

## Round Table

# Mental and social health during and after acute emergencies: emerging consensus?

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**Abstract** Mental health care programmes during and after acute emergencies in resource-poor countries have been considered controversial. There is no agreement on the public health value of the post-traumatic stress disorder concept and no agreement on the appropriateness of vertical (separate) trauma-focused services. A range of social and mental health intervention strategies and principles seem, however, to have the broad support of expert opinion. Despite continuing debate, there is emerging agreement on what entails good public health practice in respect of mental health. In terms of early interventions, this agreement is exemplified by the recent inclusion of a “mental and social aspects of health” standard in the *Sphere handbook’s* revision on minimal standards in disaster response. This affirmation of emerging agreement is important and should give clear messages to health planners.

**Keywords** Stress disorders, Post-traumatic/psychology/therapy; Mental health services/organization and administration; Social adjustment; Adaptation, Psychological; Emergency services, Psychiatric; Trauma centers (*source MeSH, NLM*).

**Mots clés** Etat stress, Post-traumatique/psychologie/thérapeutique; Service santé mentale/organisation et administration; Adaptation sociale; Adaptation psychologique; Service urgences psychiatriques; Service traumatologie (*source: MeSH, INSERM*).

**Palabras clave** Estrés postraumático/psicología/terapia; Servicios de salud mental/organización y administración; Ajuste social; Adaptación psicológica; Servicios de urgencia psiquiátrica; Centros traumatológicos (*fuelle: DeCS, BIREME*).

Arabic

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Voir page 74 le résumé en français. En la página 74 figura un resumen en español.

Recent literature records a discussion about the concepts, values and appropriateness of mental health interventions to reduce the burden of war and other disasters in resource-poor countries (1–9). The post-traumatic stress disorder (PTSD) construct and trauma-focused services are the focus of controversy. Results from epidemiological studies suggest that this disorder is prevalent (10) and, at least in the USA, disabling (11). A vocal group of observers, however, sees PTSD as a pseudocondition with no relevant burden — especially in non-western, traditional societies (1, 6, 8). While these critics point to medicalization of normal distress and the possible harm of assuming that western models of illness and healing are valid across cultures, others consider denial of the importance of traumatic stress a professional error and a denial of preventable suffering (2, 3, 5).

Trauma-focused interventions are increasingly provided to large segments of populations affected by disaster in resource-poor countries. However, the interventions that are most often implemented to reduce traumatic stress — one-off psychological debriefing (organized by international and local organizations) and benzodiazepine medication (prescribed by local physicians)

— have little evidence of effectiveness, and their indiscriminate application can be harmful (12–14). Following disasters in resource-poor countries, foreign clinicians often arrive to promote PTSD case-finding and trauma-focused treatment (6) in the absence of a system-wide public health approach that considers pre-existing human and community resources, social interventions, and care for people with pre-existing mental disorders.

The controversy is compounded by the recent development of a new field — introduced by international organizations working in low-income countries — that calls itself *psychosocial*. The term is used to indicate commitment to non-medical approaches and distance from the field of mental health, which is seen as too controlled by physicians and too closely associated with the ills of an overly biopsychiatric approach. Yet, despite highly appropriate attention to medicalization and the importance of non-medical intervention, separating *psychosocial* care services from *mental health* care services may inadvertently promote exclusively biological care for the severely mentally ill by drawing human resources skilled in non-biological interventions

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away from formal mental health services (15). This separation further divides a care system that is already fragmented.

Because of the expression of these viewpoints, the impression may have been created that programme planners are faced with choosing between setting-up vertical (separate) trauma mental health programmes, setting-up vertical psychosocial care programmes outside existing systems, or ignoring mental health care altogether. Indeed, early editions of the highly influential Sphere Project's minimum standards for disaster response (16, 17) did not cover mental health because of perceived expert disagreement (Nan Buzzard, verbal communication, October 2002).

In order to generate sound advice on strategies to assist countries, we commissioned a literature review and a postal survey of expert opinion, involving responses by experts to open-ended questions about mental health policy in the aftermath of disasters (18). In addition, we studied available consensus statements and guidelines (W19–22, 23–28), many of them published by experienced international organizations. The overall picture that emerged is that, although opinions vary widely on the public health value of focusing on PTSD and trauma services, there is agreement on basic issues: exposure to extreme stressors is a risk factor for social and mental health problems, including common mental disorders; further, emergencies can severely disrupt social structures and ongoing formal and informal care of persons with pre-existing disorders. A range of strategies seem to have wide support of much expert opinion, on the condition that they are tailored to the local context, needs and resources.

