TRAINING AND INFRASTRUCTURE FOR A PSYCHOSOCIAL RESPONSE IN DISASTER RELIEF

Training programmes for primary health care workers and other relief workers

Target groups for training programmes should come from both the health and other sectors as the first group. These should include primary health care workers, often medical doctors of first aid teams, community nurses, or other trained health care workers such as social workers, administrators from local and national administrations, policemen and firemen in reserve teams.

Training programmes for health care providers should include the health aspects of disasters, general psychological and psychophysiological concepts about people's reactions after a disaster and other stressful situations, and variations in the way different groups of people perceive the risk from different types of hazards. The programmes should also include simple ways of dealing with psychosocial problems and the teaching of simple skills for the recognition, possibly using a checklist, and the treatment of psychologically distressed victims (interviewing skills, counselling, brief and simple psychotherapeutic methods, targeted pharmacotherapy, group therapy, etc.).

For administrators the training can help them to identify vulnerable groups, demonstrate the reason why mental health services should be integrated into the general disaster plan and how a psychosocial component can be included in a comprehensive disaster plan.

The training of general health workers in mental health seems to be effective and long-lasting. In the context of a WHO collaborative study in six developing countries, general health workers were assessed after training aimed at improving their knowledge, attitudes, skills and capacity to provide mental health care; it was shown that the improvement was still apparent after 18 months and was of equal magnitude in all countries (Ignacio et al., 1989).

Planning and coordination of interventions in case of disasters

A senior mental health professional should be identified at a national level to head and plan mental health resources and consulting for disaster preparedness and relief measures. Since national or local disaster teams are primarily concerned with the provision

of emergency medical care and are often headed by a surgeon for instance, it can be useful if the professional coordinating mental health inputs is also a physician (e.g.a psychiatrist), in order to be able to operate more easily in these circles and within the disaster circumstances. Such a specialist liaison officer will take part in the multidisciplinary decision-making groups and also coordinate mental health aspects and mental health teams when these are available. Most importantly, he or she can act as a consultant to train and support the preventive and other activities of the primary health care workers.

Attention should also be paid to the mental health needs of the care givers themselves, who are faced with heavy demands during disasters and who are themselves exposed to a substantial risk of stress-related disorders.

As for service planning, it must be remembered that services should be provided on the basis of the actual needs rather than on the basis of the demand: this applies both to the timing and to the magnitude of the interventions (Ross & Quarantelli, 1976).

A major boon for the overall field of disaster prevention, preparedness and mitigation should come from the UN General Assembly Resolution 42/169, designating the 1990s as the International Decade for Natural Disaster Reduction (IDNDR) (Lechat, 1990; WHO, 1989a, 1989b). The objective of this decade would be to reduce the loss of life, property damage and social and economic disruption caused by natural disasters, particularly in developing countries. In the context of the IDNDR, WHO will play a major technical role in the health sector, including in the specific area of mental health.

Given the above constraints and consideration, the following points need to be highlighted:

1. A long range plan, including a full scale mental health intervention strategy, should be developed at national and international level. Many preparatory steps must be taken. The comments that follow present a progression from the current position towards an ultimate goal which is unlikely to be fully reached in less than 5-10 years.

2. Concurrently work on preparedness response and rehabilitation is needed, with the full understanding that these levels may proceed at different paces and influence each other (e.g.while preparedness efforts are poor, response measures may need to be emphasized; when preparedness improves other response measures may be reduced).

3. Below, three possible models for a psychosocial response to disasters are described; these may vary from country to country and they will need to be adapted to local realities.

MODEL 1 (International reliance)

This is the current structure seen in most developing countries.

An international consultant may be called upon to provide mental health assistance after a disaster has occurred, typically to the Ministry of Health, through WHO. The consultant will meet with an emergency committee and will acquire information on the country and the disaster. The consultant can advise the national Ministry of Health and the health authorities of the disaster area (and a local mental health officer if one exists) on the setting up of an appropriate emergency structure for ensuring a psychosocial component within the disaster relief operation.

The mental health workers in the area will be involved in some direct patient care, but the international consultant should promote the development and implementation of a model of care in which the general or primary health worker will take the responsibility for providing mental health care to victims with the support of mental health professionals. The role of the international consultant will be of educating the mental health officers at the national and local levels, who in turn will take the responsibility for training the local health workers in relevant mental health issues. The consultant should make available appropriate materials.

