

Translated from Spanish



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PAN AMERICAN HEALTH ORGANIZATION (PAHO/WHO)

PROGRAMME ON EMERGENCY PREPAREDNESS AND DISASTER RELIEF

MENTAL HEALTH PROGRAMME

**GUIDE TO DRAWING UP NATIONAL PLANS FOR MENTAL HEALTH DURING DISASTERS
AND EMERGENCIES IN THE COUNTRIES OF CENTRAL AMERICA**

October, 2003

I. INTRODUCTION

Over the last two decades, the importance of the psychological and social component of strategies to prevent, mitigate and deal with disasters has become increasingly apparent. In addition, there is no doubt that in recent years Central American Governments and societies have attached greater importance to the topic of mental health and the political will to give the topic priority has to some extent become apparent. Most of the countries in Central America are striving to reorient psychiatric services and to develop models focusing on primary health care and in which hospitals are no longer the cornerstone of specialized care.

Incorporation of the notion of risk management, viewed not only from the angle of threat, but also of vulnerability, has helped to enhance this community-based approach to mental health, in which preference is given to opportunities for working in groups. However, there is also no doubt that the topic of mental health during disasters has not yet received proper attention or scrutiny.

In April 2000, PAHO/WHO began the "Central American Project to Reduce Vulnerability to Disasters in Countries Affected by Hurricane Mitch", which has focused its efforts on three components: community organization during disasters, vulnerability reduction in health facilities and strengthening the capacity of the health sector to prevent, prepare for and mitigate disasters.

For several years, PAHO/WHO has also been working on its Emergency and Disaster Preparedness Programme in all the countries of the region and has successfully developed and enhanced the capacity of the sector to respond to disasters; it has directed its efforts to disaster prevention, preparedness and mitigation processes. In addition, community organization has been strengthened and the vulnerability of health facilities reduced.

This document is one of the actions of the Emergency and Disaster Preparedness Programme, which are being carried out in all the countries of Central America. Its fundamental aim is to offer the reference and methodological frame for drawing up mental health plans at the national level during disasters.

II BACKGROUND

Throughout history the countries of Central America have suffered a multitude of traumatic events such as natural disasters (hurricanes, earthquakes, volcanic eruptions, etc.) and domestic armed conflicts (such as those in Guatemala, Nicaragua and El Salvador) against a background of high levels of poverty and social inequity. As a result, the region has seen the development of numerous attempts to provide psychological and social support in a variety of situations; many are the lessons that have been learned.

Before this document was written, an evaluation was made of the current situation in this respect in the countries participating in the project "Reduction of Vulnerability to Disasters in Countries Affected by Hurricane Mitch". To this end, meetings for consultation were held in Guatemala, Nicaragua, El Salvador and Honduras. The main strengths and weaknesses identified, which were common to most countries, are summarized below.

Strengths or requirements for the Plan's implementation to be feasible:

- Availability of specialized professionals (psychiatrists and psychologists) with training in risk management. Health workers showed themselves to be motivated by and sensitive to the issues raised by disasters.

- There are educationalist with a background in mental health and disasters; universities also showed an interest in contributing to the training process.
- There are inter-institutional agreements bearing on training of human resources.
- In most countries, mental health resources and services have in one way or another been decentralized to the local level. A number of PHC mental health units have been set up in general hospitals.
- Earlier diagnoses have been carried out and have identified needs in the fields of prevention and of psychosocial care.
- Support is available from international organizations for specific actions.
- Institutional structures responsible for disaster prevention and response have been strengthened in recent years.
- The mental health programmes of ministries of health are acquainted with the topic and are willing to incorporate disasters and emergencies into their work.
- Various agencies which have disaster response plans are able to incorporate the topic of mental health.
- Community organization has gained in strength. Existing local structures may serve to increase awareness of the topic.
- Documentation of experience in providing mental health care during disasters is available. Health personnel have started to draw on the lessons learned in the wake of hurricane Mitch.
- Some countries (such as Guatemala) possess a background in and experience of work in the field of community mental health, particularly with populations who were affected by the armed conflict.
- In most countries in the region legislation concerning intervention in the field of risk management is in force.
- Continuity of the project "Reduction of vulnerability to Disasters" sponsored by PAHO/WHO in countries affected by hurricane Mitch has been assured, despite the changes of Government which have occurred.

