Building Back Better

Sustainable Mental Health Care after Emergencies

World Health Organization

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For information and feedback on this document, please contact vanommerenm@who.int.

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Sustainable Mental Health Care after Emergencies

Foreword

Already in 2013, the world has witnessed numerous emergency situations, including the refugee crisis in Syria and neighbouring countries; heavy fighting in the Central African Republic, Democratic Republic of Congo, and Mali; and major flooding in Bolivia, Colombia, Mozambique, and the Philippines. Countless people have been affected, and will continue to be affected as their countries struggle to recover and rebuild.

Displacements, food shortages, and disease outbreaks are all-too-common during and after emergencies. On top of this, families can be torn apart, children can lose educational opportunities, and important social and health services can disappear from the landscape overnight.

It is perhaps not surprising, therefore, that the mental health impact of emergencies is sizeable. Emergency situations can trigger or worsen mental health problems, often at the same time that existing mental health infrastructure is weakened. Humanitarian assistance agencies try their best to help people with their psychosocial needs in the immediate aftermath of emergencies, but too often do little to strengthen mental health systems for the long term.

It is possible to do better. Emergency situations – in spite of the adversity and challenges they create – are openings to transform mental health care. These are opportunities not to be missed because mental, neurological and substance use disorders are among the most neglected problems in public health, and because mental health is crucial to the overall well-being and productivity of individuals, communities, and countries recovering from emergencies.

This WHO report shares detailed accounts from 10 diverse emergency-affected areas, each of which built better-quality and more sustainable mental health systems despite challenging circumstances. Cases originate from countries small to large; low- to middle-income; across Africa, Asia, Europe, and the Middle East; and affected by large-scale natural disasters, prolonged conflict, and large-scale influxes of refugees. While their contexts varied considerably, all were able to convert short-term interest in population mental health into sustainable, long-term improvements.

This WHO report goes beyond aspirational recommendations by providing detailed descriptions of how mental health reform was accomplished in these situations. Importantly, case contributors report not only their major achievements, but also their most difficult challenges and how they were overcome. Key overlapping practices emerging from these experiences are also summarized.

This report provides the proof of concept that it is possible to build back better, no matter how weak the existing mental health system or how challenging the emergency situation. I call upon all readers to take steps to ensure that those faced with future emergencies do not miss the important opportunity for mental health reform and development.

Dr Margaret Chan

Director-General
World Health Organization

Preface

Emergency situations have a range of causes: natural disasters such as earthquakes and floods, armed conflicts and civil wars, and technological failures such as nuclear disasters. Regardless of the nature of the triggers, a cascade of human suffering is often the result. This can include large-scale displacements, food shortages, outbreaks of disease, violations of people's rights and dignity, and death.

But the human impact is even broader: after emergencies, people are more likely to suffer from a range of mental health problems. A minority develops new and debilitating mental disorders; many others are in psychological distress. And those with pre-existing mental disorders often need even more help than before. When the plight of those suffering becomes known to the nation and the world, others often become motivated to provide assistance.

And herein lies the paradox. In spite of their tragic nature, and notwithstanding the human suffering they create, emergency situations are also opportunities to build better mental health care. The surge of aid, combined with sudden, focused attention on the mental health of the population, creates unparalleled opportunities to transform mental health care for the long term.

As this publication demonstrates, some countries have done just this. They range from those undergoing prolonged conflict to those struck by devastating natural disasters. While the circumstances of each have been unique, all – using their own methods – have found ways to use the situation to build momentum for broader mental health reform.

The results can have an immediate and important human impact. For example, Razmy,[1] a teenage girl living in the tsunami-affected district of Kalmunai in Sri Lanka, was able to get help for both her parents following the 2004 disaster. Razmy heard a talk at her school by a newly appointed community mental health worker, and later asked the worker to visit her mother, who had become withdrawn and was hearing voices. The worker quickly identified her need for mental health services, but first had to overcome resistance by Razmy's family to her seeking care. Once this was accomplished, Razmy's mother was connected to the new mental health services in Kalmunai that she so needed. Later, Razmy's father disclosed to the community health worker his desire to deal with his alcohol use disorder. As a result, he was also able to access care.

The experience of Razmy's family is not unique. Countless families have been helped around the world as the result of mental health reform following emergencies.

