Mental health and psychosocial support after the tsunami: Discussion

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Presentation on May 5 2005
WHO Conference, Phuket, Thailand
In recent years, the world has become highly interested in mental trauma. Research has provided a body of evidence that exposure to disaster is a serious risk factor for social distress, mental distress and somatic distress. Research also shows that exposure to disaster is a risk factor for depression and anxiety disorders, such as posttraumatic stress disorder. Also, it has become clear that disaster puts people with pre-existing mental illness at further risk. As the prevalence of mental disorders and distress is higher after disaster, tsunami-affected countries need to strengthen their mental health services.

But there are challenges. One challenge - highlighted by several panelists - is the need for coordination, which becomes more difficult with the size of the disaster. Another challenge - highlighted by Panelist Professor Bhugra - is culture. Certainly, disaster and loss have different meanings to different people in different cultures. Culture has an impact on help-seeking behavior and on the appropriateness of clinical care by quickly-flown-in foreign clinicians.

There is another challenge. Only scarce resources are directed to mental health care by most Governments. In many countries the bulk of limited financial mental health resources are allocated to mental hospitals. In mental hospitals most patients often stay for months or even years, and usually in less than acceptable conditions. In contrast, community mental health services have the advantage that they can serve not only a selected number of severe mentally ill but also large numbers of disaster-affected people with depression and anxiety. Large mental hospitals cannot do this. Yet, as long as government mental health resources continue to be spent mostly on mental hospitals, it is difficult to have sustainable mental health services for traumatized people.
Some tsunami-affected areas had community mental health services before the disaster. I am speaking of Batticaloa and Jaffna in Sri Lanka and Thailand, whose strong tsunami response has been described so well by Panelist Dr Pengjuntr of the Ministry of Public Health in Thailand. It was much easier for Thailand, Jaffna and Batticaloa to respond to the disaster, because their public mental health resource infrastructure was already in place. As Panelist Dr Levav highlighted: countries should not wait for disaster before developing disaster mental health programs.

Certainly, and I would like to highlight: the best way for a country to prepare for a disaster is to build community-based mental health services involving community mental health teams and with mental health care in general health services.

Rapporteur Dr Chandra emphasized that there are different types of support that can be provided. I agree. On the Figure (shown on PowerPoint slide), you see a presentation of the different types of care and services that WHO believes should ideally be available in each district of the tsunami-affected areas. You will notice 6 types of care. All of these 6 types of care should be available in the district.

- Some types of interventions will occur even without the assistance of aid workers. For example, self and family care, the bottom of the pyramid, tends to occur automatically. The will to overcome suffering is natural and tends not to depend on outside aid. Yet, outside aid workers and media can encourage and strengthen self-care. In some cases, outsider aid workers may be helpful to give advice to not use certain harmful ways of coping. For example, traumatized men often believe that alcohol or marijuana is a good way to overcome their suffering. It can be helpful for doctors, other aid workers and media to clarify that drinking alcohol may perhaps look like an effective self-care method but that alcohol abuse is harmful.
• Some forms of care can be instituted immediately when a crisis occurs, such as the social interventions. It is often possible immediate after a disaster to create safe space for children to play, to restart schooling, to provide fishing boats and involve community members in building shelter. Indeed, many of the so-called early psychosocial interventions after the tsunami were these sort of social interventions, provided by numerous aid agencies.

• Informal psychological support by teachers, healers and leaders etc is extremely valuable. In many tsunami countries, these informal resources were quickly trained by NGOs. These teachers, healers and leaders etc, provided support to numerous people. One challenge here is that training in simple helping methods should be followed by some form of supervision to avoid poor, potentially harmful support. In the discussion that will follow, we may want to discuss a bit on this.

• Other types of care may take some time to set up. For example, although ideal, it is not easy to quickly make available mental health care in primary care, unless mental health care was already available in PHC before the disaster. So, ensuring that there is mental health care in PHC usually takes time. As I understand it, MoH in Sri Lanka is presently making great progress on this.

• Mobile community mental health teams can be set up fairly quickly— as was done in Thailand. Mobile community mental health teams need to work in collaboration with other health and social services. Otherwise the most needy tsunami-affected persons will have difficulties reaching the mobile team. I understand this was the case in Thailand. Mobile mental health teams are unlikely to be effective elsewhere unless these teams are connected to some
community-based health or social services to refer people to the mobile team. Without being connected, they will not be able to assist only few people.

- Finally, acute inpatient care, the top of the pyramid, will likely only develop through outside assistance. It is a service that may not be needed so much in the first weeks after a disaster. But eventually all districts should have acute care units to ensure that very ill people do not disappear in far away custodial hospitals.

Dr Chandra discussed on needs assessment. Traditionally in public mental health a needs assessment covers an epidemiological study of the nature and distribution of symptoms and disorders among the general population and the identification of vulnerable groups. Over the years these needs assessment have helped establish that experience disaster does have mental health consequences, both in terms of disorder and in terms of non-pathological distress. In contrast, another way of doing a needs assessment is to look at a pyramid of different services (such as shown on the PowerPoint) and to decide what services are already in place and which should be developed. As part of the discussion that will follow, we may want to reflect on whether needs assessment in mental health should cover symptoms or whether it should cover services. Or whether it should necessarily cover both?

Dr Levav stressed the need for long-term investment in mental health from national and international governments. This is very important. Unfortunately, impetus and funding for mental health programmes are highest during or immediate after acute emergencies, but such programmes may be most effectively implemented over a protracted time over the following years. The available epidemiology suggests
that most people who experience disaster will recover well without intervention. Yet, among those people who developed a disaster-induced disorder, there are many who have a chronic disorder. Community mental health services need to be available for years to come to assist these people.

I would like to summarize this session by highlighting lessons learned which imply 5 recommendations

1. Post-disaster care needs to cover a range of problems: ranging from non-pathological mental and social distress to severe mental disorder

2. The best way for a country to prepare for a mental health response after disaster is to build community-based health and mental health services before disasters.

3. Post disaster intervention should occur at different levels of the care system: ranging from family care to informal care by a range of community members to care by health and mental health professionals. There is no need for ideological debates for or against care at different levels.

4. Post disaster interventions should be based on a deep understanding of local culture and should be delivered by locally available, appropriately trained and supervised human resources.

5. The mental health and psychosocial support that is needed in the acute phase of a disaster is very different from what is needed in the post-emergency phase. Part of disaster coordination is ensuring that the right interventions are implemented at each phases of disaster.
5 Recommendations

1. Post-disaster care needs to address problems ranging from psychosocial distress to severe mental disorders.

2. Preparing for disasters means building community-based health and mental health services infrastructure before disasters.

3. Post disaster intervention should occur at different levels of the care system.

4. Post disaster interventions should be based on understanding of local culture and delivered by locally available human resources.

5. Support that is needed in the acute phase of a disaster is very different from what is needed in the post-emergency phase.