FROM DISASTER TO OPPORTUNITY: THE MENTAL HEALTH CARE RESPONSE TO THE OCTOBER 2005 EARTHQUAKE

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No one is ever really prepared for disaster. When nature strikes so mercilessly as it did during the earthquake in Pakistan and Indian administered Kashmir in October 2005, its devastating powers leave everyone in awe. After initial paralysis aid workers start to come in. But what to do and what not to do? Whom to help, whom to leave? In recent years more consensus is emerging about the organization of the mental health care response in disasters. In this article I will summarize some of these insights.

Prewitt Diaz[1] describes the different stages in the disaster response. I will follow this model and illustrate this with some of the lessons learned in recent years.

1) PREPAREDNESS

The first stage of the continuum is preparation of community and aid community to know what to do after a disaster. In general interventions need to be guided by principles as described in the working document of the WHO on emergency mental health: intersectoral collaboration, attention for training and supervision and focus on integration of mental health services within general primary health care[2]. Issues of coordination capacity and installation of mechanisms to distribute relief goods and services greatly enhance the effectiveness of disaster relief[3].

2) FIRST AID DURING THE EMERGENCY (DAYS DURING AND IMMEDIATELY AFTER THE DISASTER)

In this phase the actions need to be limited to re-establishing coherence in the chaotic situation that inevitably follows a large-scale calamity. In general emphasis should be given to:

1) Culturally appropriate social strategies aimed at providing protection for vulnerable people who lack support.
2) Reuniting families and communities wherever possible.
3) Re-establishing institutions and services that promote communal cohesion and a sense of order.

Some of the interventions that are done in the immediate aftermath or during disaster are called 'psychological first aid'. These are simple, supportive measures aimed to encourage adaptive coping and problem solving. Psychological first aid targets those individuals who exhibit extreme acute stress reactions (such as dissociative states, or extreme anxiety) and people who have clearly increased risks for developing mental health problems (such as persons with pre-existing mental health problems or people with limited support).

The basic principles of psychological first aid are:

1 Give support in establishing safety.

2 Seek to reduce extreme acute stress-related reactions through arousal reduction interventions and explanation.

3 Connect survivors to restorative resources via active help with problem solving and referral to those resources[4].

3) DISASTER RESPONSE (WEEKS AFTER THE DISASTER)

Many people have acute stress reactions after trauma but, only a minority of those will become chronic and disability is limited. The current consensus is that it is not wise to focus entirely on post traumatic stress disorder (PTSD). There is no doubt that disaster can lead to mental health problems, including PSTD but the psychological sequelae after a disaster are much more diverse that what is described in the DSM-IV category of posttraumatic stress disorder[5,6]. For example, in the Marathwada Earthquake in India (1993) a percentage of 13.9% of a cohort of survivors was found to have a psychiatric diagnosis against 6.8% of a non affected control group. The most common diagnosis was "other reactions to severe stress" and problems related to substance abuse. The study also found that levels of psychological morbidity rather quickly fell to predisaster levels[7].

It is as yet not possible to define who will develop lasting symptoms. Screening whole populations for traumatic stress soon after disasters provides little practical guidance on the need for targeted interventions[8]. Any training for health care providers about trauma mental health should be informed by understandings of the contextual and systems factors that may impact the effectiveness of training and should be embedded in supervision structures[9]. Providing training that is very brief and not followed by ongoing may result in both poor practices can even do harm[10]. In the aftermath of the Tsunami in 2004 the most needed interventions in this phase of the disaster response were found to be the delivery of acute mental health care delivery (making

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psychotropic drugs available), the provision of psychosocial support at the community level and the prevention of staff burn out[11].

4) THE REHABILITATION PHASE (MONTHS AFTER THE DISASTER)

In this phase a transition will occurs from 'disaster mental health care' to rebuilding the mental health care infrastructure and development of long term community activities and psychosocial care. The basis of mental health care delivery needs to be the general health care system[12]. This can include awareness raising and training of workers in the health care sector. A key component of the WHO mental health plans after the Tsunami of 2004 was to provide mental health training to primary care doctors, community health workers, and midwives in Sri Lanka[13]. Training needs to be followed by adequate monitoring and supervision. Again, training should not focus on trauma. In fact, trauma counseling should never be the point of departure for psychosocial programming, because structured, normalizing, empowering activities within a safe environment will help the majority of survivors to recover over time. In this process too it is probably wiser to emphasize 'social reconstruction' rather than 'psychological therapy'. In all probability it is not so much trauma counseling that provides the foundation for social recovery, but the opposite: effective social reconstruction may be the best therapy for most trauma reactions[14]. Involving the survivors of disaster in planning and organizing services for the problems they perceive as the highest priorities in critical for success of psychosocial programmes[15].

5) RECONSTRUCTION PHASE (YEARS)

This phase may take up several years. This is the time when the area where disaster struck gets less attention, but can function as a place were new policies have been realized and valuable lessons learned. Paradoxically the effect of a disaster can be that new initiatives that were hitherto unthinkable due to bureaucratic or other hindrances get a chance to flourish. For example, reports about the Tsunami-affected areas one year after the floods show that the development of community mental-health services have been greatly enhanced[16]. In Turkey two major earthquakes boosted much needed mental health care reform[17]. In Afghanistan the decades of war prompted the new Afghan Ministry of Public Health to place mental health care development firmly on the policy agenda[18].

In this way a disaster can give new opportunities to upgrade mental health services, which in Pakistan, as in many developing countries, are in urgent need of reform. Several innovative projects for mental health care modernization have taken place in Pakistan, but these were not yet reproduced on a national scale[19,20].

The earthquake of October 2005 has caused immense suffering, but it could also provide an opportunity to construct "new" public health oriented mental health services (as opposed to reconstruct previously existing 'old' structures).

In November 2005 the Pakistan Ministry of Health with support of the World Health Organization organized a workshop in Islamabad on the mental health care response to the disaster. During this meeting a strategic plan for mental health and psychosocial support in the earthquake-affected areas was presented which has as main objectives:

1) Public mental health education about the emotional impact of earthquake and promote the message that these disorders are treatable.

2) Making basic mental health services and mental health first aid available to the survivors with emphasis on vulnerable groups like children, women, elderly and the disabled.

3) To integrate mental health delivery system within the primary health care system[21].

The modern mental health services that are envisioned in this plan could provide an invaluable model for the development of mental health care, not only for the affected areas, but to the benefit of Pakistan as a whole.

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