[1] A pseudonym

The 10 cases that form the core of this report show how it can be done. Early commitment towards a longer-term perspective for mental health reform is key to success. The report summarizes lessons learnt and key overlapping practices emerging from these experiences.

By publishing this information, the World Health Organization aims to ensure that people faced with emergencies do not miss the opportunity for mental health reform. Emergencies are not only mental health tragedies, but also powerful catalysts for achieving sustainable mental health care in affected communities. We do not know where the next major emergency will be, but we do know that those affected will have the opportunity to build back better. Reading this publication is an excellent way to prepare for and respond to that eventuality.

Shekhar Saxena

Director, Department of Mental Health and Substance Abuse

World Health Organization

Richard Brennan

Director, Department of Emergency Risk Management and Humanitarian Response

World Health Organization

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WHO coordination and supervision

Mark van Ommeren (Scientist, Department of Mental Health and Substance Abuse, World Health Organization, Geneva, Switzerland) initiated and coordinated the development and production of this publication.

Shekhar Saxena (Director, Department of Mental Health and Substance Abuse, World Health Organization, Geneva, Switzerland) provided overall direction and supervision.

Managing editor

JoAnne Epping-Jordan (Seattle, USA) served as managing editor.

Contributors

JoAnne Epping-Jordan (Seattle, USA) and Mark van Ommeren (WHO/Geneva) wrote Parts 1 and 3, which introduce, justify, and analyze mental health reform and emergency recovery.

The following people contributed the case studies featured in Part 2.

AFGHANISTAN

Peter Ventevogel (HealthNet TPO), Bashir Ahmad Sarwari (Ministry of Public Health, Afghanistan), Inge Missmahl (International Psychosocial Organisation), Hafiz Faiz (International Medical Corps), Heini Mäkilä (International Assistance Mission), and Fareshta Queedes (International Psychosocial Organisation).

BURUNDI

Peter Ventevogel (HealthNet TPO), Herman Ndayisaba (HealthNet TPO), Willem van de Put (HealthNet TPO), Nancy Baron (Global Psycho-Social Initiatives and Psycho-Social Services and Training Institute), Joop de Jong (University of Amsterdam, Boston University and Rhodes University), Jérôme Ndaruhutse (WHO/Burundi), Jocelyne Miburu (Ministry of Public Health, Burundi), Wilma Meeus (HealthNet TPO), and Sonali Sharma (HealthNet TPO).

INDONESIA (ACEH) (alphabetical)

Albert Maramis (WHO/Indonesia) and Andrew Mohanraj (CBM Indonesia).

IRAQ (alphabetical)

Emad Abdulrazaq (Ministry of Health, Iraq), Ayad Nouri Fattah (Ministry of Health, Iraq), Manhal Helasa (WHO/Iraq Office in Amman), Aqila Noori (WHO/Iraq Office in Amman), and Nezar Ismet Taib (Mental Health Centre, Duhok, Kurdistan region, Iraq).

JORDAN

Anita Marini (formerly WHO/Jordan), Hashim Elzein Elmousaad (formerly WHO/Jordan), Nada Al Ward (WHO/Jordan), Zein Ayoub (WHO/Jordan), Bassam Hijiawi (Ministry of Health, Jordan), Hania Dawani (Jordanian Nursing Council), Mohammad Assfour (National Mental Health Centre, Jordan), Zuhair Zakaria (Jordanian Psychological Association), Tewfik Daradke (Jordanian University of Science and Technology), Abdel Majeed (Jordan University), Mary Jo Baca (International Medical Corps), Father Fadi Diab (Episcopal Church), Hamdi Murad, (Jordan), and Our Step (Jordanian National Users Association).

KOSOVO (alphabetical)

Ferid Agani (Ministry of Health, Kosovo), Dévora Kestel (PAHO/WHO), Besnik Stuja (WHO/Pristina),

Skender Syla (WHO/Pristina), and Liliana Urbina (formerly WHO/Pristina).

SOMALIA

Humayun Rizwan (WHO/Somalia), Mohammad Fuje (WHO/Somalia), Martha Everard (WHO/Somalia), Khalid Saeed (WHO/Cairo), and Abdur Rehman Ali Awale (Habeb Hospitals, Somalia).

