in recovery. Outside help leaves, and the affected people realise they have a lot to do for themselves.
Reconstruction Phase	May take several years	Normal functioning of the affected people is gradually re-established.

Mental health services should aim at helping the affected population reach the reconstruction phase without developing chronic mental health problems. The critical steps of planning an emergency mental health program include:

- making contacts with the affected community
- measuring the need for services
- assessing the resources
- setting goals and objectives
- developing the right approach
- working towards a sustainable program

1. Making Contacts With the Affected Community

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

2. Measuring Need and Resources

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

The following checklist may be used for a mental health assessment only after being adapted to the local situation:

Table 12-3: Mental Health Assessment Checklist

Background on disaster: • Demographic profile — total population, number of men, women, children, elderly. • Disaster experiences — pre-flight, flight, camp, etc. • Population characteristics — language, religion, rural or urban culture, level of education. Health status: • common causes of deaths (serious injury, disease) • common causes of illness (serious injury, disease) • nutritional status and micro-nutrient deficiencies Trauma events (experienced, witnessed, or heard about): • rape or sexual abuse • torture or isolation • unnatural death or murder of family or friend • forced family separations • lost or kidnapped • any other frightening event	Mental health symptoms: • physical – fatigue, headache, aches and pains, etc. • emotional – feeling sad, hopeless, anxious, lack of interest • behavioural – alcoholism, drug abuse, aggression • difficulty in recognising real from unreal events, frequent, painful memories of past events Resources available: • local services: PHC, schools, mental health care • social support network (family, peers, neighbours) • community services: traditional healing, religious or traditional ceremonies • technical resources of mental health and social workers, drugs, and health services • national curriculum on mental health training • national policy on mental health care

In addition to the above information, special surveys should be carried out. These surveys are listed and are discussed in detail below.

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

a. Identify Local Beliefs and Customs about Mental Illness

It is important to identify local terms and traditional beliefs about the causes of mental health problems. This will help identify coping behaviour and the resources available locally for mental health care. A recent assessment of how mental illness is perceived by those who are displaced was carried out in Moxico, Angola. The displaced people classified mental illness into two categories — *traditional illnesses* and *illnesses from God*.

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

The following table defines the local terms for mental illness among the displaced people in Moxico, Angola:

Table 12-4: Local Terms for Mental Illness (Moxico, Angola)

Local Terms for Mental Illness	Perceived Causes	Signs and Symptoms
CUHONGA in adults	Thinking a lot about bad events or problems, Witchcraft or bad spirits, Cuhonga in mother	Cannot function or work well, Moving slowly, difficulty getting started, Being unhappy, Crying at night, Bad dreams, sleepiness
CUHONGA in babies	Cuhonga in mother, Abdominal worms (in babies)	Weight loss, Not moving much, Crying, Poor feeding
KUKASUMUKA	Thinking a lot about a terrible event, Abdominal worms	Frequent waking at night, Startling easily, Neck stiffness, Laziness, weakness, falling down, Weight loss, reduced appetite
KUZALUKA (equivalent to English concept of “madness”)	Thinking a lot about terrible events, especially own actions, Bad spirits, Serious illness	Running a lot, running all day, Assaulting, attacking people, Headache, Not staying in the house, Not able to wear clothes
MATACHI (early form of Kuzaluka, which can progress to other forms)	Serious illness, Wanga (witchcraft), Drugs/alcohol	Running, moving constantly, Not sleeping well, waking early, Attacking people, Irrational acts, Talking a lot
MANYONGA (remember/re-experience what happened in day time)	Thinking a lot about a terrible event (intelligent people)	Re-experiencing a terrible event when awake, Nervousness, weakness and thinking a lot while this is happening, Talking to oneself, Unhappiness, Thinking a lot

b. Screen the General Population

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

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

c. Individual Evaluation

Every person suspected of having a mental health problem through the general screening should be referred to the health facility for an individual mental health evaluation. This will help identify the nature of the problem and determine the effects of the emergency experiences. Standard evaluation instruments may be used, which allow an individual to disclose more about his/her psychological state and trauma experiences than they might otherwise do. Below is the Hopkins Symptom Checklist-25, which has been successfully used by mental health workers and health providers. It was found to be a valid and reliable instrument for detecting symptoms of anxiety and depression among individual Southeast Asian refugee patients.

