World Health Organization

REGIONAL OFFICE FOR South-East Asia

WHO Framework for Mental Health and Psychosocial Support after the Tsunami

This document was produced through collaborative efforts of Country Focal Points in Mental Health from tsunami-affected countries, Department of Noncommunicable Diseases and Mental health (NMH) of the WHO Regional Office for South-East Asia, and the Department of Mental Health and Substance Abuse, WHO Headquarters.

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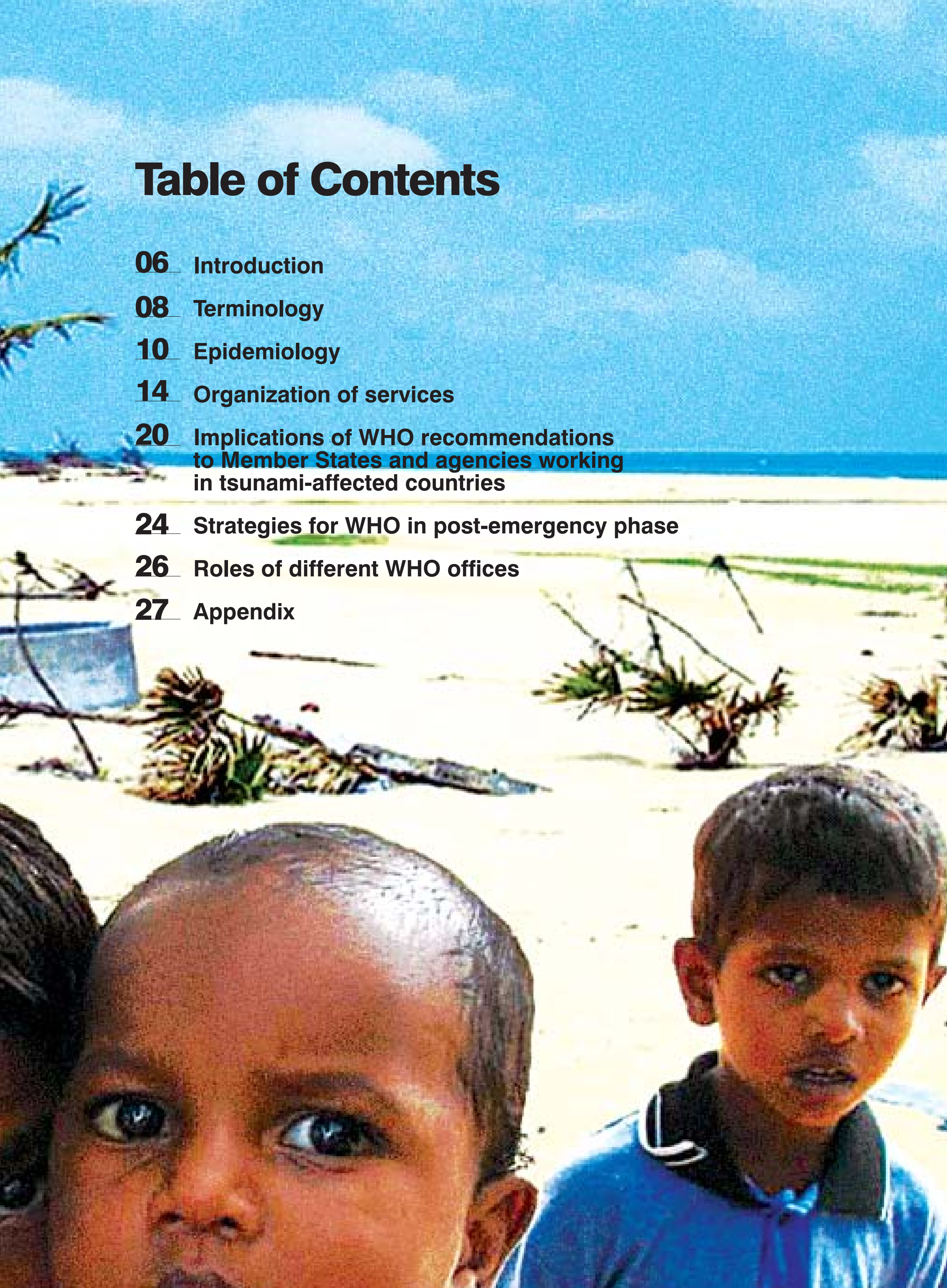