SRI LANKA

T Suveendran (WHO/Sri Lanka), FR Mehta (WHO/Sri Lanka), Jayan Mendis (National Institute of Mental Health, Sri Lanka), M Ganesan (National Institute of Mental Health, Sri Lanka), TRC Ruberu (Ministry of Health, Sri Lanka), PG Mahipala (Ministry of Health, Sri Lanka), Prasantha de Silva (Ministry of Health, Sri Lanka), Lakshmi C Somatunga (formerly Director of Mental Health, Ministry of Health, Sri Lanka) Berit Kieselbach (formerly WHO/Sri Lanka), and John Mahoney (formerly WHO/Sri Lanka).

TIMOR-LESTE

Derrick Silove (University of New South Wales), Teofilo Julio Kehic Tilman (Department of Mental Health, Timor-Leste), and Zoe Hawkins (formerly Ministry of Health, Timor-Leste).

WEST BANK AND GAZA STRIP

Hazem Ashour (Ministry of Health, Palestinian Authority), Nargiza Khodjaeva (formerly WHO/West Bank and Gaza), Dyaa Saymah (WHO/West Bank and Gaza), Rajiah Abu Sway (WHO/West Bank and Gaza), and Tony Laurance (WHO/West Bank and Gaza).

Expert reviewers

The following people reviewed draft versions of this publication or parts thereof and provided comments and guidance on its further development.

Stephen Alderman (Peter C. Alderman Foundation), Dan Chisholm (WHO/Geneva), Julian Eaton (CBM International), Michelle Funk (WHO/Geneva), Berit Kieselbach (WHO/Geneva), Dévora Kestel (PAHO/WHO/Washington), Thierry Liscia (Agence Française de Développement (AFD)), John Mahoney (formerly WHO/Sri Lanka), Anita Marini (formerly WHO/Jordan), Claire Milligan (Absolute Return for Kids), Harry Minas (University of Melbourne), Andrew Mohanraj (CBM Indonesia), Matt Muijen (WHO/Copenhagen), Arne Ørum (Norwegian Council for Mental Health), Pau Perez-Sales (Médicos del Mundo [MdM-Spain]), Benedetto Saraceno (Universidade Nova de Lisboa), Khalid Saeed (WHO/Cairo), Alison Schafer (World Vision International), Yutaro Setoya (WHO/Geneva), Mathias Themel (European Commission), Graham Thornicroft (King's College London), Peter Ventevogel (HealthNet TPO), Xiangdong Wang (WHO/Manila), and Inka Weissbecker (International Medical Corps).

Technical editing

David Wilson (Oxford, United Kingdom)

Graphic design and layout

Alessandro Mannocchi (Rome, Italy)

Support by interns

Michelle Hourigan and Karen Paul (WHO/Geneva)

Administrative support

Mylène Schreiber (WHO/Geneva) and Grazia Motturi (WHO/Geneva)

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List of abbreviations

ADB	Asian Development Bank
BPHS	Basic Package of Health Services (Afghanistan)
CMHC	Community mental health centre (Jordan)
CSO	Community support officer (Sri Lanka)
CWGER	Cluster Working Group on Early Recovery
EC	European Community
ECHO	European Community Humanitarian Office
EPHS	Essential Package of Hospital Services (Afghanistan)
IASC	Inter-Agency Standing Committee
KTSP	King's THET Somaliland Partnership
mhGAP	WHO Mental Health Gap Action Programme
MOH	Ministry of Health
MOPH	Ministry of Public Health
NGO	Nongovernmental organization
NMHAC	National Mental Health Advisory Council (Sri Lanka)
NMHC	National Mental Health Council (Iraq)
NMHP	National Mental Health Policy (West Bank and Gaza Strip)
PHC	Primary health care
PTSD	Post-traumatic stress disorder
PRADET	Psychosocial Recovery and Development in East Timor
SLCP	Sri Lanka College of Psychiatrists
TFG	Transitional Federal Government (Somalia)
TPO	Transcultural Psychosocial Organization
UNDP	United Nations Development Programme
UNMIK	UN Interim Administration Mission in Kosovo
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
USAID	United States Agency for International Development
WHO	World Health Organization
WHO-AIMS	WHO-Assessment Instrument for Mental Health Systems

Executive summary

Emergencies, in spite of their tragic nature and adverse effects on mental health, are also unparalleled opportunities to improve the lives of large numbers of people through mental health reform. This is important because mental health is crucial to the overall well-being, functioning, and resilience of individuals, societies, and countries recovering from natural disasters, armed conflicts, or other hazards.