On the basis of our study of the above-mentioned survey, consensus statements and guidelines, we have proposed principles and strategies for populations exposed to extreme stressors (29). The eight principles are: contingency planning before the acute emergency, assessment before intervention, use of a long-term development perspective, collaboration with other agencies, provision of treatment in primary health care settings, access to services for all, training and supervision, and monitoring indicators (see Table 1).

Distinct intervention strategies should be considered for the acute emergency and post-emergency phases, and these will be discussed separately. Also, we aim to achieve a conceptual distinction between social and mental health interventions. The term social intervention is used for interventions that aim primarily to have social effects, and the term mental health intervention for those that aim primarily to have mental health effects. It is acknowledged that social interventions tend to have secondary mental health effects and the converse. Social interventions are typically not in the domain of expertise of mental health professionals. As such interventions tend to deal with important factors influencing mental health, however, health and mental health professionals should work in close partnership with colleagues from other disciplines (e.g., communication, education, community development, and disaster coordination) to ensure that relevant social interventions are fully implemented.

Many of the strategies described here may be common sense, but by making them explicit in documents and policy statements they become a powerful tool for programme planning and evaluation. These principles and strategies have been developed for resource-poor countries — where the vast majority of disasters arise — but they are also considered appropriate for high-income countries. In high-income countries additional strategies also apply, involving, for example, cognitive-behaviour therapy (30) by clinicians with advanced training, who are a rare resource in poor countries (31).

## Acute emergency phase

For the purpose of this paper, the acute emergency phase is defined as the period where the crude mortality rate is elevated because of disaster-induced deprived physical needs (such as food, shelter, physical security, water and sanitation), access to health care, and management of communicable diseases. A key early social intervention concerns information: a reliable flow of credible information must be ensured about the emergency,

Table 1 **Mental health in emergencies: basic principles**

Principle	Explanation
1 Contingency planning	Before the emergency, national-level contingency planning should include (a) developing interagency coordination systems, (b) designing detailed plans for a mental health response, and (c) training general health care personnel in basic, general mental health care and psychological first aid.
2 Assessment	Assessment should cover the sociocultural context (setting, culture, history and nature of problems, local perceptions of illness, and ways of coping), available services, resources and needs. In assessment of individuals, a focus on disability or daily functioning is recommended.
3 Long-term perspective	Even though impetus for mental health programmes is highest during or immediately after acute emergencies, the population is best helped by a focus on the medium- and long-term development of services.
4 Collaboration	Strong collaboration with other agencies will avoid wastage of resources. Continuous involvement of the government, local universities or established local organizations is essential for sustainability.
5 Integration into primary health care	Led by the health sector, mental health treatment should be made available within primary health care to ensure (low-stigma) access to services for the largest number of people.
6 Access to service for all	Setting up separate, vertical mental health services for special populations is discouraged. Nevertheless, outreach and awareness programmes are important to ensure the treatment of vulnerable groups within general health services and other community services.
7 Thorough training and supervision	Training and supervision should be carried out by mental health specialists (or under their guidance) for a substantial amount of time, in order to ensure lasting effects of training and responsible care.
8 Monitoring indicators	Activities should be monitored and evaluated through key indicators that need to be determined, if possible, before starting the activity. Indicators should focus on inputs (available resources, including pre-existing services), processes (aspects of programme implementation), and outcomes (e.g., daily functioning of beneficiaries).

efforts to establish physical safety, relief efforts (including what each aid organization is doing and where it is located), and the location of relatives. Access to valid information is a basic right and is essential to reduce public anxiety and distress. Information should be uncomplicated, so as to be comprehensible at the cognitive level of local 12-year-olds, and empathic, showing understanding of the situation of the survivors.

Two other core social strategies are likely to reduce public stress: encouraging normal activities and encouraging active participation in the community. For example, re-establishing cultural and religious events is seen as helpful. Such events typically include funeral ceremonies and grieving rituals involving spiritual and religious practitioners. For children, restarting formal or informal schooling is considered important, together with the provision of some recreational activities. Health professionals should be active advocates for safe, physical space for all these activities. In terms of achieving participation, adults and adolescents need to be encouraged to engage in tangible, purposeful activities of common interest, such as relief efforts. Community activities that facilitate the inclusion in social networks of people without families are strongly recommended.

