

What are the most common Mental Health problems following emergencies?

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Emergencies, both natural and man-made result in an increased rate, or prevalence, of Mental Health problems in the communities affected by them¹.

This occurs due to:

- the breakdown of social and psychological supports that may otherwise protect against mental illness
- an increase in risk factors for mental illness
- and the intensification of pre-existing social inequalities²

The type of illness and the cross-section of those affected are influenced by many factors such as fear³ practical stressors⁴ and pre-existing illness⁵

Prior to 2007, the harmful effect of emergencies on Mental Health had not been extensively studied⁶.

However **more evidence is steadily becoming available**. It is now clear that **many survivors will experience short-lived, or “transient” distress**, however **others may develop more serious Mental Health problems that require ongoing support⁷.**

The most commonly noted mental health issues that arises is Post-Traumatic Stress Disorder (PTSD)⁸

PTSD is partly characterised by persistent re-experiencing of the event, often in the form of distressing dreams or recollections, and physical symptoms such as difficulty sleeping and concentrating. The **symptoms last for more than one month and cause impaired social, occupational and mental functioning⁹**

A recent Melbourne study¹⁰ demonstrated the potential for PTSD to adversely affect ability in thinking and memory tasks in young-adult survivors of bush fires.

PTSD can potentially affect a large proportion of the population. For example, 40 days after the earthquake in Bam in 2003, approximately 81% of the survivors interviewed satisfied the criteria for PTSD¹¹. The effect is seen to varying extents in a diversity of populations, from survivors of the 1998 landslide in Sarno, Italy¹² to children who have survived the super-cyclone in Orissa, India¹³.

¹ IASC Guidelines (2007)

² IASC Guidelines (2007)

³ Salcioglu *et al.* (2007)

⁴ Galea *et al.* 2007; Soeteman *et al.* (2007)

⁵ IASC Guidelines (2007)

⁶ Soeteman *et al.* (2007); Galea *et al.* (2007); Pivasil *et al.* (2007)

⁷ Bryant 2006; Yule (2006)

⁸ Salcioglu *et al.* (2007)

⁹ Bloch & Singh (2001)

¹⁰ Parslow & Jorm (2007)

¹¹ Hagh-Shenas *et al.* (2006)

¹² Catapano *et al.* (2001)

¹³ Kar *et al.* (2007)

Other common problems include anxiety and mood disorders, such as depression¹⁴, which may affect an individual both emotionally and physically¹⁵.

These effects may be **ongoing, and may even worsen with time¹⁶**. In a study of survivors of the 1999 earthquake in Turkey¹⁷ found **that 40% satisfied the criteria for PTSD at least 3 years following the event, and 18% of the survivors also had depression.**

Practical and Social Stressors:

Loss of property, physical injury and harsh conditions can intensify mental health problems.¹⁸

Those displaced by Hurricane Katrina experienced a high prevalence of anxiety and mood disorders¹⁹. Similarly it was noted that forced relocation was the strongest predictor of psychological after-effects in a group of people displaced by an explosion in a firework depot in the Netherlands²⁰.

Following the Indian Ocean tsunami affecting researchers²¹ found that survivors who were without family income, or who were physically injured were more likely to develop PTSD.

The researchers also found that **women who survived the tsunami were more vulnerable to developing PTSD than their male counterparts.**

Pre-existing Illness:

A preceding history of mental illness also places a person at higher risk for ongoing psychological problems following an emergency²²This may be due to a disruption in social structures and ongoing care of survivors with pre-existing mental illness²³

Further, **exposure to traumatic events also increases a person's risk of developing Mental Health problems (Acierno *et al.* 2007).**

Link between Mental health and Physical Illnesses:

Poor Mental Health resulting from emergencies may also contribute to worsening physical health. Research in the Netherlands²⁴ found a **link between PTSD and the subsequent development of vascular problems in a population affected by man-made disasters.**

The long-term effects of emergencies on Mental Health may also manifest in an increase in life-threatening behaviours such as drug abuse and dependence²⁵. as noted by in a study of post-disaster impact among Chi-Chi earthquake survivors in Yu-Chi, Taiwan. The study found that the **prevalence of drug abuse more than doubled from 2.3% at six months, to 5.1% at 3 years** and also noted a **worrying increase in suicidality from an already high 4.2% at six months to 6.0% at 3 years.**

¹⁴ Galea *et al.* (2007)

¹⁵ Bloch & Singh (2001)

¹⁶ Pivasil *et al.* (2007)

¹⁷ Salcioglu *et al.* (2007)

¹⁸ Kumar *et al.* (2007); Galea *et al.* (2007); Acierno *et al.* (2007)

¹⁹ Galea *et al.* (2007)

²⁰ Soeteman *et al.* (2007)

²¹ Kumar *et al.* (2007)

²² Soeteman *et al.* (2007)

²³ van Ommeren *et al.* (2005)

²⁴ Dirkzwager *et al.* 2007

²⁵ Chou *et al.* (2007)

Survivors with Disabilities:

Survivors with **pre-existing disabilities are at an increased risk of both short- and long-term Mental Health problems following an emergency.**

They have:

- greater difficulty accessing basic needs such as food, water and shelter
- often lose their assistive devices such as walking aides, spectacles and hearing aides.