Table 12-5: Hopkins Symptom Checklist-25 and Analysis

Anxiety Symptoms	**1** **Not at all**	**2** **A little**	**3** **Quite a bit**	**4** **Extremely**
1. Suddenly scared for no reason				
2. Feeling fearful				
3. Faintness, dizziness or weakness				
4. Nervousness or shakiness inside				
5. Heart pounding or racing				
6. Trembling				
7. Feeling tense or keyed up				
8. Headaches				
9. Spell of terror or panic				
10. Feeling restless, can't sit still				

Depression Symptoms	1 Not at all	2 A little	3 Quite a bit	4 Extremely
11. Feeling low in energy, slowed down				
12. Blaming yourself for things				
13. Crying easily				
14. Loss of sexual interest or pleasure				
15. Poor appetite				
16. Difficulty falling asleep, staying asleep				
17. Feeling hopeless about the future				
18. Feeling blue				
19. Feeling lonely				
20. Thoughts of ending your life				
21. Feeling of being trapped or caught				
22. Worrying too much about things				
23. Feeling no interest in things				
24. Feeling everything is an effort				
25. Feelings of worthlessness				

Note: *Before administering the checklist to individual patients, it must be adapted to the local language and culture.*

Analysis of the Hopkins Symptom Checklist-25

To identify individuals with mental health disorders, responses in each table are summed up and divided by the number of answered items, as shown below:

$$\textit{Anxiety} = \frac{\textit{Items 1-10}}{10} \qquad \textit{Depression} = \frac{\textit{Items 11-25}}{15} \qquad \textit{Total} = \frac{\textit{Items 1-25}}{25}$$

Individuals with any score greater than 1.75 are considered symptomatic.

3. Setting Goals and Objectives

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

- to restore normal functioning among the affected population
- to relieve and alleviate stress and psychological suffering resulting from the emergency situation

Immediate and long-term **objectives** should be defined that can help achieve the goals that have been set. Objectives are useful for monitoring the effectiveness of the program. Below is a list of possible objectives:

- to help the people in the affected community understand the current situation and their options
- to increase awareness about normal and abnormal reactions to stress
- to mobilise social support within the community
- to reinforce normal coping mechanisms
- to identify those individuals who are unable to cope
- to offer support to those who cannot cope with the current situation
- to effectively prevent milder mental health problems from becoming long-lasting mental health disorders
- to reduce the need for medical treatment in somatization disorders

4. Developing the Right Approach

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

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

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

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

5. Working Toward a Sustainable Program

Ways of sustaining a program should be determined at every step of program planning. Displaced people may suffer from mental health problems for years after the emergency is over. Many people continue to suffer long after the relief agencies pull out from the program, and the effects can be felt well into future generations. Even though there is much sympathy for these problems, resources for promoting mental health care for displaced populations are extremely limited. Therefore, the design of the program should not be too ambitious and planners should develop cost-effective ways of complementing the program, which focus mainly on local resources and volunteers.

From the start, relief agencies must decide how long they are going to support mental health services. Well-established mental health services may not be suitable for relief programs that are supported for two years or less. Programs that intend to go on longer should have a well-developed plan in place that shows how the program will continue both financially and administratively.

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

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

6. Train the Trainers Model

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

Selecting Mental Health Services

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

General Measures

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

1. Aiding People to Resume Normal Cultural Practices

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

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

2. Educating the Community

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

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

3. Linking People with Other Services

Displaced people often need food, shelter, and health care, as well as non-emergency social services. For the affected population to fully benefit from a mental health program, relief workers must pay attention to the people's material needs as well as their emotional needs. Linking people with other essential services can help them take the first steps toward regaining their health and normal routines. In addition, relief agencies and the host community should help the affected people find opportunities for meaningful work. This includes involving the displaced people in delivering relief services as much as possible.