Table of Contents

06 Introduction

08 Terminology

10 Epidemiology

14 Organization of services

20 Implications of WHO recommendations to Member States and agencies working in tsunami-affected countries

24 Strategies for WHO in post-emergency phase

26 Roles of different WHO offices

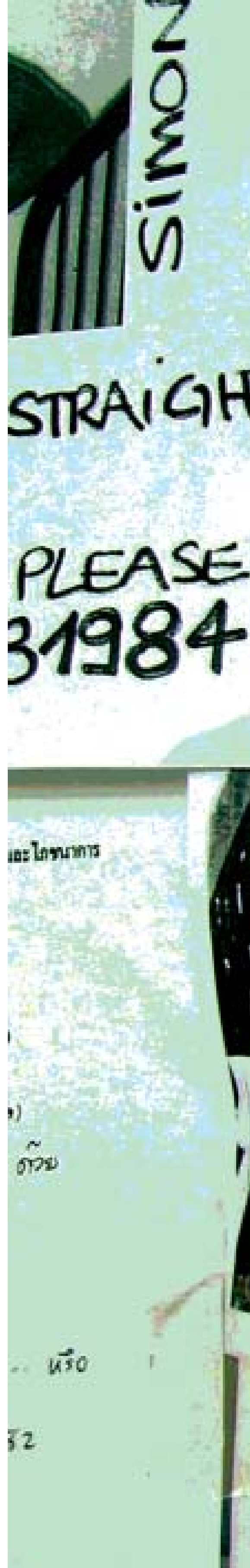
27 Appendix

Introduction

The tsunami of 26 December 2004 caused death and destruction on an unprecedented scale in tsunami-affected regions.

Following the disaster, WHO was urged by Member States to support ministries of health in affected countries, to restore health resources and in the area of mental health and psychosocial support.

This brief document aims to provide a framework for WHO assistance in this area.



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Terminology

It is noted that in the field and within WHO, different people use the terms mental health and psychosocial differently. It is unlikely that in the near future all relevant stakeholders (even within WHO) will use these terms in the same manner. For that reason it is proposed to avoid focusing on possible conceptual distinctions between these two terms, especially because, in practice, good mental health and good psychosocial interventions tend to be the same.

It is proposed to use the phrase, 'mental health and psychosocial support' in titles of documents, proposals, notes, and meetings. Some recent WHO documents on the subject have been ignored by other agencies because only the term 'mental health' was used in the title. Conversely, some stakeholders are known to have ignored documents that only use 'psychosocial' in the title). Although 'mental health and psychosocial support' may sound odd to some, the term reflects an inclusive, integrated way of approaching this public health issue.

Nevertheless, there is a need to use precise language in this document. Here, the term social intervention is used for interventions that primarily lead to social effects, and the term mental health intervention is used for interventions that primarily lead to mental health effects. (It is acknowledged that social interventions have secondary mental health effects and that mental health interventions have secondary social effects, as the term 'psychosocial' suggests.) In this document, mental health interventions cover both clinical interventions (medication, psychotherapy) as well as basic, non-clinical, psychological support interventions (e.g. psychological first aid).

Epidemiology

The epidemiological projections of WHO are summarized in the table in Appendix. These projections are useful to maintain consistent communication with the media about the size of the problem. In other words, these projections reduce the chance of different WHO staff and outside experts providing different and contradictory information to the media.

These projections help communicate the important public health message that problems range from mild distress to a variety of mental disorders, including very severe mental disorders.

These numbers are mere projections based on available literature. It is likely that epidemiologists will conduct studies and find much higher or lower rates of disorder in some tsunami-affected countries. This is because in disasters the distinction between normal psychological distress and mild mental disorder is unclear. Prevalence rates found in disaster studies tend to be extremely reactive to variations in assessment method, case definition, and the population's willingness to endorse symptoms in studies.

A POPULATION PERSPECTIVE FOR ADDRESSING THE MAGNITUDE OF PSYCHOLOGICAL DISTRESS AND MENTAL DISORDERS

Viewing the situation from a public health perspective (i.e. a population perspective), rather than a clinician's perspective, we see the situation as follows:

Although there are no reliable data on the numbers of people with mental health problems in the tsunami-affected countries, the following rule-of-thumb estimates indicate the likely size of the problem. These rates vary with the setting (e.g. involving sociocultural factors, current and previous disaster exposure) and assessment method and give a very rough indication of what WHO expects the extent of the morbidity and distress to be. There are three groups each requiring a different response:

(1) People with mild psychological distress that resolves within a few days or weeks: A very rough estimate would be that perhaps 20-40% of the tsunami-affected population falls in this group. These people do not need any specific intervention.