Sierra Leone. © Tommy Trenchard/IRIN. Reprinted with permission.

Building back better: sustainable mental health care after emergencies raises awareness about this type of opportunity, and describes how this was achieved in 10 diverse emergency-affected areas. Lessons learnt and key overlapping practices emerging from these experiences are summarized.

By publishing this report, the World Health Organization (WHO) aims to ensure that people faced with emergencies do not miss the opportunity for mental health reform and development.

The report is divided into three distinct parts.

Part 1

Part 1 provides the rationale for understanding emergencies as opportunities to build better mental health care.

During emergencies, mental health requires special consideration. This is due to three common issues: increased rates of mental health problems, weakened mental health infrastructure, and difficulties coordinating agencies and actors providing mental health and psychosocial support.

Emergencies present unique opportunities for better care of all people with mental health needs. During and immediately after emergencies, the media often rightly focus on the plight of surviving people, including their psychological responses to the stressors they face. In some countries, senior government leaders express – for the first time – serious concern about their nation's mental health. This is frequently followed by the willingness and financial ability of national and international agencies to support mental health and psychosocial assistance to affected people. In other words, in emergencies attention and resources are turned towards the psychological welfare of affected people, while decision-makers become willing to consider options beyond the status quo.

Collectively, these factors create the possibility of introducing and implementing more sustainable mental health services. But momentum needs to be generated at an early stage so that investments continue after an acute crisis.

The possibilities presented by emergency situations are significant because major gaps remain worldwide in the realization of comprehensive, community-based mental health care. This is especially true in low- and middle-income countries, where resources are often scant.

Countries faced with emergencies should not miss the chance to use available political will for change and to initiate mental health reform.

Indonesia (Aceh). © Jefri Aries/IRIN. Reprinted with permission.

Part 2

Part 2 presents 10 case examples of areas that have seized opportunities during and after emergencies to build better mental health care. They represent a wide range of emergency situations and political contexts. Still largely unknown, they offer proof of concept that it is possible to take action in emergencies to make systemic change to build better mental health systems. Lessons learnt are highlighted within each account.

Afghanistan: Following the fall of the Taliban government in 2001, mental health was declared a priority health issue and was included in the country's Basic Package of Health Services. Much progress has been made. For example, since 2001, more than 1000 health workers have been trained in basic mental health care and close to 100 000 people have been diagnosed and treated in Nangarhar Province.

Burundi: Modern mental health services were almost non-existent prior to the past decade, but today the government supplies essential psychiatric medications through its national drug distribution centre, and outpatient mental health clinics are established in several provincial hospitals. From 2000 to 2008, more than 27 000 people were helped by newly established mental health and psychosocial services.

Indonesia (Aceh): In a matter of years following the tsunami of 2004, Aceh's mental health services were transformed from a sole mental hospital to a basic system of mental health care, grounded by primary health services and supported by secondary care offered through district general hospitals. Now, 13 of 23 districts have specific mental health budgets, compared with none a decade ago. Aceh's mental health system is viewed as a model for other provinces in Indonesia.

Iraq: Mental health reform has been ongoing since 2004. Community mental health units now function within general hospitals, and benefit from more stable resources. Since 2004, 80–85% of psychiatrists, more than 50% of general practitioners, and 20–30% of nurses, psychologists, and social workers working in the country have received mental health training.

Jordan: The influx of displaced Iraqis into Jordan drew substantial support from aid agencies. Within this context, community-based mental health care was initiated. The project's many achievements built momentum for broader change across the country. New community-based mental health clinics helped more than 3550 people in need from 2009 to 2011.

Kosovo:[2] After the conflict, rapid political change generated an opportunity to reform Kosovo's mental health system. A mental health taskforce created a new strategic plan to guide and coordinate efforts. Today, each of Kosovo's seven regions offers a range of community-based mental health services.

Somalia: The governance structure in Somalia has been fragmented for more than 20 years, and during most of that time the country has been riddled with conflict and emergencies. Despite these challenges, mental health services have improved. From 2007 to 2010, chains were removed from more than 1700 people with mental disorders.