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

Table 12-6: Needs of Displaced People

Problem	Service	Target Group
Insecurity	Teach self-protection, ensure sufficient camp security, promote peace/reconciliation	All displaced people (especially vulnerable groups)
Family Missing or Killed	Tracing, family reunification, foster family placement	Orphans
Food Insecurity	Provide adequate food supplies	All displaced people, vulnerable groups (elderly, female-headed households)
Interrupted Education	Re-establish schools, sports, play	All children and adolescents
Disability	Counselling, health care, rehabilitation (including mechanical aids)	Physically and mentally-disabled people, mentally ill/retarded, landmine victims
Idleness	Support small-scale IGAs, response to substance abuse, education	Entire population (especially men, youth, and the elderly)
Insufficient Health Services	Extend coverage via outreach, ensure regular drug supply	Physically ill people

Therefore, mental health workers must be aware of the resources available to the affected community and be prepared to help people reach the resources they need. Whenever possible, they should use the affected community's own resources for this effort.

Specific Mental Health Services

Displaced individuals whose mental health condition does not respond to the above general measures may require more specific mental health care, such as:

1. The Talking Cure

There is a lot of discussion and disagreement within the field of emergency mental health services about the use of western-oriented "talking therapies" in Africa. Most of the disagreement centres around two concerns:

- It is not possible to provide *individual* talking sessions with a specially-trained worker for every displaced person in need of mental health services in a poor or war-torn country.
- Cultural norms tell people what they can and cannot talk about and to whom. Programs that expect victims or patients to talk openly about traumatising events to someone who may not be related to them may never be fully integrated into the communities they hope to serve.

However, talking therapies can be especially useful in helping displaced people deal with their traumatic experiences and to adapt to their new environment. People in distress often seek someone who is experienced and compassionate in talking and giving support during a crisis. Someone that can help them find solutions to problems, resolve conflict, bear the burden, or provide soothing comfort. This relationship in developed countries consists of a therapist and a patient.

In developing countries, the therapist may be a relative from the extended family, a traditional healer, or other member of the community. In either culture, talking can be useful for the following:

- affected individuals to promote individual healing
- affected families to promote healing of the relationships between family members
- affected groups and communities (from classrooms to entire cities) to promote healing of a society

Note: *Those who cope by avoiding talking about their experiences should be assisted in overcoming their negative experiences through other means, such as support groups.*

2. The Medical Cure

There is strong cultural resistance toward treating displaced people having mental illness with Western style medical treatment. Cultural beliefs about the root cause of mental disorders and their probable course should be understood before prescribing psychotropic medication. To be effective, it should be combined with other mental health interventions, such as counselling.

Psychotropic medication can be useful for controlling severe symptoms of mental illness. However, it is not enough to solve all mental health disorders. Caution is essential when introducing medications in an emergency program because of the following:

- Medication for mental health problems is usually expensive and can be difficult to obtain.
- Using medication requires advanced medical training that is not available to many doctors.
- To be useful, it usually needs to be taken regularly for weeks, months, and possibly longer.
- Displaced people unfamiliar with psychotropic drugs may share their prescriptions with other people complaining of similar symptoms.
- Other drugs (prescribed or over-the-counter drugs, traditional remedies, etc.) may interfere with the action or increase the side effects of psychotropic medication.

Nevertheless, for programs operating in areas where money and medical expertise is available, the following psychotropic medications may be considered as a treatment option for people with major mental disorders:

- *Benzodiazepines* may be given for problems of anxiety or sleeplessness.
- *Imipramine* may be a cost-effective choice for depression.
- *Other drugs* may be necessary to treat serious psychosomatic symptoms such as hypertension, peptic ulcers, and migraine headaches.

Note: *Any program considering using psychotropic medications should first consult with local doctors and WHO to assess the availability of these medications in that area.*

The above medication is relatively inexpensive and can be administered with little concern for side effects. Thorough education and re-education of the patient and his or her family is necessary to prevent compliance problems and unpleasant side effects. The patients should be cautioned against taking higher doses without approval of the physician.

