

# Emergency psychiatric care in North Kivu in the Democratic Republic of the Congo

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*People with psychiatric disorders in humanitarian emergencies are primarily neglected and lack appropriate treatment. This results in unnecessary suffering, stigmatisation, loss of dignity and increased mortality. This paper describes the experience of Médecins Sans Frontières in providing emergency psychiatric treatment as a component of a busy medical programme in Mwezo, a conflict affected region of North Kivu, the Democratic Republic of the Congo. Interventions included treatment with psychotropic medications by non specialist physicians and counselling by lay counsellors. Most patients were treated for psychotic disorders with good results. Our experience shows that generalist medical doctors can be trained to diagnose and treat psychiatric disorders. Introduction of emergency psychiatric care in humanitarian emergencies is needed and feasible, despite multiple competing priorities. Key issues to consider are contingency planning for programme interruptions due to security issues, simplification of protocols and shared care with mental health counsellors.*

**Keywords:** emergency psychiatric care, Médecins Sans Frontières, psychiatric care within a conflict zone, the Democratic Republic of the Congo

## Background

Severe psychiatric disorders are common (psychosis, severe depression, disabling anxiety disorders), with a 12 month estimated prevalence of 2–3%. This prevalence almost doubles in the context of a humanitarian emergency to 3–4%. This is

a ‘best guess’ based on assumptions that a disaster will precipitate a relapse of mental disorders in previously stable patients, as well as contribute to people developing severe disorders in response to stress (World Health Organization (WHO) & United Nations High Commissioner for Refugees (UNHCR), 2012). The situation is further complicated by an ongoing lack of access to psychiatric treatment in low and middle income countries due to scarce or no treatment resources, in particular, the lack of trained professionals in mental health. It is estimated that the vast majority of patients with severe disorders in low and middle income countries never receive treatment for psychiatric disorders (Chisholm et al., 2007).

There have been attempts to address this lack of access to psychiatric care in humanitarian interventions. It is expected that, within a humanitarian response, people with severe mental health problems should be treated within available health services (The Sphere Project, 2011). Emergency mental health guidelines include a section on psychiatric treatment (Inter-Agency Standing Committee (IASC), 2007). WHO now also includes psychotropic medications from five classes in the Inter-Agency Emergency Health Kit Version 4 (van Ommeren et al., 2011). This should ensure the availability of psychotropic medications with the initiation of interventions during humanitarian disasters. The challenge is to ensure that medical staff, responding in

humanitarian crises, will be motivated to use these medications and have the necessary knowledge to do so.

There are numerous examples of the life saving nature of psychiatric treatment within emergency settings. Jones et al. (2009) describe the experience of the International Medical Corps in the management of severe mental disorders in five complex emergencies. They conclude that *even with minimal resources, the simple creation of an accessible service and treatment of sufferers with dignity challenge ostracism and stigmatising beliefs*. Souza et al. (2009) demonstrated the feasibility of integrating mental health, including psychiatry into primary care within a humanitarian emergency. Other investigators stress the importance of psychiatric interventions as part of a disaster response, as well as the feasibility of training existing medical providers in psychiatric management (Conrad & Lavigne, 2013; Norwood, Ursano & Fullerton, 2000; Prasetiyawan, Maramis & Keliat, 2006; Stratta et al., 2012).

Médecins Sans Frontières (MSF) is an international medical humanitarian organisation that aims to provide life saving care to people in crisis through intervening in conflict, natural disasters and disease outbreaks. In 1990, the Dutch section of MSF, introduced mental health programming into its programmes. This focus has grown slowly over the years, with over 55,000 individual consultations in 2012. The interventions in these programmes consist mainly of psychological first aid, psychosocial activities and supportive counselling, but do not aim to treat those with severe mental health disorders. These individuals require referral to medical care, ideally to specialised psychiatric care. However, the reality is that within many humanitarian settings, psychiatric referral options do not exist, and where they do exist quality may be poor, or respect for basic human rights lacking. There is, therefore, an urgent need to integrate psychiatric care into primary health care. Recognising this need, MSF-Operational Centre Amsterdam

