WHO Department of Mental Health and Substance Abuse[1]

Briefing note on psychosocial/ mental health assistance to the tsunami-affected region

4 February 2005

Since the 26 December 2004 earthquake/tsunami, our Department has received numerous generous offers from individuals and organizations to assist WHO in mental health field missions, trauma training and the organization of meetings to discuss mental health strategies. We are thankful for the many offers of help that we have received.

Through the years, WHO and its staff have accumulated experience and knowledge on post-disaster activities. We have published a number of documents (See http://www.who.int/mental_health/resources/tsunami/en/) that summarize our advice, which is based on experience and the scientific literature. These documents are applicable to a variety of crises, whether caused by natural disaster or conflict.

In January we conducted extensive on-site assessments in Indonesia, Sri Lanka, Maldives (and co-incidentally in conflict-affected Darfur), which has reaffirmed our perspective of what should be done in terms of psychosocial/ mental health assistance after large scale disasters, such as the present one. Our work in countries has focused on assisting the Ministry of Health of Indonesia, Maldives and Sri Lanka in assessing, planning and coordinating activities in the health sector.

A population perspective

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 numbers of people with mental health problems in the tsunami-affected countries, the following rule-of-thumb estimates give context to the likely size of the problem. These rates vary with setting (e.g. involving sociocultural factors, current and previous disaster exposure) and assessment method and give a very rough indication what WHO expects the extent of morbidity and distress to be. We see 3 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 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 the people that tend to be labelled with psychiatric diagnoses in many surveys involving psychiatric

[1] All Department activities related to the tsunami are conducted in close collaboration with the WHO Department Health Action in Crises, the WHO Southeast Asia Regional Office, and relevant WHO Country Offices.

instruments that have not been validated for 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. [2]

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 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 rate, possibly at 15% in severely affected areas. Thus, in short, as a result of 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 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 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 approx. 2-3% in 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 go-up (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.

Recommendations

1. The destruction of 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 disorder to be about 5-10% across all mental disorders. This implies that:
    - There is no justification to use psychiatric interventions for the majority of the population affected.
    - There is no justification for a specific focus on PTSD over and above other trauma-induced mental disorders, such as (non-PTSD) anxiety disorders and depression.
2. WHO is advising tsunami-affected countries to urgently make available mental health care interventions in the health sector. People with mental disorder - 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

[2] These interventions - which are generally made available to anybody (whether or not they have disorder) in a variety of sectors - tend to be called 'psychosocial' by humanitarian and development workers. Traditionally mental health specialists have used the term 'psychosocial intervention' to describe non-biological mental health interventions for people with mental disorders, which is in contrast to the way the term 'psychosocial' is used these days by humanitarian and development workers.

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 programs, and economic development initiatives. An example of basic psychological intervention is teaching listening 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 counselling) even when they are implemented outside 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. WHO provides advice on these activities (see *Mental Health in Emergencies*, WHO [2003]), but is not seeking to lead the coordination of activities outside the health sector.

- 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.
- Also, 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 on trained interventions into existing systems. Such initiatives may cause more harm than good. WHO advises outside international groups to carefully study *the Guidelines for Internatiomnal Trauma Training by the International Society for Traumatic Stress Studies guidelines* 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 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.

The text of this note is summarized in a table (see next page)

References

- International Society for Traumatic Stress Studies (2002). Guidelines for international trauma training. Chicago: ISTSS.
- IRC, SC-UK, UNICEF, UNHCR, WVI. (2005) Psychosocial Care and Protection of Tsunami affected Children.
- WHO (2003). Mental Health in Emergencies. Geneva: WHO.

Further reading

See http://www.who.int/mental_health/resources/tsunami/en/

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 acros countries)	AFTER DISASTER: 12-month prevalence 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 (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 reduces 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 psychologica support interventions available in the community	1) Health sector (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 psychologica 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 setting (e.g. sociocultural factors, previous and current disaster exposure) and assessment method but give a very rough indication what WHO expects the extent of morbidity and distress to be.