(2) People either with moderate or severe psychological distress that may resolve with time or with mild distress that is chronic: This group is estimated to be 30-50% of the tsunami-affected population. This group covers people that tend to be labeled with psychiatric problems in many surveys involving psychiatric instruments that have not been validated in the local cultural and disaster-affected context. This group would benefit from a range of social and basic psychological interventions that are considered helpful to reduce distress.

(3) People With Mental Disorders

MILD AND MODERATE MENTAL DISORDER: In general populations, 12-month prevalence rates of mild and moderate common mental disorders (e.g. mild and moderate depression and anxiety disorders, including Post-traumatic Stress Disorder (PTSD)) are on average about 10% in countries across the world (World Mental Health Survey 2000 data). This rate is likely to rise – possibly to 20% after exposure to severe trauma and resource loss. Over a number of years, through natural recovery, rates may go down and settle at a lower level, possibly at 15% in severely affected areas. Thus, in short, as a result of a disaster, the population rates of disorder are expected to go up about 5-10%. A misconception is that PTSD is the main or most important mental disorder resulting from a disaster. PTSD is only one of a range of (frequently co-morbid) common mental disorders (mood and anxiety disorders), which tend to make up the mild and moderate mental disorders, and which become more prevalent after a disaster. The low level of help-seeking behaviour for PTSD symptoms in many non-western cultures suggests that PTSD is not the focus of many trauma survivors. Consequently, WHO is concerned that agencies are over-emphasizing PTSD and are creating narrowly defined, vertical (stand-alone) services that do not serve people with other mental problems. This way of working could waste precious resources.

SEVERE MENTAL DISORDER: Severe mental disorder that tends to severely disable daily functioning (psychosis, severe depression, severely disabling anxiety, severe substance abuse, etc.) is approximately 2-3% among general populations of countries across the world (World Mental Health Survey 2000

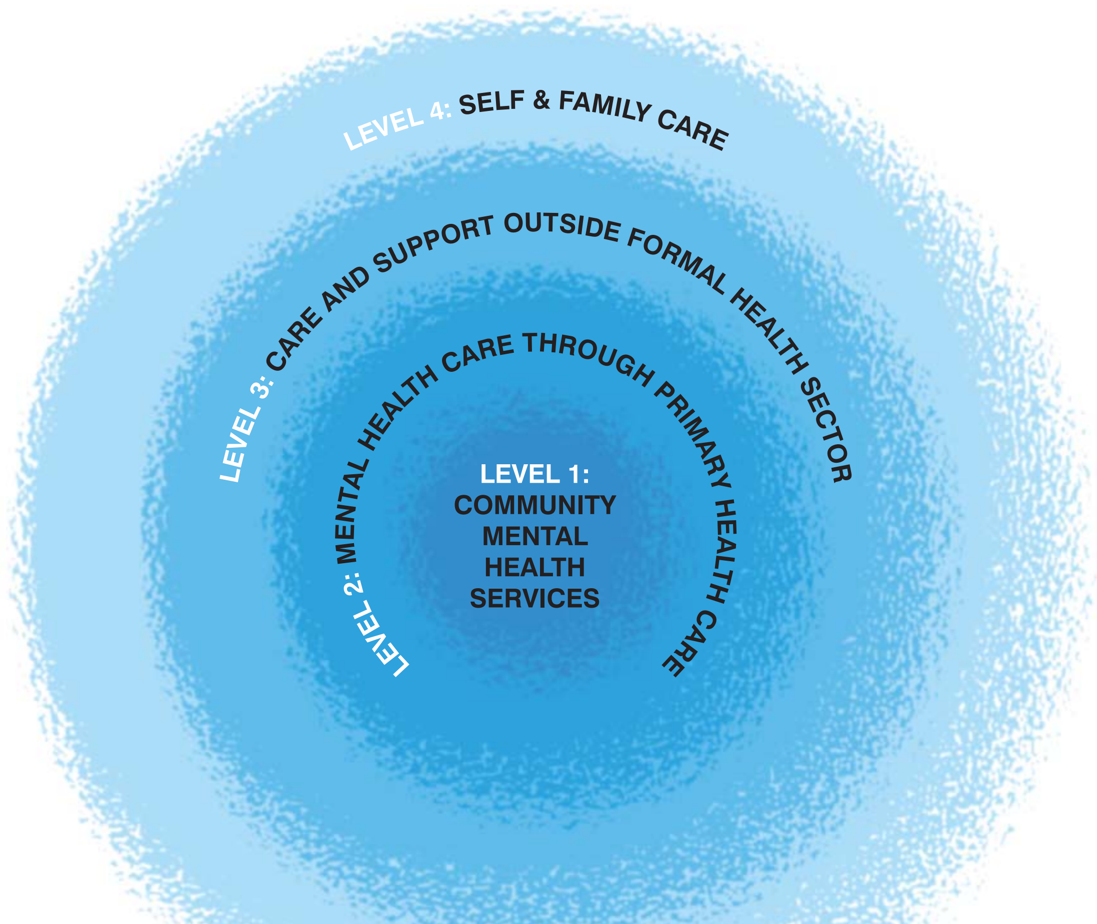
data). People with these disorders may experience inability to undertake life-sustaining care (of self or of their children); incapacitating distress; or social unmanageability. The 2-3% rate may be expected to increase (e.g. to roughly 3-4%) after exposure to severe trauma and loss. Trauma and loss (a) may exacerbate previous mental illness (e.g. it may turn moderate depression into severe depression), and (b) may cause a severe form of trauma-induced common mental disorder in some people.