Further, **the rehabilitation infrastructure is often lost, with carers often being injured or killed** in the emergency.

Survivors with **new mental health disabilities** following the emergency **may not receive adequate health care** and may not have access to appropriate specialist referral or rehabilitation, **thereby prolonging the period of disability.**

They may also **suffer from loss of livelihood resulting in further social stress**²⁶

Can Mental Health Support help post emergencies?

In a study of **children** from the Takuapa district of the Phang-Nga region in Thailand **post Tsunami**²⁷, **up to 57.3% satisfied criteria for PTSD.**

The children were given **ongoing rehabilitation, mental health and financial support such that the rate declined to 7.6% at two years.** This was supported by a study of PTSD-prone children from the nearby Ranong province²⁸ that showed a significant reduction in many aspects of PTSD after a psychological intervention.

In Turkey²⁹, a study found **up to 80% improvement in PTSD symptoms** of earthquake survivors **following psychological interventions**

A similar improvement was also noted in survivors of the 1999 Athens earthquake³⁰ where the children of the study showed improvement in psychological and social wellbeing. This positive effect was still present to the same extent when the children were re-interviewed four years following the event. Further, the study used readily available psychological techniques such as cognitive-behaviour therapy (CBT), which can be offered in many settings and where resources are limited.

In a study of earthquake survivors in Northern China³¹, found that **post-disaster support was also important for those not at the epicenter of the earthquake.** Whilst these survivors were not initially as badly affected by the earthquake, they reported a better quality of life if they received support.

In an outcome intervention study following Hurricane Hugo in South Carolina, long-term **psychosocial intervention in schools significantly decrease mental distress in adolescents** over 2 years by increasing their understanding of stress and by enhancing their self-efficacy and social support following the catastrophic event.³²

This demonstrates the need for wide-reaching Mental Health screening and care provision.

²⁶ (WHO 2005).

²⁷ (Piyasil *et al.* 2007)

²⁸ (Pityaratstian *et al.* 2007),

²⁹ Başoglu *et al.* (2007)

³⁰ (Giannopoulou *et al.* 2006)

³¹ Wang *et al.* (2000)

³² Hardin *et al.* (2002)

What can be done?

The co-ordination of Mental Health care provision in emergencies improves with shared experience, as demonstrated by a marked improvement in the Royal Darwin Hospital's mental health care response following the 2005 Bali bombings after using lessons learned from the earlier 2002 bombings³³

However, single hospitals often may not have the resources or infrastructure to meet the Mental Health Care needs of a population affected by emergencies.

The prompt determination of those at risk requires the implantation of tested screening techniques on a large scale, and allows for targeted and appropriate provision of psychological first-aid³⁴

The training of NGO personnel and Health Care practitioners in evidence-based techniques is therefore imperative in the effective and timely provision of Mental Health care after an emergency³⁵:

An important study³⁶ noted interventions that target practical and social issues provide a positive effect on Mental Health and vice versa. The study outlines the importance of:

- early access to valid information in reducing public anxiety and stress.
- recommencing normal activities such as religious events and funeral ceremonies
- the recommencement of informal schooling with recreational activities
- and the development of social inclusion by providing community activities

Care for survivors with disabilities should include:

- Early identification of injuries and appropriate referral so that resultant disability may be avoided
- Provision of Assistive devices where possible,
- The Building of new rehabilitation infrastructures in either an institution-based setting, or a community-based setting where other survivors can be trained to provide care³⁷

Principles of Care

In 2003, the WHO created a series of guidelines including principles of care for best Mental Health provision in emergencies³⁸:

1. Preparation before an emergency (Contingency Planning)
 - developing a system of inter-agency coordination
 - providing psychological first-aid and general mental health training to general health care personnel
 - designing a detailed response plan for emergencies
2. Assessment
 - using specific socio-cultural understanding to identify need
 - documenting available resources
3. Collaboration
 - involvement of NGOs, Government organizations, local universities and groups allows sustainable care and avoids wastage of resources

³³ Guscott *et al.* (2007)

³⁴ (Bryant 2006).

³⁵ (Riddell & Clouse 2004; Bryant 2006; Yule 2006).

³⁶ van Ommeren *et al.* (2005)

³⁷ WHO (2005).

³⁸ (WHO 2003)

4. Integration into primary health care
 - allows low-stigma access to mental health care
5. Access to services for all
 - equal availability of care, rather than separate vertical care for each group
 - additional outreach groups for survivors at higher risk may be useful
6. Training and supervision
 - long-term guidance from Mental Health care specialists to ensure ongoing training and lasting effects of care
7. Long-term perspective
 - consistent Mental Health care is particularly important in the medium to long-term following an emergency
8. Monitoring indicators
 - careful review of each intervention to ensure that availability of resources, method of provision of care and outcomes of care are ideal

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