(MSF-OCA) developed the ambition for all MSF primary health care programmes to diagnose and treat acute psychiatric disorders, namely acute psychosis, severe depression with/without suicidal ideation, mania, delirium, acute anxiety and acutely violent patients (MSF, 2011). This policy applies to all general medical programmes where there is no access to quality psychiatric referral, including those without mental health and psychosocial programming. The policy is limited in scope to direct service provision for those patients who need care the most, and does not aim for wider coverage, or for longer term policy change. This limitation does not preclude these wider objectives from being implemented where possible, but rather allows teams to focus on direct service provision where there are high numbers of competing needs and also removes a potential barrier to initiating treatment. Furthermore, in most cases, the intervention is designed to be integrated into existing primary care services without additional or specialised human resources.

To assist practitioners in implementing treatment, the revised version of the MSF mental health guidelines now includes a section on the treatment of psychiatric emergencies (de Jong, 2011). The focus in this section is on treatment of emergency psychiatric conditions only. A short description of the main diagnostic features is given along with treatment options using a limited list of medications. More complex presentations are to be referred to the headquarter specialists for long distance consultation.

However, implementation of the guidelines has proven to be a challenge, as we have found that medical teams are often reluctant to respond to psychiatric emergencies with the same sense of urgency as other medical priorities in humanitarian settings. Reasons for this lack of prioritisation, as communicated to headquarter staff during (de)briefings and field visits, include a lack of recognition of the significant mortality and morbidity associated with severe psychiatric

disorders, competing medical priorities against a background of limited resources, lack of training on diagnosis and management, and a belief that psychiatric care is complex and difficult to implement by non-specialists. This is compounded in projects where there are no mental health programmes, both due to lack of active case finding in the community and limited awareness by the medical team. Finally, concerns linked to starting a long term treatment within an unstable setting, or worries about sustainability of treatment after the emergency is over and MSF leaves, have also been barriers. In this paper, the experience of one programme where emergency psychiatric care was successfully introduced in a conflict setting, despite overwhelming competing medical needs, is presented.

### **Setting**

While providing medical care in Mweso, North Kivu, the Democratic Republic of the Congo (DRC), the need for emergency psychiatric intervention became increasingly apparent. The DRC is afflicted by one of the most complex protracted humanitarian crises in the world. Violence against the population by armed forces and rebel groups takes severe forms, including attacks on villages, sexual violence and displacement. Access to psychiatric care is extremely limited, with just 45 psychiatrists and six psychiatric hospitals for a country with a population of close to 68 million (WHO, 2011).

Since 2008, MSF has supported the Ministry of Health (MoH) in Mweso, North Kivu in terms of both outpatient and inpatient care in a 200 bed hospital and several health posts. Services are free and include surgery, general medical care including treatment of HIV/AIDS and tuberculosis, reproductive health, medical management of sexual violence survivors and a mental health programme. The mental health care is provided by an expatriate psychologist supervisor and trained lay counsellors who provide

supportive counselling and psychosocial services in order to reduce trauma and related complaints and enhance functionality. The lay counsellors are recruited from the local population on the basis of literacy and empathic qualities. Further details of their training and the intervention model have been described elsewhere (Shanks et al., 2013). The patients include displaced populations who live in the IDP camps of Mweso, survivors of violence, including gender based violence and domestic violence, and members of the population experiencing high levels of distress related to the conflict and instability (MSF, 2012).

The need for psychiatric intervention with psychotropic medication became apparent when patients presented to the mental health programme and the medical outpatient department with symptoms suggestive of a severe psychiatric disorder including hallucinations, delusions, aggression, and suicidal ideation. These patients had previously had no opportunity for treatment and were unable to care for themselves. A number of cases presented where patients were protected and controlled by families by being held in chains. Some individuals had experienced emotional and physical abuse due to the manifestations of their illness. In April 2010, in response to these human, including medical, needs and with the only option for referral being a psychiatric hospital several hours away on often dangerous or blocked roads, MSF began providing emergency psychiatric treatment integrated within existing medical services. The authors describe this process and the feasibility of initiating emergency psychiatric treatment within a general medical setting in a conflict region, the challenges involved, early treatment results and lessons learned.