Organization of Services

WHO's framework for organizing mental health and psychosocial support may be summarized in the figure below.

People should be able to find a solution to all their mental health needs within their district (or, when districts are small, within their own or adjacent districts). Within districts, mental health and psychosocial support should be available at four levels:

FIGURE: OPTIONAL MIX OF SERVICES WITHIN ONE DISTRICT



COMMUNITY MENTAL HEALTH TEAMS:

(levels 1 and 2)

These teams can provide mental health services through mobile/outreach facilities or through the primary health care system (levels 1 and 2 in the figure). The team may have as base a small, acute ward at a general hospital but does most of its work in the community. In most districts, such teams do not exist. External technical and financial support is needed for developing these teams.

It is recommended that the teams be multidisciplinary, but their exact composition of the team will vary depending on the availability of human resources in mental health in the country.

The community mental health teams could consist of:

- One medical doctor with mental health skills;
- Three nurses of which one nurse is specialized in non-medical (psychosocial) support, and
- Three technicians (nurse aides/community health workers/paraprofessional health staff) who are trained and supervised in nonmedical (psychosocial support).

The minimal acceptable size of the team should be at least have 3-4 staff (the composition of which can vary), and have clear non-medical (psychosocial) helping skills.

Primary health workers (which may have different cadre positions in different countries, e.g. doctors, nurses, community health workers, etc.) should be trained and supervised by the community mental health team. External technical support is needed to help the community

mental health team in training and supervising the primary care workers. Primary health care workers should be drawn from within the community so that they have an appreciation of the local culture, its historical roots and the way it has shaped indigenous concepts of well-being.

CARE AND SUPPORT ACTIVITIES OUTSIDE THE FORMAL HEALTH SECTOR:

(levels 3 and 4)

This level is broad and covers: (a) strengthening the support provided by pre-existing community resources (e.g. by training traditional healers, teachers, religious leaders, women leaders and other community leaders in providing support), (b) community participatory activities that involve getting members of the community together in self-identifying and planning community activities to reduce mental and social suffering (local solutions), (c) activities that address important social factors to reduce social suffering (income generation activities, educational activities), (d) structured social services outside the health sector (e.g. community social work), (e) strengthening community networks through community activities that ensure that isolated persons come in contact with one other and thus generate mutual support. It covers many other activities as well.

The immediate need of the Member Countries after the tsunami disaster has been reaching out to the hundreds of thousands of people who have been affected. One way to reach such huge numbers of people was through appropriately trained community-level workers from within the community who understood the local culture and could provide psychosocial support to them. The table in Appendix suggests that as much as 80% of the victims have psychosocial needs that may benefit from this community-based approach. One of the tasks of the community-level workers is to identify those in need of clinical services to be provided by mental health professionals.

Mental health and psychosocial support does not necessarily mean providing medication or consultations with counselors and psychiatrists.

It is a health subject as community level workers have to be trained in appropriate methods of psychosocial first aid, identification of persons who need additional help etc. Being a health subject, this non-clinical support should also be the responsibility of WHO rather than leaving it only to NGOs or other UN agencies.