MODEL 2 (National reliance)

Continuing efforts to achieve disaster preparedness even before a disaster occurs, should be taken to ensure national capability for managing the mental health consequences of disasters. These include the development of appropriate training materials (e.g.manual, slides, video tapes) which will be used to train national staff to be responsible for the disaster mental health activities within their home country. Without there being a disaster, a workshop could be convened, to be led by one or more international consultants with the national mental health authorities and designated staff who would be responsible for a disaster mental health programme. The goal of the workshop would be to develop the appropriate training materials and plan for their use. When a disaster strikes a country, the international consultant should no longer be needed and the country will have attained a greater degree of self reliance.

Given that an international consultant does not have to be recruited for work to be initiated, interventions can be implemented much earlier, probably within one week of the disaster. It will also be possible to involve the mental health workers almost entirely in supervision and support of direct service providers.

To achieve Model 2, the following preliminary steps are suggested:

1. Development of a core of training material for national or Regional use: manual, slide set, video, etc. These should be available for various levels of staff, e.g.
   (i) the mental health professional;
   (ii) the general health professional;
   (iii) the auxiliary health workers;
   (iv) the community (non-health) workers.

2. Compilation of a literature review accessible to non-mental health professionals.
3. Workshop/conference on "disaster mental health training" for the national mental health leaders and/or persons designated by them.
4. Specific allocation of money from the general health budget should be obtained in order to implement the above mentioned plans.

MODEL 3 (Local reliance)

Later on, and in zones at clear risk for disaster, the local mental health team (if one exists) should be responsible for managing the psychosocial components of disaster relief in its area of responsibility, and a local disaster committee should be formed, rather than relying on the national authorities when disaster strikes. This requires that the Ministry of Health organizes training for selected local mental health officers.

Using this model, mental health interventions can occur sooner. The mental health officers will only be directly responsible for those referred by the general health worker, including those requiring hospitalization. The greater proximity to the community allows for a much greater degree of community participation.

POSSIBLE RESEARCH PRIORITIES

1. Much of the research on the psychosocial effects of disasters has been carried out among Western populations. It is therefore imperative to carry out extensive research with populations from developing countries, those that are most affected by natural and man-made disasters, both large and small-scale; this research will allow the study of cross-cultural variations in frequency, symptomatology, temporal patterns and outcome of psychological disorders, and will clarify the moderating effect of culture on these disorders. This research, to be practically and ethically feasible, needs to follow strict guidelines, and should adopt a rigorous research methodology. To achieve this, every effort should be made to obtain reliable pre-disaster baseline health data (preferably from various sources); to have a control group; to have high follow-up response rates; to use a longitudinal design; and to find valid screening instruments to be employed as a first step in mass screening programmes in the acute post-disaster phase.

2. Although there is agreement that social support and intense kin relationships are highly supportive and facilitate post-disaster recovery among victims, little empirical evidence is available in this regard. Therefore, the specific role of these variables in modifying the overall frequency, severity and course of psychological disorders needs to be further explored, as do the importance of personal vulnerability and prior psychopathology in their occurrence. Specific groups, particularly dependent on social support (such as children, the elderly, the physically ill) should be carefully investigated.

3. Investigations into physiological determinants and correlates of psychological and psychiatric disorders, especially PTSD, so far mainly laboratory-based, should be strengthened and should be mainly clinically based. It would therefore be useful to find reliable, valid and feasible physiological measures of stress to be used as diagnostic tools. For practical reasons, this research is more feasible with individual victims of a single trauma or in more limited accidents or disasters occurring in developed countries.

4. The diagnostic specificity of the symptoms of PTSD also needs to be further explored, as does the natural history of this disorder.

5. An important area of research is comorbidity, especially among persons suffering from PTSD: for instance, substance abuse, frequently associated with PTSD, has been interpreted as a long-term attempt to numb oneself against intrusive images and nightmares, thus representing a secondary response to primary PTSD symptoms.

6. The experience of facing a trauma as an individual, versus the effect of trauma when experienced with others needs to be investigated.

7. Finally, treatment of the main psychological and psychiatric post-traumatic disorders is an important area for research. The main psychotherapeutic and pharmaco-logical treatment methods deserve detailed consideration and need to be adequately tested and verified for cross-cultural applicability as well as for general effectiveness.

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