Weaknesses or critical variables:

- Questions relating to mental health during disasters have not yet been given due priority in most countries. Mechanism to provide evaluation and follow-up in the different spheres of action are limited.
- There is a lack of common strategies and complementarity among institutions to facilitate decision-taking and action. Such coordination mechanism as exist among public and private institutions and universities, as well as among those providing health services, NGOS and other agencies involved in mental health care are unsatisfactory.
- The actions for which each level is responsible have not been properly determined (regional, national and local).
- Strategies and plans to provide the population and institutions' staff with training on how to prevent and mitigate the psychosocial consequences of disasters are either non-existent or weak.
- Mental health has not effectively been incorporated on a regular basis into the disaster programmes of health-sector institutions.
- The legislation and norms applicable in each country to disasters have not been adequately publicized.
- The population is poorly informed about psychosocial issues.

III. THEORETICAL FRAME OF REFERENCE

Until 1985 (when the Mexican earthquake and the Armero disaster occurred), little importance was attached to questions of mental health during disasters. Studies to evaluate psychiatric morbidity during disasters were conducted in Mexico and Armero, and at the same time strategies were put in place for the management of mental health problems by primary health care workers (PHW). The importance of group work was also recognized, together with the value of the community as a sphere for action.

As an example, we present below research sponsored by PAHO in Honduras; it analyses prevalence of psychiatric disorders in the immediate aftermath of Hurricane Mitch.

***Psychosocial phenomena in the immediate aftermath of hurricane Mitch. Findings of research involving the adult population in Tegucigalpa, Honduras.
(Pan American Health Organization / 1998-1999)***

A total of 19.5% of the population suffered from a severe depressive episode. The proportion was 24.2% in areas highly exposed and 14.2% in districts that were less exposed.

Post-traumatic stress disorder (PTS) affected 10.6% of the population; 7.9% among those less exposed and 13.4% among those highly exposed. However, the proportion of PTS symptoms related to the hurricane was much higher (23.0%) if the criteria of duration and disability were excluded. The proportion of co-morbidity (PTS and severe depressive episode) was 6.9%; 8.9% among the highly exposed group and 4.9% among those less exposed.

The number of alcohol-related problems rose significantly among the highly-exposed low-income group living in shelters.

Risk factors: High exposure, female, low-income group, divorced, separated or widowed, low level of education and "previous history of nervous problems" were significant risk factors for morbidity.

Care seeking patterns: 26.5% of the sample sought care from health services in the wake of hurricane Mitch. 8.9% said that they had consulted someone or sought care because of "nervous problems". More women than men attended health services and they sought assistance more frequently on account of "nervous problems".

Exposure to violence: Approximately one third of the sample was exposed to violence in the aftermath of the hurricane, and 6.2% said that they had been personally assaulted. A total of 7% of interviewees admitted to committing acts of violence. The poorest were the most affected.

It is now recognized and accepted that natural disasters and emergencies not only cause death physical illness and economic loss but also seriously affect people's mental health. Consequently, in countries that are seriously affected, constant monitoring is required to determine the impact over the medium and long terms.

Previously, the response to crises was viewed from the biomedical angle, with an emphasis on identifying symptoms, drug treatment and admission to hospital. However, as the health-care paradigm in response to disasters has evolved, a more comprehensive and community-based approach to psychosocial problems has been adopted.

At the same time, and in particular during the 1990s, understanding of and the approach to mental health in Latin America underwent an evolution. The Caracas Declaration (1991) and subsequent resolutions of the Directing Council of PAHO (1997 and 2001) have emphasized the development of community-based and decentralized mental health services. As a consequence, psychiatric hospitals are no longer the cornerstone of mental health care.

Thanks to the restructuring or reorientation of psychiatric services, in conjunction with the inclusion of psychosocial care into primary health care (PHC), it has been possible to change methods of work in many countries in the region; as a result, in the face of disasters or other emergencies they are better able to take up the challenges laid down.

The table below gives a summary of the main trends in Latin America in the mental health and emergency fields:

Mental Health	Emergencies
<ul style="list-style-type: none"> • Development of national mental health programmes. • Inclusion of psychosocial aspects into PHC. • Decentralization of psychiatric services. • Shift from psychiatric hospitals as the cornerstone of mental health care. • Evolution from a medicine-based care model focusing on disorders to a comprehensive community-based approach. 	<ul style="list-style-type: none"> • Risk-management-based approach, i.e. one based on prevention intended to eliminate or mitigate the possibility of injury. • Development of organizational plans and structures within the health sector to cope with disasters. • Efficient health care which is also compatible with the needs of the population. <p>Recognition for the mental-health component as part of the response to emergencies.</p>

Three main groups of psychosocial problems stand out in emergencies:

- Fear and distress.
- Psychological disorders or psychiatric illnesses.
- Social disorder, violence and consumption of addictive substances.

This finding holds three messages:

- It is not sufficient to consider psychological disorders alone; the whole range of social problems also calls for attention.
- The area of competence of mental health professionals needs to be broadened.
- Psychosocial problem can and must be dealt with - to a considerable extent - by non-specialized staff.