It should be noted that the experience of some Member Countries has been that certain NGOs claim to be providing “psychosocial support” by sometimes undertaking very arbitrary activities without knowing the local language or the local culture. The experience of Sri Lanka and Aceh shows that it is extremely difficult to coordinate or change the ways of working of these agencies as they have their own mandate, own budget and their own leadership to whom they report. On the other hand, there are NGOs doing exemplary work, from which much can be learned.

Self and family care

Workers from the aforementioned two levels (levels 3 and 4 of the figure) should increase people’s capacity to take care of themselves and their family through psycho-educational activities.

Three important components of the aforementioned 4-level system are: (a) referral, (b) supervision and (c) competent care for vulnerable groups.

(a) REFERRAL should be in two directions: from less specialized to more specialized care and vice versa. Thus, persons with severe depression identified by community leaders (at level 3 in the pyramid) may be referred to primary health care (at level 2), who may treat the person or who may refer the person to care by the community mental health team (at level 1). Conversely, the community mental health team may refer a person with a

depression for follow-up care in primary health care (at level 2), encourage the person to join a range of community group support activities (at level 3) and train family members (at level 4) on supporting the person.

(b) SUPERVISION is essential. Post-tsunami mental health care without supervision is an increasing problem in different countries. Initially, community mental health teams are likely to need supervision by outside experts (e.g., from outside the district or abroad). The teams may also need assistance from outside expertise to help supervise the primary care workers. Activities with a clear psychological component (e.g. counselling) at level 3 also need supervision. This may be provided eventually by the community mental health team, but only when it is sufficiently strong in comprehending how non-medical care can be helpfully provided outside the health sector. Meanwhile, supervision may be carried out by NGOs with competence in counselling.

(c) COMPETENT CARE FOR VULNERABLE GROUPS should be available at all levels of the system. Women, children and the elderly (among others) have specific issues, and workers at different levels should have competency to deal with these issues. The framework strongly advocates integrating care for vulnerable groups within the overall system. This will facilitate access to care for the largest number of vulnerable people.

Implications of WHO Recommendations to Member States and Agencies Working in Tsunami-affected Countries

1.

The destruction brought about by the earthquake/ tsunami has caused distress (traumatic stress, loss-related stress, etc.) in the majority of the population.

Yet, WHO expects the increase in mental disorders to be about 5-10% across all mental disorders. This implies that:

(a) there is no justification to use psychiatric interventions for the majority of the population affected

(b) there is no justification for a specific focus on PTSD compared to other trauma-induced mental disorders such as (non-PTSD) anxiety disorders and depression.

WHO is concerned that many clinical interventions (e.g. PTSD-focused psychotherapy) that are not basic are being introduced outside the health sector in an uncoordinated and vertical, stand-alone manner in tsunami-affected areas.

2.

WHO is advising tsunami-affected countries to urgently make available mental health care interventions in the health sector. People with mental disorders – whether or not disaster-induced, need access to basic mental health care, which should be provided through general health services or through community mental health services, within the health sector. It is WHO's role to work with the Ministry of Health to help coordinate such activities. WHO has selected partner organizations to work with governments to strengthen the mental health system in affected countries.

3.

WHO is advising countries to make social and basic psychological interventions available to the population-at-large in the community through a variety of sectors in addition to the health sector. Such interventions may:

(a) address widespread psychological distress in people without disorders, and
(b) provide some support to those people with mental disorders who do not seek help within the health sector.

Examples of social intervention would be (re)starting schooling, organizing child-friendly spaces, family reunification programme, and economic development initiatives.

An example of basic psychological intervention is teaching to listen and psychological support skills to a community worker. Many of these social and basic psychological interventions are included and described in Mental Health in Emergencies [WHO, 2003].

Social and basic psychological interventions occur typically in a range of sectors and tend to involve working with the school system and with other existing human resources in the community (e.g. community workers, leaders and traditional healers, etc.). Many of these interventions require a thorough understanding of the sociocultural context. Outsiders rarely have this understanding.

Mental health professionals (especially those from affected regions) have a role to play in training and supervising basic psychological support interventions (such as psychological first aid and problem-solving counseling) even when they are implemented outside the health and mental health services.

Professionals from other disciplines (e.g. protection, communication, education, community development, and disaster coordination, etc.) tend to lead the implementation of relevant social interventions (restarting schools, organizing child friendly spaces, family reunification, economic development, etc.). In terms of reaching many people, it is more efficient to use social interventions than basic psychological interventions. Collaboration among professionals and agencies is essential to make basic social and psychological support interventions available to the population at large.

