

Applicability in highly industrialized, resource rich Communities: the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

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Both natural and human made disasters create distress in large populations. The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings set forth principles and a system for their employment, aimed at minimizing the psychological consequences of public health emergencies created by disasters. Guidelines cannot dictate which principle, or principles, of mental health and psychosocial support have the most relevance to the needs of a specific culture in a specific disaster. However, recent experience in the United States suggests that the core principles articulated in the guidelines are appropriate for use in industrialized and resource rich nations, and that approaches outlined within the guidelines are of practical use in these populations.

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The ravaging effects of earthquakes, armed conflict, and/or famine in less industrialized nations have been well documented by local and international observers over the last century. Public health emergencies occur when demand (e.g., for food, shelter, or health care) outstrips available resources. The *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* set forth principles

and a system for their employment aimed at minimizing the psychological consequences of these emergencies. Except for the recent WHO efforts, prevalence rates of mental illness have not been well studied in most nations, particularly those with limited resources. However, often it is those countries with limited resources and limited health infrastructures that experience the most increased- and unmet- psychiatric or psychosocial demands in the aftermath of mass violence and disasters. The guidelines provide a framework for the coordination and delivery of acute and intermediate term public health and psychosocial intervention in such resource deprived environments.

Yet, do these guidelines also have applicability for highly industrialized and relatively resource rich nations? Recent experience in the United States would suggest that the answer is 'yes'.

As a result of events, such as September 11, 2001, the wars in Iraq and Afghanistan, and hurricane Katrina, Americans are increasingly alert to important public health issues that arise from deficits in psychosocial resources after mass violence and disaster in their own communities. The public health response to large scale public health emergencies and catastrophes requires consideration of mental

disorders (e.g. posttraumatic stress disorder (PTSD), depression, etc.), distress (e.g. sleep disturbance, fear, changes in economic behaviours, such as purchasing houses) and health risk behaviours (e.g. increased smoking, or alcohol use, lack of timely adherence to warnings to evacuate in the face of tornado, hurricane or even fire) of those exposed (IOM 2003; Ursano, et al., 2008).

We now realize that the rates of mental disorders in New Orleans doubled six months after Katrina, from about 15% to 30% (Kessler et al., 2006; Ursano, 2008). The mental health costs of this, the largest natural disaster to hit the United States, continues today. Such disasters, as well as those caused by terrorism and war, remind us that recovery of populations is a long and arduous task.

As natural disasters again inform Americans of the effects of traumatic exposure, so too, does war. There are more than 29 armed conflicts occurring now around the globe involving 25 countries (Project Plowshares, 2007). Few large scale studies have addressed country populations exposed to armed conflict. Recently, Karam et al. (2008), using the WHO Composite International Diagnostic Instrument (CIDI) addressed the lifetime prevalence, age of onset, and treatment delay for mental disorders in a nationally representative population survey of Lebanon. They also examined individual and cumulative war exposures as risk factors for the development of mental disorders. Nearly 70% of the population were exposed to one or more war events including nearly 60% of children ages 0-10. About 38% of the population had been a war refugee. Importantly, although not surprisingly, those exposed to war events were at a higher risk for developing a mental disorder for the first time (after controlling for age, gender, marital status, and education), and there was a cumulative effect of war exposures increasing the likelihood of

developing anxiety (including social anxiety disorder, PTSD and generalized anxiety disorder), mood (dysthymia and major depressive disorder, but not bipolar disorder) and impulse control disorders.

On the other side, those who fight in wars, like first responders in disasters, are also exposed to the stressors of war. For those in the United States, Iraq and Afghanistan are the present teachers of lessons long known and too often forgotten. Epidemiological surveys conducted during current conflicts in Iraq and Afghanistan suggest that as many as 13-17% of service members screen positive for PTSD (Hoge, et al., 2004). The Mental Health Advisory Team (MHAT), established by the office of the US Army Surgeon General, assessed the mental health of deployed US Soldiers in the fall of 2006. This team noted increases in behavioural health consequences for service members involved in multiple deployments. US Soldiers deployed to Iraq more than once were more likely to screen positive for acute stress (PTSD), anxiety, depression, or any other mental disorder than those who had been deployed only once. Soldiers deployed multiple times were 1.6 times more likely to screen positive for PTSD than one-time deployers, and 1.2 and 1.7 times more likely to screen positive anxiety and depression, respectively. Soldiers deployed for greater than 6 months were between 1.5 and 1.6 times more likely to screen positive for acute stress than those deployed for less than six months (MHAT, 2007, pp. 23-24).

