

Mental Health and Psychosocial Support in Humanitarian Settings: Role of Psychological First Aid (PFA)

Mark van Ommeren
Mental Health and Substance Abuse
MSD/WHO, Geneva
vanommerenm@who.int

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SCIENTOLOGY INTERNATIONAL VOLUNTEERS

Puzzle:

Please find the 5 controversies in this poster.



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Response: 5 controversies in poster

- Unrealistic to become effective helper in 1 day
- Focus on trauma relief only
- Overcoming sadness 2 weeks after tsunami is unrealistic
- Open to anybody
- . . .

What about psychological debriefing?

- Critical Incident Stress Debriefing formally involves
 - Group of co-workers who experienced potentially traumatic event
 - One-off group discussion in which each worker discusses their emotional and cognitive experience of the event.
 - Participation in group discussion is voluntarily but strongly encouraged within many organizational cultures
- Informally (in reality) debriefing typically involves
 - One-off interaction between helper and non-help-seeking emergency survivor
 - Promoting of ventilation by pressing the person to share in detail the facts, thoughts, impressions of the event and reactions to the event

Both is at best ineffective. Ask your organization to stop any debriefing programs. Yet, survivors do have pressure to talk and survivors should never be discouraged from talking – a listening ear should be available!

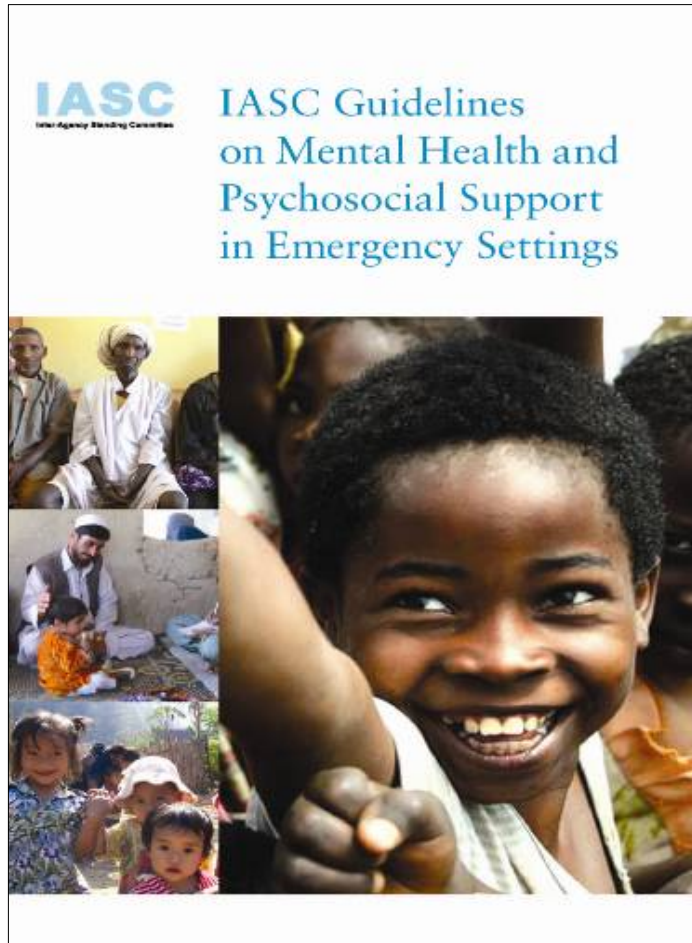
Make psychological first aid (PFA) available in the clinic & through other sectors

- Does not necessarily focus on events (i.e not debriefing)
- Not clinical
- Key elements
 - Protecting from harm
 - Listening
 - Assessing basic needs
 - Organizing company
- Promotes a dignified response
- Unlike debriefing, does not claim to prevent disorder
- Strong consensus for PFA
- No direct evidence for PFA
- Plenty of indirect evidence for PFA (eg Hobfoll review)
- Forthcoming: *WHO, WVI, WTF. Model Guide on PFA*
 - Currently under peer review
 - First peer reviews very positive
 - Do you want to peer review?

Diverse mental health and psychosocial needs in midst of emergencies: for which problems may PFA work?

