Looking back, thinking forward

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Disasters imply multiple threats, to life, physical integrity, basic needs and, at times, to values. In addition, they involve losses of dear ones, mementos, pets, physical property, sources of livelihood.

These dimensions as well as others, both of general and specific nature, frame this powerful stressful and fateful life event. In addition to the impact on the individual, community life becomes disrupted. How well individuals and communities face those natural disasters depend on a number of variables. What is common to all experiences is that the outcome does not result solely from random factors. Indeed, human action can modify outcomes in both the short and long term.

THE ROLE OF HUMAN ACTION IN DECREASING THE IMPACT OF A NATURAL DISASTER.

Let us examine human action from the perspective of both, the inputs of mental health agents and services and the international collaboration in mental health.

Let us examine both with an emphasis on the future capitalizing on the experience of the past. Let us look back and think forward.

MENTAL HEALTH AND THE NATIONAL/LOCAL LEADERSHIP

First, it is essential to persuade decision-makers that there is a hidden psychological impact caused by a disaster. Knowledge about such an impact, that may affect personal coping abilities and community reconstruction efforts, is obvious to us mental health workers. Yet all aspects of such a knowledge are not necessarily available in the public domain. As it is often the case, stigma and limited awareness act as an obstacle. No less important than that for decision-makers is the knowledge that adverse psychological effects can be ameliorated, if proper action is taken by them timely. Note, however, that our persuasion efforts might collide against prevailing cultural mores, such as concepts of destiny or fate, and psychological factors, such as hopelessness.

Let us see some policy illustrations originated in our experience on the occasion of the Hurricane Mitch in Central America. I believe that such an experience is valid elsewhere.

At the time of the disaster, leaders have to make decisions such as to order the public to vacate a location and to seek shelter; they must decide whether school classes ought to continue or be suspended, or whether pets may be forbidden in the shelters. Later, at the time of reconstruction, a question was posed to us, should community members and local volunteers be actively involved in those efforts or was it preferable that more experienced international aid workers be exclusively involved?
We think –although empirical demonstration is missing- that proper inputs by mental health advisors do contribute to make a difference in the decision-making process and outcome. But when should “psychological-friendly” policy decisions be developed?

And when is the proper time to carve the role for the mental health consultant to the national or local leadership? Ideally, not at the time of a disaster but much earlier. That is before the natural Disaster takes place. To lay out this ground early is essential, but does not suffice; periodic boosters are needed.

THE MEDIA IS A PARTNER
Second, what about the role of the media in mental health? We all know that it is the media that informs, often in real time, about the magnitude and characteristics of the disaster. Importantly, it is the media that is in direct contact with the people affected by the disaster whether by portable radio, TV or the press. The mental health literature often pointed out the adverse effect of the information conveyed by the media, such as the repetitive TV clips showing people been carried away by overpowering waves or throwing themselves out of windows and crushing into the ground from the World Trade Center. The latter has been imputed as a possible cause for stress reactions in viewers located far from the site of the terrorist attack in NYC on September 11.

Despite the centrality of the media, what remains missing in many countries are agreements on the provision of helpful information. In Central America messages conveyed by the media on psychological explanations for possible acting-out behavior of the children following the Mitch were judged as helpful by the parents. Thus what is advisable is to jointly draft messages with the media and negotiate the way, timing and frequency of reporting and, especially, the repeated viewing of scenes of horror such as human debris. As it has been noted by researchers on the atrocities committed in Vietnam, witnessing may carry an adverse risk.

Again here as above, the alliance with the media should be established before a disaster ever strikes to lay out the ground for the mobilization of such an alliance during and following the disaster, and even before the disaster takes place for preparedness sake.

PROGRAMS AND SERVICES
Thirdly, the time has come to focus on measures of direct action, such as programs and the role of services. We have learnt from public health the benefit of formulating comprehensive programs rather than merely providing an answer to a demand by a user.