With respect to mental health interventions, *The world health report 2001* recommends making mental health treatment available within primary and other health-care settings, which requires staff training, supervision, and a referral system (32, 33). This recommendation tends to apply whether primary health care is run by government or by nongovernmental organizations, because integrated care within primary and other health facilities maximizes access to mental health care. Health officials need to ensure the availability of essential psychotropic medications for urgent psychiatric problems, for example psychoses and severe depression. During the acute emergency, most persons with urgent psychiatric complaints will have pre-existing disorders, which may have been exacerbated by suddenly discontinued psychotropic medication. We have outlined elsewhere essential strategies to address ongoing care and protection of people in custodial psychiatric hospitals during acute emergencies (34).

Some people will immediately seek help at health services because of mental health problems directly related to their exposure to extreme stressors. According to a recent consensus-building exercise (26), most acute stress problems during acute emergencies are best managed without medication following the principles of psychological first aid, which involves non-intrusive emotional support, coverage of basic needs, protection from further harm, and organization of social support and networks. When community workers are available, outreach and psychological first aid may be organized in the community. Nevertheless, the weight of current evidence discourages the blanket use of isolated sessions of psychological debriefing that push people to share their personal experiences beyond the extent to which their natural inclination would prompt them to do so (12, 14).

The strategies outlined here may be adapted for use in acute emergencies caused by unpredictable infectious diseases, along the lines of the WHO document on public mental health aspects of biological and chemical weapons (35).

## Post-emergency phase

The acute emergency phase is followed by a post-emergency phase when the crude mortality rate is again at a level comparable to that before the acute emergency or, in the case of displacement, at the level of the surrounding population. In

complex disasters — typically with coexisting conflict, population displacement, food scarcity, and the collapse of basic health services (36) — the sequence of events is less linear, and different areas of a country may oscillate between acute and post-emergency phases.

In the post-emergency phase, the social interventions outlined above should continue. Moreover, whenever disaster-inflicted poverty becomes an evident ongoing source of suffering, it is appropriate for health workers to advocate economic re-development initiatives, such as microcredit schemes or income-generating activities.

During this phase, general health care should continue to form the basis of the mental health care system. Accordingly, mental health specialists should provide thorough supervision and on-the-job training to health-care staff (33). Community workers may be trained and supervised to assist primary care staff with heavy case-loads (33) and to conduct outreach activities. The development of a multitude of specialized trauma-focused services should be avoided unless mental health care is available in general health care and other community settings (the school health system, for example). Trauma-focused care may be best integrated into general mental health services.

Organizing community-based self-help support groups is likely to provide a valuable form of assistance (25). The focus of such groups is usually problem-sharing, brainstorming for solutions or for more effective ways of coping (including traditional ways of coping), and generation of mutual emotional support, and sometimes promotion of community-level initiatives. In certain contexts, collaboration with traditional resources such as faith healers may be an opportunity in terms of care, provision of meaning, and generation of community support.

These post-emergency strategies need to be carried out in synergy with ongoing mental health system development priorities, especially the development of national plans for the organization of mental health services (37), which is increasingly a focus of work by WHO. Executing such plans involves downsizing existing custodial mental hospitals, making mental health care available in general health care settings (4), and strengthening community and family care of persons with chronic, severe mental disorders (32, 37).

## Conclusion

This paper began with a summary of the debate on the controversial value of PTSD and trauma-focused care during and after acute emergencies. This debate has attracted much attention and has been valuable in bringing to light fundamental issues and various views with respect to the needs of trauma survivors. We acknowledge that there is no agreement on the public health value of the PTSD concept (e.g., the extent to which non-comorbid PTSD is associated with disability), and the appropriateness of vertical trauma-focused services. We share the concern of Silove et al. (7) that because of heated expressions of opinions an impression has been created that programme planners during and after acute emergencies are faced with a choice between specialized, trauma-focused care or completely ignoring mental health. We advocate the implementation of social interventions and the integration of trauma-focused care into general mental health care, which should be available in general health care settings.