### **Programme description**

#### **The process**

Patients initially presented to the outpatient department and were then, based

on presenting symptoms, referred by a triage nurse to the mental health programme.

The mental health officer (expatriate psychologist) and a lay counsellor conducted an assessment and, based on the findings of psychiatric symptoms, would refer a patient to the general medical doctor to rule out a medical condition, verify a psychiatric diagnosis and, where indicated, to prescribe appropriate psychotropic medication. One doctor initially did psychiatric consultations and prescriptions in order to maximise consistency and continuity. Ambulatory treatment was provided where possible and families were instructed as to how to care for the patient within a home setting. Follow-up visits were scheduled on a 2–4 week basis, depending on the acuity of the patient and the travel distance. There were no available community resources and the responsibility for care remained within the family. Referrals to a psychiatric hospital was not geographically feasible, therefore, severe cases were admitted into the general medicine or paediatric wards when necessary.

Due to concerns about being unable to meet the anticipated high demand for the service, the medical team created strict criteria for admission to psychiatric treatment. There was no active case finding nor community sensitisation. Only those patients who represented a danger to themselves or others, and who were judged to be able to adhere to long term treatment based on distance to treatment centre, and having a supportive caretaker or ‘*treatment buddy*’ were eligible for treatment. Over time and with experience, these criteria were slightly modified. Patients who came from further away were included if they were willing to return for follow-up, or if the psychosocial teams in other MSF projects in the region could follow them. The emphasis for the past 2 years has been on treatment with psychotropic medication for severe urgent disorders, primarily psychoses, accompanied by supportive counselling from the mental health team.

The mental health team and the generalist medical doctors have worked in close collaboration. The mental health team was responsible for the psycho-education of patients and their families, including the importance of adherence to medication. As patients experienced reduction of symptoms, counsellors focused on helping them re-integrate into community life. To ensure that services were culturally and linguistically sensitive, a local counsellor was always present at consultations with the physician.

Within a few months, the programme was treating more than 10 psychiatric patients as outpatients, and was caring for two to three hospitalised patients each month. As the service became known in the community through word of mouth, there was a steady increase in numbers of cases. These patients, usually brought by their families, spontaneously presented in the outpatient department. Patients with epilepsy were treated in the paediatric and medical programmes and were not included under the psychiatric umbrella.

### **Training**

Training was essential as many physicians have limited exposure to psychiatry during their medical training and hence are reluctant to treat psychiatric patients. As the programme began seeing psychiatric patients, a MSF psychiatric consultant went into the field for 2 weeks and trained doctors, nurses, and lay counsellors on site in the identification of psychiatric symptoms and basic patient care. Doctors were trained in the diagnosis and classification of psychiatric conditions and treatment according to MSF recommended guidelines including the WHO mhGAP intervention guide (WHO, 2010) and the MSF mental health guidelines (de Jong, 2011). Training sessions for nurses were subdivided to serve the specific needs of each department: outpatient, mobile clinic, maternity, internal medicine, surgery and intensive care. There was also a need for training in appropriate

nursing care and humane treatment of psychiatric patients. The expatriate medical doctor and mental health officer provided additional training and on-the-job coaching. Long distance consultation was available from the MSF network of volunteer psychiatrists and the Netherlands based advisers via email, telephone, and Skype. Programme staff emailed the MSF psychiatrist with questions about management of patients, such as management of psychosis during pregnancy and when to taper or stop treatment with anti-psychotic medication.

### Programme outcomes

Between April 2010 and February 2012, 72 patients with psychiatric symptoms were registered: 39 male and 33 female between 8 and 67 years of age. The majority (82%) were aged 15–45 years. The most frequent diagnosis was psychotic disorder, based on DSM-IV-Tr Criteria (44 patients, 61%); Table 1 lists the diagnoses. Seven patients had a secondary psychiatric diagnosis of substance abuse (primarily alcohol abuse in five patients) or developmental delay (two patients) (American Psychiatric Association, 2000).

Treatment interventions included counseling by lay counsellors, and psychotropic medications and hospitalisation when necessary. Forty-three (60%) patients were treated solely on an ambulatory basis. Twenty-nine were hospitalised, either initially or during treatment, and then discharged to the outpatient clinic. Hospitalisation lasted an average of 7 days. The main reasons for hospitalisation included prevention of patients harming themselves or others, stabilisation and monitoring of potential side-effects. Commonly used medications are shown in Table 2.