It is clear that not all emotional distress resulting from disaster, terrorism or war amounts to mental disorder but fear, worry, insomnia, and changes in health risk behaviours all contribute to the health burden of mass violence. Therefore, all should be targets for early public health intervention. Substantial evidence supports essential principles of immediate and midterm mass

trauma intervention, which is now described as psychological first aid (PFA) (Hobfoll, et al., 2007). The principles are: (a) ensuring safety; (b) supporting calming; (c) increasing interpersonal connectedness; (d) building skills and belief in ones skills; and (e) fostering hope. These principles have evidence bases that support their use and provide some assurance of their efficacy. However, translating these principles into widely accepted (e.g., destigmatized), rapidly disseminated, culturally informed intervention programmes and policy remains a present and future challenge (Benedek & Fullerton, 2007).

The guidelines provide a framework for the delivery of public health assistance which emphasize coordination and synergy of available resources, scalability or response, and consideration of cultural norms and expectations in the delivery of assistance. Recent American experience demonstrates that none of these core principles are any less relevant in highly industrialized nations. Lack of integration and coordination of federal assistance with local resources was an unfortunate hallmark of the Federal Emergency Management Agency's initial and ineffectual response to hurricane Katrina victims. More successful and ongoing efforts to provide assistance to victims of the hurricane centred around the principles of psychological first aid (PFA) highlighted in the guidelines. References to Psychological First Aid (both directly and indirectly) are pervasive throughout the guidelines but Psychological First Aid is discussed as a core principle of the guideline on page 13, and elaborated on in more detail on pages 91-93 and again on action sheet 6.1 and pages 116-119. Current efforts recognize the idea that while the majority of disaster victims may not suffer from mental illness, efforts to foster a sense of safety, calmness, self and

community efficacy, interpersonal connections and hope (the core principles of PFA) enhance individual and community health and resilience (Hobfoll, et al., 2007).

Resilience of communities is a part of community capacity to care for itself and respond to needs of its members. Those communities with more resources are in general, but not always, better positioned to respond to the trauma, adversity and losses of public health emergencies.

In addition, US government leaders are increasingly attuned to the range of responses to traumatic exposures of combat on returning troops. Not only PTSD, but difficulties related to grief and mourning over lost comrades, substance abuse, domestic violence, marital discord, and child neglect are increasingly the focus of government mandated policies and programmes. The establishment of the first Disaster Research Center funded by National Institutes of Health (tasked with developing rapid needs assessment capability for post disaster mental health and behavioural health surveillance) and the quiet transformation of the United States' (congressionally funded) Department of Defense (DOD) Center of Excellence for PTSD and Traumatic Brain Injury into the DoD Center of Excellence for *Psychological Health* and Traumatic Brain Injury reflects an awareness of the need to address the wide range of post national emergency mental health and behavioural responses that are critical to health and the function of a nation. Similarly, focus on the needs of first responders (i.e. firefighters, police and health workers, etc.) has broadened the scope of psychological health in emergencies and the need for widely applicable principles that are applicable for population level intervention (Benedek, et al., 2007). However, the treatment and prevention of PTSD is only one facet of the public health

response to the public health emergencies of disaster, war and terrorism. While research in the last quarter century has begun to identify effective pharmacological and psychotherapeutic treatments for this disorder, these treatments may not be effective or feasible in all environments. Furthermore, with regard to the greater range of traumatic stress responses, it is less clear which intervention (or combination of interventions) is most effective for a particular set of emotional needs or symptoms at the individual and population levels of intervention. Assisting in restoring sleep for individuals and enhancing feelings of safety for entire populations are critical non disease interventions for public health emergencies. The degree to which specific core principles of mental health and psychosocial support in emergencies may have more relevance to specific needs or specific cultures is a question that must be answered.

The *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* do not provide the answers to these questions, but they do provide a set of potential tools, and a system for employing these tools in the context of humanitarian, equitable and just care in the aftermath of mass violence and disaster of all kinds. The lessons of the recent history in the United States further indicate that, not only the core principles articulated in the guidelines are appropriate for use in industrialized and resource rich nations, but that the specific tools in this toolbox may be of practical use in such populations.

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