Despite ongoing debate, we argue that there is considerable agreement on what entails good public mental health

practice. Most of our proposed early intervention strategies have now been included in a “mental and social aspects of health” standard in the health chapter of the recently revised *Sphere handbook* on minimum standards in disaster response (38). It is the first time that this widely used handbook — written to improve humanitarian assistance and enhance accountability — includes a standard covering mental and social health. Because of frequent war and other disasters in many regions of the world, this affirmation of emerging consensus is important and gives clear messages to health planners. ■

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## Résumé

### Santé mentale et sociale pendant et après les situations d'urgence aiguë : émergence d'un consensus ?

Les programmes visant à dispenser des soins de santé mentale pendant et après les situations d'urgence aiguë dans les pays à faibles revenus sont considérés comme d'un intérêt discutable. Aucun accord n'a été trouvé sur la valeur en termes de santé publique du concept de trouble de stress post-traumatique et sur l'utilité de services verticaux (séparés) dont l'activité est axée sur les traumatismes. Il semble cependant qu'une série de stratégies d'intervention en santé sociale et mentale bénéficie d'un large soutien parmi les experts. Bien que les débats se poursuivent, un

accord se fait jour sur ce que comportent les bonnes pratiques de santé publique en matière de santé mentale. En ce qui concerne les interventions précoces, cet accord est illustré par l'introduction récente d'une norme sur les aspects mentaux et sociaux de la santé dans la révision du *Manuel Sphère* sur les normes minimales à respecter dans la réponse à un désastre. Cette affirmation d'un accord émergent est importante et devrait se traduire par des messages clairs pour les planificateurs dans le domaine de la santé.

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## Resumen

### La salud mental y social durante y después de las emergencias agudas: ¿principio de consenso?

Los programas de atención de salud mental durante y después de las emergencias agudas en los países con recursos escasos han sido objeto de polémica. No hay ningún acuerdo sobre el valor del concepto de trastorno de estrés posttraumático en el terreno de la salud pública, ni lo hay tampoco acerca de la idoneidad de los servicios verticales (independientes) centrados en los traumas. Sin embargo, hay varias estrategias y principios de intervención en la salud social y mental que parecen gozar de un amplio respaldo entre los expertos. Aunque prosiguen los

debates, se observa un principio de acuerdo sobre lo que definiría las prácticas más adecuadas de salud pública en el campo de la salud mental. En lo referente a las intervenciones precoces, ese consenso se ve ilustrado por la reciente inclusión de una norma sobre los «aspectos mentales y sociales de la salud» en la revisión de *Sphere handbook* sobre las normas mínimas de respuesta ante desastres. Esta confirmación de un principio de acuerdo es importante y debe traducirse en mensajes claros para los planificadores de la salud.

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## Round Table Discussion

### The best immediate therapy for acute stress is social

Derrick Silove<sup>1</sup>

The above paper by van Ommeren et al. is of immense importance in guiding future mental health service developments in low-income countries afflicted by conflict. As such, the article should be essential reading for leaders of international nongovernmental organizations and United Nations agencies. Although measured in its style, the arguments mobilized present a radical challenge to those single-issue advocates promoting trauma counselling programmes or short-term psychosocial projects.

I believe that some of the arguments, however, need to be considered further. One problem is that trauma advocates do not distinguish sufficiently between common, self-limiting psychological responses to violence and the persisting reactions that become complicated and disabling. My rule of thumb is that the best therapy for acute stress reactions is social: providing

safety, reuniting families, creating effective systems of justice, offering opportunities for work, study and other productive roles, and re-establishing systems of meaning and cohesion — religious, political, social and cultural.

Nevertheless, there will be a small minority of persons who do continue to suffer from severe traumatic stress reactions, and that group emerges in increasing numbers over time. Services then should be accessible, inviting (people with chronic PTSD are wary of presenting themselves) and offer state-of-the-art interventions: this is difficult to ensure, because such interventions are multimodal and require substantial skills. Yet, at present, nongovernmental organizations fuelled by donor enthusiasm rush in to debrief trauma survivors *in the early phase* when such interventions are not needed and, commonly, leave just at the point when the more chronic cases emerge, the minority who really do need expert assistance! In that respect, the dictum “not too early but not too late” may serve as a useful guide to reverse the present trend.

A second problem is that we have become accustomed to epidemiological studies yielding rates of PTSD or depression of 30–40% in postconflict populations. These figures provide little guide to actual need. The rates of help-seeking behaviour for severe psychiatric disorders (including the minority with

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unremitting traumatic stress) may be more like 2–3% per year. This represents, in fact, a huge number of persons in dire need, especially if one considers the adverse multiplier effect on families and communities of caring for a person who is disabled, acting in a bizarre way or possibly violent.

In my view, therefore, two key issues confront the field from a practical point of view. The first challenge is changing entrenched perspectives and practices of international agencies and donors, so that they give priority to supporting integrated community-based mental health programmes that focus on social need arising from mental disturbance, rather than special issues or particular diagnoses.