A physician assessed progress at each visit, based on the report of the patient, treatment buddy or family, and observations made during the clinical interview. The observations recorded at the final visit were used to report on overall outcome.

**Table 1. Diagnoses among registered patients**

Diagnosis	Number of patients (%)
Psychotic disorder	44 (61%)
Schizophrenia	21 (29%)
Psychotic episode NOS	16 (22%)
Post-partum psychosis	3 (4%)
Delusional disorder	4 (6%)
Bipolar disorder mania	11 (15%)
Anxiety disorder	7 (10%)
Major depressive disorder	2 (3%)
Substance abuse	2 (3%)
Organic brain syndrome	2 (3%)
Conduct disorder	1 (1%)
Antisocial personality disorder	2 (3%)
No diagnosis	1 (1%)
Total	72 (100%)

*NOS = not otherwise specified.*

Forty-five patients (63%) were seen for  $\geq 1$  month (range 1–24 months), of which 39 (87%) showed improvement or resolution in symptoms during treatment. Five of 27 patients with  $< 1$  month follow-up showed improvement in symptoms after a short hospitalisation, or 1–2 ambulatory visits. The remaining 22 either defaulted (12; 17% overall default rate) or no further information was captured by data collection (10; 14% overall). Overall, 44 (62%) patients

**Table 2. Commonly used drugs**

Drug	Dosage (mg/day)
Chlorpromazine	12.5–100
Haloperidol	1.25–10
Risperidone	0.5–6
Carbamazepine	200–400
Diazepam	5–15 or as needed
Fluoxetine	20
Biperiden	2

showed either improvement or resolution of symptoms. Anecdotally patients and their families verbally reported in follow-up sessions a reduction of symptoms and improvement in functioning, including return to school or work, as well as resumption of family and social relationships. These changes were also apparent to the medical and counselling staff.

The data included in this paper were part of routine data collection and, therefore, have limitations such as missing or incomplete data. In addition, assessment of outcomes was not done by an independent evaluator, but rather by the clinician caring for the patient.

Presentation of this data meets the MSF Ethics Review Board standards for analyses of routine programme data and did not require review by the MSF Ethics Review Board.

## **Discussion**

Patients who urgently presented to the outpatient departments with symptoms of severe psychiatric disorders benefited from psychiatric intervention. Those patients who adhered to treatment were able to resume activities of a normal life, including family relationships, work related activities and education. In spite of cultural beliefs in traditional cures, families who brought their relatives for treatment understood the importance of conventional medical treatment.

There have been ongoing challenges with the inclusion of urgent psychiatric treatment within a general medical setting. Health workers have exhibited fear towards patients. This was particularly obvious when inpatient care was necessary. It was not rare for the MSF team in the early days to discover that the psychiatric patients had been locked up in their rooms and left unattended during the entire night. Nurses and doctors expressed not feeling trained nor capable of handling psychiatric patients. Over time,

and with visible improvements in the condition of psychiatric patients on treatment, health workers became more comfortable in intervening with this group of patients. Recognition of psychiatric pathology among medical patients was another challenge. Cases of post-partum psychosis, for example, were misinterpreted, despite the fact that the psychiatry component had started and staff had obtained training. Correct use of psychiatric medication needed to be enforced as sometimes patients were treated with two anti-psychotics, neither being used at adequate treatment dosage. Finding sufficient time to treat psychiatric patients amid the multiple severe and acute medical patients continues to be a challenge for all cadres of medical staff.

The programme did prove possible to implement with minimal extra resources. No extra staff was hired as the intervention was integrated into existing medical services. The main costs were travel for the volunteer psychiatrist to visit the field for the training, and the drugs. Subsequently, MSF were fortunate in having a psychiatrist advisor on staff for long distance consultation by email or phone. The drug costs were not significant, as all are available in lower cost generic formulations.