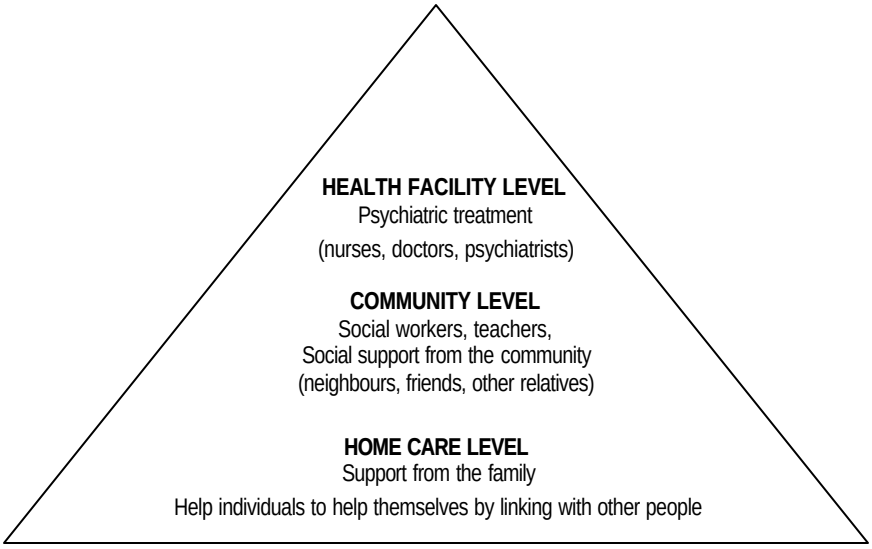
3. Crisis Intervention

A timely, discrete and non-stigmatising approach is essential for assisting individuals who require specialised and prolonged care for emergency mental health conditions. Special interventions may be developed with the health care team and community members to assist the following:

- *Severely depressed or suicidal patients* that have experienced tremendous loss or stress may require special medical care with close monitoring to ensure safety during their period of hopelessness. Mechanisms for integrating the individuals back into their families and community should be in place.
- *Victims of sexual violence* — counselling and treatment of rape victims call for a high degree of discretion and sensitivity. Many well-meaning initiatives by NGOs to identify and help rape victims have failed. Rape victims may prefer to remain silent and hidden from the outside world. How these victims are helped at the individual, family, and community levels requires exploration of each particular emergency situation.
- *Survivors of extreme violence* (e.g., torture) — may require care by specialised mental health centres and health providers to prevent long-term mental and physical health consequences.

Conclusion On Mental Health Services

Figure 12-3: Mental Health Services within a Primary Health Care Framework



The above Figure shows how various mental health services can be supported within a Primary Health Care framework. A mental health program that is modest in scope, but is well staffed and relies mainly on local resources and services, will provide better assistance to the community. Therefore, emergency mental health services should include both general measures and specific mental health care that involve the family, community and health facilities. Most of the mental health services should be delivered through community and home care, the levels that can assist individuals with minor mental health disorders more effectively. Only a few individuals will have severe or chronic mental health disorders that require more advanced mental health care.

Selecting Staff

Mental health care providers should have the following skills:

- an understanding of the affected people's culture and reactions to stress
- the ability to listen to the affected individuals, groups and communities as a whole, relate their experiences, and identify their specific need
- the ability to give guidance and support, which are necessary for easing anxiety and tension

Three categories of staff are required for a mental health program:

1. *Administrative staff who will be based at the project office and make regular field visits:* in addition to the above skills, they require management skills for co-ordinating activities and collaborating with other partners.
2. *Mental health professionals who will be based at the health centre and hospital*: require technical and interpersonal skills to deliver mental health services and train other staff
3. *Direct service staff who will be based within the community (outreach):* may not always have full technical qualifications but must have strong interpersonal skills.

1. Administrative Staff

In order to succeed, a program needs the *right* administrative staff, including representatives from the affected community. These representatives can be valuable in making contact with the community and helping the program to respond to the needs of the community.

Whenever possible, administrative staff should be people who are able to make a commitment of at least one year to a program. The staff that is selected should be able to accept and work with people from different backgrounds for a common cause.

2. Mental Health Professionals

A mental health program will be more effective if it is staffed by people who are technically qualified to provide mental health care, who can train the local staff to deliver services, and who can educate the affected population about mental health problems. However, most humanitarian emergencies occur in developing countries that have very few or no mental health professionals.

When there are not enough skilled people locally to carry out a mental health program, expatriate staff may be recruited as a temporary alternative. Expatriate staff must focus on transferring the essential mental health skills to the local staff. This will increase the level of mental health expertise within a country and decrease the long term need for expatriate staff.

3. Direct Service Staff

The success of mental health services depends greatly on the interpersonal skills of the worker and how they relate to the people being treated. These mental health workers must be able to reach the most needy of the affected population, to observe and communicate with them, and to offer the required support and guidance.