The second consideration is whether such programmes can be undertaken entirely within primary health care systems, given the wide range of skills needed to deal with psychosis, severe mood disorders, postpartum disorders, severe anxiety disorders including the minority with disabling PTSD, organic disorders, and epilepsy and its complications, among others. Many community health services in conflict-affected countries are depleted of resources and skills and face overwhelming demands in relation to other obligations. Brief training in mental health is hazardous (and training-the-trainer programmes even more so); in this field, a little knowledge is a particularly dangerous thing.

In some resource-poor settings, therefore, there is a case for establishing, at least as a developmental step, a small, expert resource team with international input to provide supervision, training and consultation in order to ensure the promotion of skills and professionalism. As a core team develops and the initial pressures of other work lessen to some extent, skills can then be transmitted to primary care workers. ■

## What exactly is emergency or disaster “mental health”?

Derek Summerfield<sup>1</sup>

Firstly, I must own to being one of the “vocal group of observers” mentioned in the paper by van Ommeren et al. a critic of the field that sprang up little more than 15 years ago around the idea that “post-traumatic stress” was an urgent public health matter in its own right. Indeed, “trauma” may now have displaced hunger as the first thing the Western general public thinks about when a war or other emergency is in the news.

The authors make succinct mention of some of the problems associated with the development of PTSD, but omit a key one: the largely non-Western populations targeted did not ask for interventions of this kind. As an illustration, I was recently on a professional visit to the occupied Palestinian territories, where something akin to a mental health melee has resulted from a plethora of programmes imported to deliver counselling because outsiders thought it was a good idea. Most Palestinians do not: counselling is not a culturally familiar activity, and the people use all their energy to survive in a deepening health and human rights crisis.

Many programmes of this kind have been funded under the umbrella term “psychosocial”, as mentioned in the base

paper. When I was a consultant to Oxfam I was against this term since in practice it had become too quickly collapsible into “psycho”. When van Ommeren and colleagues opt for a conceptual distinction between social and mental health interventions, they are reproducing the tradition since the Enlightenment to regard the physical confines of the human individual as the basic unit of study, and for the mind to be examined by a technical methodology akin to that applied to the body. Thus mind, or “psychology”, is to be located inside the body — between the ears — whereas what is “social” is outside the body and outside the frame of reference. But it would be more realistic to see our psychology as having a root outside the body, in the way that we live, and to consider the meaning of things — in particular a sense of coherence — as arising from our practical engagement with the world. Lack of coherence is bad for people: if there is such a thing as a core fact about human response to disasters and violent upheavals, it is that survivors do well (or not) in relation to their capacity to re-establish social networks and a viable way of life. Western mental health models have always paid too little attention to the role of social agency, including work, in promoting stable well-being and mental health.

The authors’ description of basic responses in the acute emergency phase seems broadly right (though “psychological first aid”, like “public mental health”, may be an oxymoron). In relation to the restoration of normal activities, I was pleased to see their mention of schools: the child trauma literature can sometimes give the impression that counsellors are more critical than schoolteachers.

It is right to point out that in complex disasters there will be no clear demarcation of “emergency”. Indeed, we talk of the trauma of war but not the trauma of hunger. Why are the deaths of millions — yes, millions — of children every year from the diseases of poverty not an emergency, but “normal”?

In relation to advocating the training of primary health workers by “mental health specialists”, whose knowledge counts? There has often been a tension in WHO material on mental health between the wish to acknowledge local worlds and the wish to promote Western mental health technology as a reproducible toolkit. How, for example, would primary health workers be trained about depression? Forecasts by WHO that within two decades depression will cause the second highest disease burden globally assume that the Western psychiatric construct is valid everywhere. This is surely to commit the same error bedevilling most of the psychiatric literature on war and refugees: it is what Kleinman called a “category fallacy” to assume that, just because similar phenomena can be identified in various settings worldwide, they mean the same thing everywhere. Even the best back-translation methodologies cannot solve the problem, as it is not one of translation between languages but of translation between worlds. We need to remember that the Western mental health discourse introduces core components of Western culture, including a theory of human nature, a definition of personhood, a sense of time and memory, and a secular source of moral authority. None of this is universal.

Consensus statements have to keep their feet on the ground, and I am pleased that this one largely does so. The note of caution seems wise, if only because the business of other people’s minds is ultimately as much a matter of philosophy as of science. ■

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