The advantage of a program, that may use the logical framework as a matrix, is that it builds an interlocked set of actions thus providing a fuller reply to needs arising from the threats and losses alluded earlier. A well formulated program includes all available community resources for both personal as well as community needs. Also, a program spells out the responsible agents, indicators and means of verification of the actions. Ideally, disaster-related programs ought to have a double purpose, to prepare the population, community agents and leaders for the disaster, and to guide actions during and following the event.
Needless to say, these programs ought to be built during the pre-disaster period by all relevant stakeholders. They may not be formulated a novo by a country; they may adhere to a standard, universal protocol although they may require local adaptation. International experts may be instrumental in assisting countries to develop such programs.

These considerations may sound obvious, the sad truth is that often countries lack such well-planned programs, as we learnt the hard way in Central America.

Let us move on to the services? Often the attention of the international collaboration is geared towards strengthening the care capacity of the specialized services, yet countries that are at higher risk to be affected by natural disasters are precisely those who have limited specialized services.

More experienced advisors will thus seek to provide support to the general health agents; even this further extension may not suffice. What appears needed is to build the capacity of countries to respond to natural disasters by relying on the fuller network of community agents. Such a network includes the primary health care agents and extends to other conventional agents. We must recognize that the network is indeed wide and that conventional and less conventional agents may be called to action.

Therefore, a well designed national capacity building effort cannot neglect training and strengthening skills and knowledge that are available in those agents. To identify, convene, train and establish the basis for collaboration with those agents is a task for the pre-disaster time.

Often, some international experts, whose loci of practice are highly specialized trauma units in their developed countries, favor the notion that disasters require specialized services. A sober look at country needs and resources, particularly of those more often affected by natural disasters, preclude such a strategy. The reason being that it depletes the scarce human resources available thus establishing the basis for further inequality. WHO recommends that specialized care, when and if needed, should better be provided by regular mental health services.

One word about the timing of the training; when should it be provided? The answer is simple: in the pre-disaster period. An anecdote from Nicaragua is highly illustrative. The mayor of a highly affected town pleaded with me to help her to stop the stream of international consultants who were providing training to their personnel. For the previous 21 days since the hurricane, her personnel worked only for 5 days because on the other days they were attending training sessions! What may be needed during the disaster is ad-hoc consultation and general support to reorganize the disrupted services.

PARAMETERS OF INTERNATIONAL COLLABORATION

International mobilization during disasters is an expression of solidarity, of brotherhood and sisterhood among people. To fully maximize its effect it is essential that it should be timely, coordinated and well-directed. Let us examine these parameters.
Timely, if I have succeeded to make the case that a more adequate mental health response to a disaster should start during the pre-disaster period and stretches to the time when the lights on the event are dimmed, then it is essential to stress to donor countries that their inputs should be made early than late. Fortunately, many donor countries understand this. Their technical advisors should thus work at the pre-disaster period collaborating with countries, among other activities, in devising policies, programs, capacity-building, and preparing simple research protocols for monitoring and evaluation.

Coordination is a second requirement to fully profit from the generous international support. Advisors entering into the field ought to act according to well-thought out planning and coordination. Without doubt, WHO is among the best positioned globally and locally to act as the coordinating body with regard to health, and should be the one that calls on the collaborators as need arises and time elapses. Those needs vary according to different factors, by disaster stage and magnitude, by the level of development of the mental health program of the country, and by cultural and political factors. WHO has all these data available and updated, and keeps continuous communication with country authorities, including the mental health focal point.

Concretely, the collaboration from donor countries and other international and regional organizations could have greater effect if they would operate under the umbrella of WHO and the Ministry of Health. Conceivably, WHO is in possession of a roster of consultants by field of expertise that command the knowledge and experience that WHO amassed over the years. We can trust that WHO will know how to deploy such a valuable resource. Well-directed is to us the third essential condition for a successful collaboration. We have briefly reviewed several components of the mental health intervention with regard to natural disasters, such as inputs for health public policies, support to the leadership facing decisions, partnership with the media for information purposes, and issues related to program and service development, monitoring and training. No single component may suffice, more than one may be needed over time. They all need to be addressed.

In a world often divided by rivalries, the international mobilization during disasters reaffirms the common destiny of humankind. By supporting a common mental health doctrine and by working together, mental health workers will better succeed at making their professional contribution.