Some symptoms are culturally shaped, and might not be the manifestation of a disorder, but a normal cultural mode of expression (Tseng, 2007). Nonlocal staff may confuse manifestations of beliefs, cultural behaviour or psychological reactions with psychiatric symptoms, and misinterpret specific manifestations of psychiatric disorders. In Mweso, for example, panic attacks are often manifested as an abrupt run into the forest away from a perceived threat. This could be mistaken for a psychotic state. For the national and local staff it is important to learn how to integrate their own knowledge and beliefs into the interaction with patients. Often, the tendency is to rigidly hold onto the western medical point of view and label the patients' (and their own) beliefs as

irrelevant. Families regularly attend prayer groups and traditional healers before and during psychiatric treatment. Respect for these choices alongside medical treatment is important, as well as discussion on avoiding specific detrimental practices such as prolonged sleep deprivation and fasting.

Few of the patients who presented were diagnosed with severe depression. This is consistent with a larger cohort reported from Burundi where depression was recorded infrequently relative to psychotic disorders in a mental health treatment programme (Ventevogel et al., 2011). It was noted by the health staff in Mweso that people with mental disorders that were most disruptive to family and community were more likely brought for treatment. Depressed people, within this context, were usually withdrawn and quiet and did not draw attention to themselves. It is also likely that the restrictive admission criteria played a role in limiting access to patients with severe major depression.

In addition to these challenges, there is a regular turnover of medical staff and new staff require training. A disruptive and difficult to manage patient can discourage medical staff in the care of other psychiatric patients. In a busy medical service there is the fear that treating some psychiatric patients will eventuate in being overloaded with many more. Ongoing training and support are key to overcoming these obstacles.

A positive development has been a recent widening of the criteria of treatment of psychiatric disorders so that any patient now presenting to the OPD is accepted for treatment without the previous restrictive criteria. Whereas the vast majority of patients are still presenting with symptoms of psychosis, patients are also being seen and treated with diagnoses of autism, post-traumatic stress disorder and depression. This has occurred as medical staff becomes more confident in their abilities to diagnose and treat severe psychiatric disorders along with seeing the positive results of their interventions (Box 1). Nevertheless, it is important to note that even with the more open criteria, MSF is still seeing only a small fraction of the prevalent psychiatric conditions expected to be in the community and overall numbers remain low. A key factor here is that due to the emergency nature of the project, coverage is not an objective of the programme and, as such, there has been no community outreach programme nor active case finding put in place.

Another key challenge, when providing any kind of long term medical therapy in conflict settings, is how to deal with interruptions of treatment due to lack of security. MSF first faced this challenge with tuberculosis (TB) treatment in refugee and conflict settings when the decision was made to treat TB patients despite the guidelines that advised against treatment (Keus et al., 2003). The next challenge was the provision of

**Box 1: *Quotes from emails sent to the MSF psychiatrist***

Patient 1: *'One patient who came back on Monday, who hadn't been talking and moving for the past three years, has started to say small sentences and has expressed his will to go to work to the fields, what he is now doing! I must admit that even though we had small signs of improvement since we started to treat him, I wouldn't have bet on him. We'll see how things will continue.'*

Patient 2: *'He is difficult to recognise: he is calm, no hallucinations, no psycho-motor agitation or aggressive behaviour, his thought is coherent, his mood not high any more. He started to go to school again, has a social life and the relationships with his family are good. He now comes alone to take his medication (anti-psychotic). It is beautiful to see!'*

anti-retroviral treatment to HIV patients. MSF was able to show good outcomes could be achieved in resource-limited settings, but there remained a hesitancy to treat HIV in unstable settings due to fear of development of resistance to the antivirals. Operational research helped to demonstrate that it was both safe and effective to provide this treatment within settings with lack of security and to displaced populations (Culbert et al., 2007; O'Brien et al., 2010). The fact that the organisation had actively debated both TB and HIV treatment in unstable settings made it easier to consider offering psychiatric treatment, particularly as there was no additional risk of treatment resistance.

Strategies employed to reduce the risk of treatment interruption for TB and HIV that could also be used for psychiatric treatment include placing emergency drug stocks with local staff or health facilities, communication plans to spread information of where to go to get interim treatment during a crisis, treatment cards with information of diagnosis and drug dosages, and giving patients 'run away' bags with several weeks of treatment in case of an emergency. The learning from TB/HIV is that patient involvement in contingency planning is critical to success, and this may pose some issues for psychiatric patients before they are stabilised and for those with poor insight. Borrowing again from HIV/TB treatment, treatment buddies can be helpful as were employed in the Mweso programme.