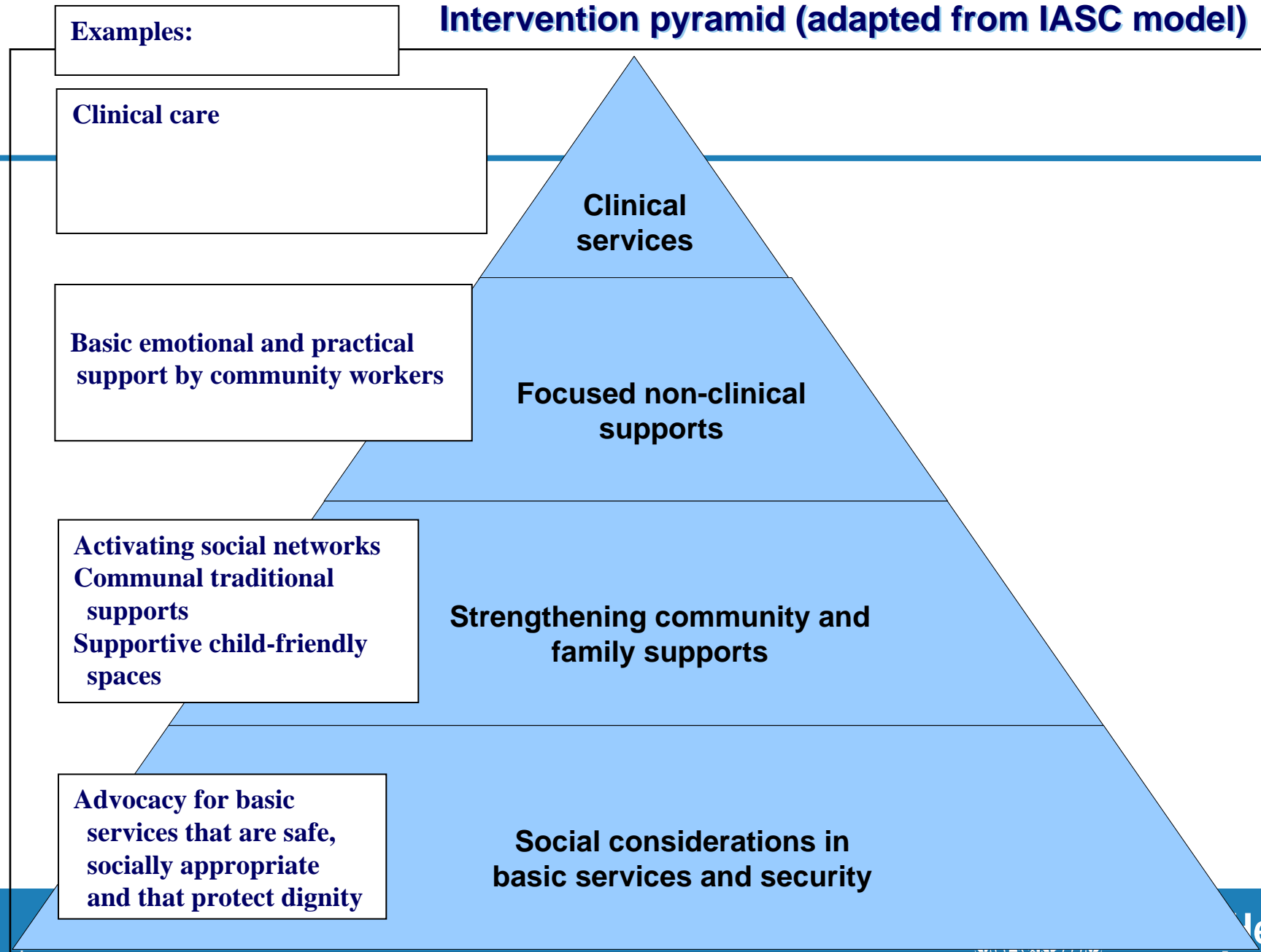
- pre-existing social problems?
- emergency-induced social problems ?
- pre-existing psychological/psychiatric problems ?
- emergency-induced psychological/psychiatric problems (related to past, present, future)
- humanitarian aid-induced psychosocial problems?