Sri Lanka: In the aftermath of the 2004 tsunami, Sri Lanka made rapid progress in the development of basic mental health services, extending beyond tsunami-affected zones to most parts of the country. A new national mental health policy has been guiding the development of decentralized and community-based care. Today, 20 of the country's 27 districts have mental health services infrastructure, compared with 10 before the tsunami.

Timor-Leste: Building from a complete absence of mental health services in 1999, the country now has a comprehensive community-based mental health system. Today, the Timor-Leste National Mental Health Strategy is part of the Ministry of Health's overall long-term strategic plan. Mental health-trained general nurses are available in around one quarter of the country's 65 community health centres, compared with none before the emergency.

West Bank and Gaza Strip: Significant improvements in the mental health system have been made over the past decade, towards community-based care and integration of mental health into primary care. In 2010, more than 3000 people were managed in community-based mental health centres across the West Bank and Gaza Strip.

[2] Throughout this document the name Kosovo is used in accordance with United Nations Security Council Resolution 1244 (1999).

Part 3

Part 3 summarizes overlapping practices among the 10 cases. Despite substantial variability in their contexts, certain commonalities can be identified between many cases.

1. **Mental health reform was supported through planning for long-term sustainability from the outset.** As demonstrated by several cases in this report, successful mental health reform commenced meaningfully in the midst of emergencies when an early commitment was made towards a longer-term perspective for mental health reform.
2. **The broad mental health needs of the emergency-affected population were addressed.** In many cases in this report, reforms were undertaken that addressed a wide range of mental health problems. No case established stand-alone (vertical) services for just one disorder (e.g. post-traumatic stress disorder) that ignored other mental disorders.
3. **The government's central role was respected.** During and following some of the emergencies described in this report, government structures were adversely affected but humanitarian aid helped subsequently to strengthen them. Examples included seconding professional staff and temporarily assigning certain functions to nongovernmental organizations (NGOs) under government oversight.
4. **National professionals played a key role.** Local professionals – even when they were too few in number – were powerful champions in promoting and shaping mental health reform. Helpful international experts and agencies involved themselves in mental health reform only to the extent that they were specifically invited to do so.
5. **Coordination across agencies was crucial.** Coordination of diverse mental health actors was typically crucial when working towards mental health reform. It helped facilitate consensus among diverse partners and then worked from an agreed framework. It also often helped partners complement – as opposed to duplicate – one another by taking different areas of responsibility.
6. **Mental health reform involved review and revision of national policies and plans.** Most cases featured in this report describe an overall process that involved policy reform. In the context of disaster, when political will for mental health care was high, the policy reform process was typically accelerated.
7. **The mental health system was considered and strengthened as a whole.** Many cases described processes that reviewed and assessed the mental health system as a whole, from community level to tertiary care level. Doing so provided an understanding of the overall system and how it was affected by the emergency. Decentralization of mental health resources towards community-based care was a key strategy.
8. **Health workers were reorganized and trained.** Opportunities frequently arose post-emergency to reorganize, train, and provide ongoing supervision to health workers so that they were better equipped to manage mental health problems. The majority of investments were made in people and services, rather than in buildings.
9. **Demonstration projects offered proof of concept and attracted further support and funds for mental health reform.** Demonstration projects provided proof of concept. They also helped ensure momentum for longer-term funding. The latter was particularly true when the demonstration projects were explicitly linked to discussions and plans on broader mental health reform.
10. **Advocacy helped maintain momentum for change.** Almost all cases featured in this report described individuals or groups who became successful advocates of broader mental health reform. They helped maintain momentum for change. Advocacy was most successful when diverse groups of people were not only informed about the issues, but also asked to become part of the solution.

Somalia. © Kate Holt/IRIN. Reprinted with permission.

The cases featured in this report show that mental health reform is realistic as part of recovery from crisis, even in highly challenging circumstances. Although the majority of mental health investments were directed towards humanitarian relief, exceptional efforts were made to redirect a portion towards mental health reform. The 10 practices summarized above were likely key in achieving success.

Global progress on mental health reform will happen more quickly if, in every crisis, strategic efforts are made to convert short-term interest in mental health problems into momentum for mental health reform. This would benefit not only people's mental health, but also the functioning and resilience of societies recovering from emergencies. Readers are encouraged to review these cases to consider how the overlapping practices and lessons learnt can be applied in their own situations.

Part 1.
Seeing Opportunity In Crisis: Using Emergencies to Build Better Mental Health Care

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