Although social and psychological support is not necessarily a medical (clinical) matter, it remains a health issue and thus an important mandate of WHO to co-lead the effort in terms of providing of technical material and training. Such material has been developed by SEARO.

4.

PARTNERSHIPS

WHO is concerned with many international aid initiatives that focus on training only, without an understanding of the culture, without proper follow-up supervision, and without integration of trained interventions into existing systems. Such initiatives may cause more harm than good.

WHO advises outside international groups to carefully study the Guidelines for International Trauma Training by the International Society for Traumatic Stress Studies and the interagency document, Psychosocial Care and Protection of Tsunami-affected Children, before initiating trauma-focused training initiatives.

WHO is one of the few agencies that are present before, during and long after an emergency is over in most countries. Mental health activities related to emergencies have an increasing role in WHO work as well as in the work of other agencies. WHO is planning to initiate the development of interagency guidelines on psychosocial/mental health interventions in emergencies.

Strategies for WHO in the Post-emergency Phase

1.
In general, to continue to promote a balanced, multisectoral approach endorsing:

(a) social and basic psychological interventions addressing disaster-induced distress, and

(b) clinical interventions addressing mental disorders (whether disaster-induced or pre-existing).

Operationally this means:

- assisting MoH to coordinate mental health and psychosocial activities, and
- providing technical advice to MoH and cooperating agencies (e.g. NGOs).

2.
To use:

(a) WHO's comparative advantage, and

(b) the current interest in mental health, to work with MoH and develop community mental health care (in general health and

community mental health services) in tsunami-affected countries.

Operationally this means:

- working with MoH to orient countries' policy and service planning framework towards community mental health care,
- guiding and supporting MoH (and cooperating agencies) at the district level to:
    - develop district-level mental health plans on the organization of community mental health services and mental health in general health services
    - organize the posting, training and ongoing supervision of human resources for mental health
    - ensure the functioning of community mental health services (e.g. assistance in administrative aspects of organizing and running services; organizing reliable availability of essential medicines, etc)
    - monitor district-level mental health system development over time.

Roles of Different WHO Offices

1.
HEADQUARTERS (HQ):
To make available evidence and consensus about interventions; to lead the development of an overall framework for intervention, and, upon request, to provide technical and facilitate financial assistance to country- and regional-level activities.

2.
REGIONAL OFFICE:
To lead the support to countries in implementing the framework; to serve as a bridge between the overall generic framework and actual implementation; and to facilitate technical collaboration among countries.

3.
COUNTRY OFFICE:
To coordinate and collaborate with MoH to implement the framework, adapted to the country's needs.

Appendix

SUMMARY TABLE ON PSYCHOSOCIAL/MENTAL HEALTH ASSISTANCE TO TSUNAMI-AFFECTED POPULATIONS: WHO PROJECTIONS AND RECOMMENDATIONS

Description	Before Disaster: 12 Month prevalence rates (median of world mental health survey 2000 data across countries)	After Disaster: 12 Month prevelance rates (projected)	Type of aid recommended	Sector/Agency expertise
Severe disorder (e.g., psychosis, severe depression, severely disabling form of anxiety disorder, etc)	2-3%	3-4%	Make mental health care available through general health services and in community mental health services	Health sector and social services (with WHO assistance)
Mild or moderate mental disorder (e.g., mild and moderate forms of depression and anxiety disorders, including of PTSD)	10%	20% (which, over the years, will reduce to 15% through natural recovery without intervention)	1) Make mental health care available through general health services and in community mental health services 2) Make social interventions and basic psychological support interventions available in the community	1) Health sector and social services (with WHO assistance) 2) A variety of sectors
Moderate or severe psychological distress that does not meet criteria for disorder, that resolves over time or mild distress that does not resolve over time	No estimate	30-50% (which, over the years, will reduce to an unknown extent through natural recovery without intervention)	Make social interventions and basic psychological support interventions available in the community	A variety of sectors
Mild psychological distress, which resolves over time	No estimate	20-40% (which will, over the years, increase, as people with severe problems recover)	No specific aid needed	No specific aid needed

Note: These rates vary with the setting (e.g. sociocultural factors, previous and current disaster exposure) and assessment method but give a very rough indication of what WHO expects the extent of the morbidity and distress to be.

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