Launch of the IASC Guidelines at the United Nations in New York, 2007

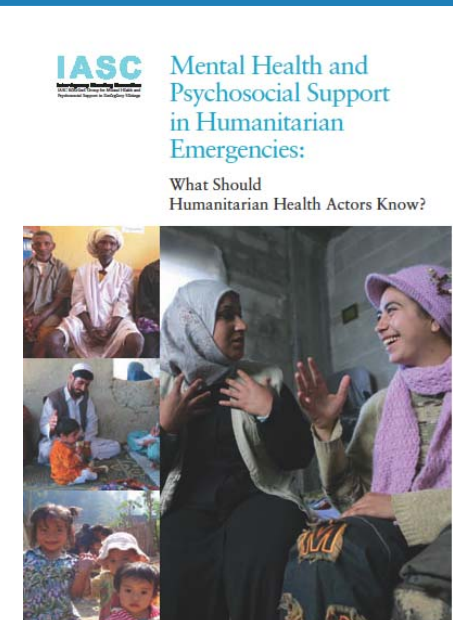
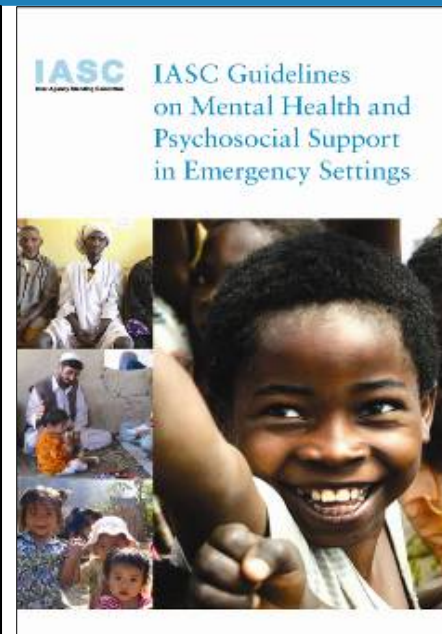
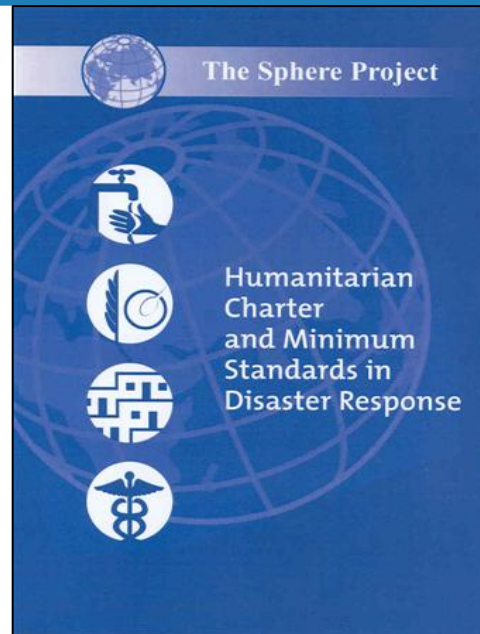
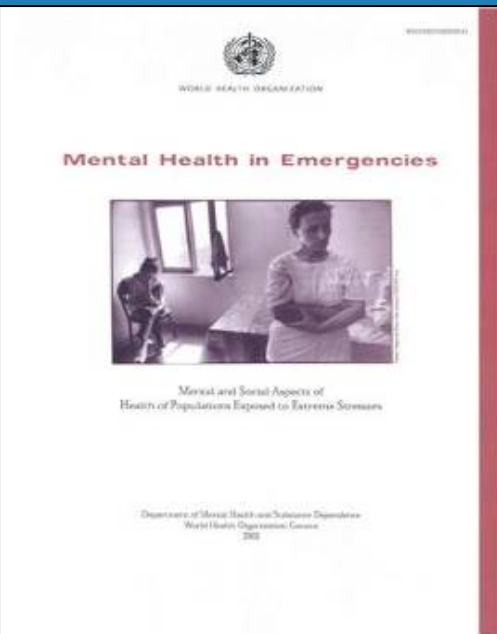


- a multi-sectoral, inter-agency framework
- that enables coordination,
- that identifies useful practices,
- that flags harmful practices
- that clarifies how different approaches to mental health and psychosocial support complement one another.

Intervention pyramid (adapted from IASC model)



Key global policies and resources on humanitarian aid: all recommend PFA



WHO (2003), Sphere (2004), IASC (2007, 2010)

What should health actors aim for at a minimum (draft Sphere 2010)?

1. Basic needs of people with mental disorders in institutions are addressed.
2. Individuals who have been receiving mental health treatment before the crisis continue to receive treatment, Harmful, sudden discontinuation of medications is avoided.
3. All facilities at different levels of the health system provide access to **psychological first aid** to people in acute distress after exposure to extreme stressors.
4. Psychological debriefing is not provided, and benzodiazepines are avoided.

What should health actors do? (*continued*)

5. There is access to basic mental health care for urgent mental complaints in the primary health care system. Staff should be skilled, and essential psychotropics are available at primary care facilities
6. Community health workers strengthen community self-help and social support
7. Plans are initiated to provide a more comprehensive range of interventions and to develop a sustainable community mental health system in the region.



Staff well-being

Key determinants of staff well-being

- Pre-existing mental health/well-being
- Work-related stressors (Supervision and management, security, work load/hours, accommodation, witnessing suffering etc)
- Adversity (eg trauma exposure) on the job
- Support after adversity

Care for staff after adversity

- Before: Enhance chance for resilient response (improve work and living environment, stress management)
- After: 100% of people: access to **psychological first aid** + useful self-care materials
 - Single session psychological debriefing is ineffective
- If not able to function or if suffering intolerable, immediate referral to mental health professional trained in managing of acute problem (few %)
- **100% systematic follow-up (1-3 months)**