Mental health programs should be staffed by people from the affected population who are well respected and chosen by the community. They may be peers, educators, religious leaders, or community health workers who are involved in other community-based activities. The direct service staff will require additional training to do the following:

- increase awareness among the affected populations about normal and abnormal reactions to stress and the possible existence of mental health problems
- actively screen and recognise those who are unable to cope with stress on their own
- refer those with mental health needs to the appropriate providers
- mobilise the social network to provide the necessary mental health support

Evaluating Mental Health Programs

The success of mental health programs for displaced populations are rarely measured because no standards of measurement have been developed. Many relief agencies set up inappropriate mental health programs because there are no guidelines for collecting base-line data. This data would be helpful in determining the true needs and available resources. In addition, measurable objectives may not be set, making it impossible to measure the benefits of the mental health programs.

Monitoring and evaluating should be carried out for mental health services as well as other related services that may affect the success of a mental health program (e.g., basic health and social services).

Monitoring helps programs to improve services by adapting them to the changing needs of a community. To monitor the program effectively, mental health workers should be trained to keep records of the people assisted, the service provided, and the resources used. Valid indicators can be defined based on this information to measure if a program is meeting its objectives and for tracking the outcome of various activities. The table below shows examples of indicators which may be useful.

Table 12-7: Useful Indicators for Tracking Activities

Services/ Target Group	Activities	Program Indicators	Outcome Indicators
Cultural	Ceremonies, prayer	Frequency of events, attendance	Normal function
School	Education, sports, play	Attendance, lessons taught	Teenage vandalism, Hyperactive children
Self-Help	Relief services, gardening, markets, etc.	Workers recruited	Violence
Family Reunification	Tracing, counselling	Contacts made	Domestic abuse
Women	Support network	Women involved	Psycho-somatic disorders (missed periods)
Unaccompanied Minors	Nutrition, shelter	UAM fed	Malnutrition rate
Physically Handicapped	Rehabilitation, surgery, counselling	Crutches issued, people counselled	Frustration, boredom
Mental Health Education	Home visiting, meetings, advertising	Home visits	Attitude to mental illness
Talking Cure	Counselling, emotional support	People counselled	Level of mild mental health disorders
Medical Cure	Diagnosis, treatment, counselling, referral	Cases treated, drugs issued	Level of chronic mental health disorders
Basic Services	Food supply, sanitation, water supply, health care, security	Coverage	Psychosomatic illness, communicable diseases malnutrition rate

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

Table 12-8: Information Provided from Evaluating a Mental Health Program

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

SUMMARY OF EMERGENCY MENTAL HEALTH PROGRAMS

This chapter is aimed at relief agencies and NGOs interested in designing, implementing and evaluating community-based mental health programs that can help displaced people to resume normal lives.

The chaos and confusion that come with a humanitarian emergency is devastating not only physically, but also emotionally and psychologically. The emotional toll can result in mental health problems that, if left untreated, can affect people and communities for years to come. Humanitarian agencies usually have limited resources and are faced with displaced populations with overwhelming needs. Addressing the mental health needs of victims in a humanitarian emergency is a courageous step. Emergency mental health programs are relatively new interventions and there are no clear standards. But some programs have had success. To ensure sustainability, there should be greater involvement of the affected community and use of local resources within the displaced families and the community.

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Report prepared by:Paul Bolton MD MPH ScM and William Weiss MA, The Johns Hopkins University
Available: This report was made possible through Cooperative Agreement Number HRN-A-00-96-9006 between the US Agency for International Development and The Johns Hopkins University; and the support of Moxico staff of Save the Children USA

For information on psychological support for disasters and stressful life events, see:
The Federation Reference Centre for Psychological Support, Danish Red Cross, Post Box 2600, DK-2100 Copenhagen 0 Denmark. ⁄

ENDNOTES

1. It is also important to be realistic about how much good mental health programs can accomplish when fighting is ongoing. Healing usually only takes place in a safe environment. Emergency mental health programs must be sensitive to the dangers, real or imagined, the people they serve are worried about. Security takes precedence over healing, and resources may be wasted if mental health services are introduced into an emergency situation before safety, food, shelter, and basic health care are in place.

2. Adapted from Farberow and Gordon, 1981, pp 3-4; Weaver, 1995, pp 31-32)

[1] www.disasterrelief.org/Disasters/991203Turkmentalhealth/index_txt.html