Building Back Better

Sustainable Mental Health Care after Emergencies

Overview

World Health Organization

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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
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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.

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[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.

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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.

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

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

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.

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[2]   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.** 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.
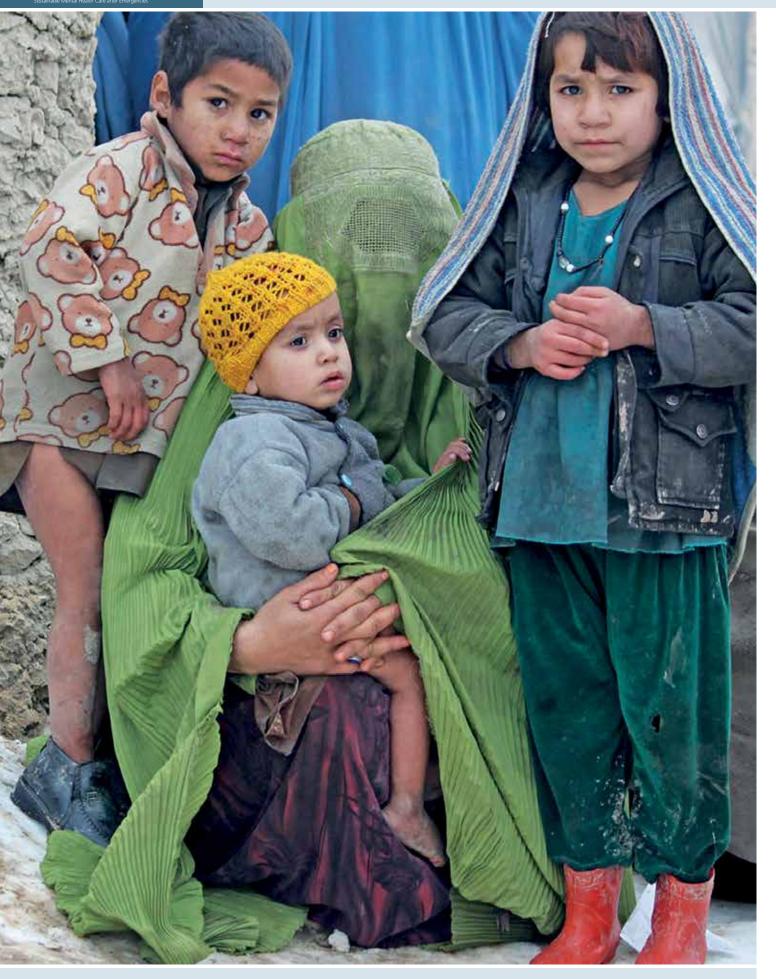
8. **Health workers were reorganized and trained.** Opportunities frequently arose post-emergency to reorganize, train, and provide ongoing supervision to health workers so that they were better equipped to manage mental health problems. The majority of investments were made in people and services, rather 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.

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.

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

"In my experiences working in areas ravaged by natural disasters and man-made catastrophes, I've found that emotional wounds can present obstacles just as daunting as the physical destruction. I'm grateful that in *Building back better* the World Health Organization is shedding new light on this important issue and explaining how creating sustainable mental health systems must be part of any long-term recovery in the aftermath of emergencies."

President Bill Clinton

"Mental health is an important aspect of crisis recovery as I have personally experienced in a number of countries I have served. Indeed, the long-term cost to individuals and to societies' development can even be greater than the immediate effects. This impressive publication rightly guides agencies to adopt a long-term approach to mental health care after crises."

Neil Buhne
Chair, IASC Global Cluster Working Group on Early Recovery Bureau
for Crisis Prevention and Recovery
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"Emergencies create critical opportunities to develop better health care systems for the long term. This book illustrates beautifully how colleagues in mental health – an important but thus far neglected area of health – have used the opportunity to 'build back better.' This publication goes beyond aspirational recommendations, providing proof of concept that it is sensible to invest in mental health systems after emergencies."

Paul Farmer
Founding Director, Partners In Health
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Emergencies, in spite of their tragic nature and adverse effects on mental health, are unparalleled opportunities to build better mental health systems for all people in need. This is important because mental health is crucial to the overall well-being, functioning, and resilience of individuals, societies, and countries recovering from emergencies.

Global progress on mental health reform will happen more quickly if, in every crisis, efforts are made to convert short-term interest in mental health into momentum for long-term improvement. *Building back better: sustainable mental health care after emergencies* shows how this was done in 10 diverse emergency-affected areas.

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

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