While interruption of treatment was not a major issue for the Mweso programme during the study period, the security has since deteriorated to the point that MSF teams have had to temporarily withdraw teams and services. During a recent two week withdrawal of the team (October 2013), patients either had adequate supplies of medications or were able to obtain refills from the remaining MoH doctors. MoH doctors work side by side with MSF staff and have participated in the psychiatric

trainings. Hence, they are able to follow-up patients in the absence of MSF.

This raises the important issue of sustainability of the treatment programme once MSF leaves. As with HIV and TB, guaranteeing sustainability should ethically never be a pre-condition to starting treatment, but sustainability does need to be considered during the planning and implementation phases. Given the limited resources found in Mweso, the focus has been on developing local capacity through training local MoH doctors and nurses who will remain after MSF leaves. Experience from handing over a previous programme in a remote region of DRC is that drug supply is a challenge. Patients may not be able to afford the purchase of drugs, and some of the drugs may not be part of the usual stock of the health centre. In this case, MSF was unable to find a hand-over partner to support the MoH in providing this service and others, and therefore provided a free supply of drugs to the patients for a set period to ease the transition. More structural solutions to the problem of psychiatric drug supply would be to ensure these medications are part of the standard drug list for health centres, and to advocate for free supplies of drugs for psychiatric patients as is the case for HIV and TB.

Finally, the focus in this paper differs from that of a series in this journal in 2011 on integration of mental health care during and after complex emergencies primarily because the context in Mweso is still that of an emergency that requires a focus on direct service provision. Furthermore, our objective in describing this model of care is to demonstrate that psychiatric patients in urgent need of care within conflict settings can be treated safely in a busy medical programme, without expert or additional resources. Through sharing this experience, we hope to provide support for a model of care that normalises the integration of psychiatric care with primary care in conflict settings.

## Conclusions

Patients with severe psychiatric disorders who present danger to themselves and others require urgent treatment. With limited but sustained interventions it is possible to have a significant human and medical impact on the lives of psychiatric patients and their relatives. General medical doctors and nursing staff can deliver this care, but require training with periodic refresher training as well as the option of consultation, which can be long distance, with qualified psychiatrists. Hospitalisation on general medical wards is possible, but challenging. Improved education for families and increased expertise in the use of psychotropic medication could result in improved adherence and decrease the need for inpatient care. Awareness, training, and professional support of medical professionals in humanitarian emergencies in psychiatric diagnosis and treatment will lead to treatment of people who sometimes have experienced years of neglect. This is one strategy that can contribute to the management of psychiatric disorders during a humanitarian disaster in low and middle income settings.

## Lessons learned

1. Emergency psychiatric care can be introduced with minimal additional human resources in the acute phase of an emergency.
2. Recognition by programme planners of the urgent, life saving need for treatment of severe psychiatric conditions is critical to assist in prioritisation of health needs in an emergency.
3. Remote support from psychiatrists via telephone or email can build confidence of non-specialist physicians in diagnosing and treating psychiatric disorders.
4. Simplification of diagnostic and treatment guidelines is a precondition to introducing psychiatric care in emergency settings. This should include a limited range of drugs, which as much as possible, reflects the national essential drug list.
5. Shared care between mental health counsellors and medical staff facilitates the introduction of psychiatric care and improves the quality of care given to patients and families.
6. Limits to the scope of the programme may be necessary when competing health demands exist; these limits need regular review as the situation evolves.
7. Where inpatients services are offered, training needs for nursing staff will be high and should focus on awareness of mental health issues and humane care.
8. It is important to share widely early successes, within the limits of patient confidentiality, in order to increase buy in from health staff and programmers.
9. Planning for interruption of services is critical and often includes active collaboration with local providers, prepositioning of drugs in a secure location, education to patients and families, along with community leaders and a communication plan.
10. Medical staff can benefit from ongoing oversight and in-service training on prescribing habits.

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