IV. RECOMMENDATIONS FOR DRAWING UP NATIONAL PLANS FOR MENTAL HEALTH DURING DISASTERS

Contrary to what is widely believed, plans for mental health during disasters need to be quite simple, practical and low-cost; they fundamentally depend on human resources.

Before drawing up a plan it is desirable:

- a. To review the country's existing norms and legislation;
- b. To review national disaster-prevention and response plans in the ministries of health and the main institutions in the sector;
- c. To review national mental health plans;

- d. To compile existing documentation on the topic;
- e. To interview key actors at the national and local levels;
- f. To set up a multi-sector working group to draw up the plan;

Inter alia, the following actors need to be taken into consideration:

- The governmental agency responsible for coordinating the disaster and emergency response (whose designation differs depending on the country).
- The Ministry of Public Health, as the governing body of the health sector.
- Other government agencies (education, culture, sport, public works, labour and other State economic actors).
- Mayors' offices and city authorities.
- The armed forces.
- The police force and other public security agencies.
- Civil defence.
- The fire service.
- Universities.
- Professional associations or councils.
- Churches.
- The Red Cross.
- Nongovernmental organizations (national and foreign).
- Private enterprise.
- The media.
- International organisms or agencies.
- The community and community leaders.

Structure of the Plan

Recommended structural elements for designing national plans:

- Introduction to and analysis of the mental health situation and of natural or man-made risks in the country.
- Purpose.
- General objective.
- Specific objectives.
- Strategies
- Expected outcome or products, which determine the spheres of action.
- Activities required to attain the different results, depending on the different stages in the disaster.
- Identification of those responsible for each activity.
- Indicators and means of verification.
- Working hypotheses.
- Periodic evaluation and supervision.
- Establishment, in so far as possible, of a budget, and of an operating schedule.
- Recognition of the need to develop supplementary material, such as organizational and procedural manuals, educational and training documents, etc.

Purpose:

To reduce the risk of and mitigate the psychological and social repercussions of disaster situations among the population.

General objective:

To introduce and develop the mental health component in health care during emergencies, so as to offer an appropriate response to the psychological and social needs of the population by preventing and mitigating the impact of disasters.

We have defined the specific objectives in accordance with the major psychosocial problems defined above:

- To eliminate or reduce the risk of suffering psychosocial injury.
- To avert and/or reduce distress among the populations.
- To help to prevent and control the range of social problems arising among the population, and especially among those most affected, those living in hostels and displaced persons.
- To diminish, treat and rehabilitate the mental disorders occurring as a direct or indirect consequence of the disaster or emergency.
- To provide support and psychosocial care for the members of the response teams.

Strategies:

1. Consistency of the Emergency Programme with the National Health System and the mental health services network.
2. Interdisciplinary and multi-sector approach to foster coordinated involvement of governmental and nongovernmental organizations.
3. A comprehensive approach to health, focusing on Primary Health Care and including promotion of mental health and ad-hoc preventive measures.
4. An approach based on vulnerability and risk.
5. A human-rights based approach.
6. An approach based on ethnic, linguistic, cultural and religious considerations.
7. An approach based on gender equity.
8. A child-child and child-adult strategy.
9. Reliance on group activities, games, sports and other physical activities, as fundamental tools for the rehabilitation and full development of children and adolescents.
10. Development of human resources.
11. Flexibility and adjustment to local circumstances.
12. Development of monitoring and evaluation skills.

Log frame matrix showing expected outcomes:

Objectives	Indicators	Means of verification	Assumptions
<p>Aim: To help to improve the mental health of populations affected by natural disasters and other emergencies.</p>			
<p>PURPOSE: To reduce the risk of and mitigate the psychosocial impact on the population of disaster situations.</p>	<p>A functioning National Operational Plan for Mental Health Care during Natural Disasters and Other Emergencies.</p>	<p>Documents relating to the plan and progress reports.</p> <p>Budget and resources allocated to the operational plan.</p>	<p>Political will on the part of the authorities to address the issue.</p> <p>Commitment to the process and availability of the planned resources at the time specified.</p>
Objectives	Indicators	Means of verification	Assumptions
<p>R. 1. Capacity rapidly to conduct a preliminary mental health diagnosis during an emergency.</p> <p>R. 2. Availability of mental health care for survivors, with a suitable and effective model for intervention during crises (by non-specialized staff / direct specialized clinical care for persons with more complex mental disorders / priority for care for risk groups).</p> <p>R. 3. Members of the response teams, PHC staff and community health workers trained on psychosocial issues.</p> <p>R. 4. Implementation of health promotion and education activities, with a focus on groups of children and adolescents and in schools. Participation of community organizations in educational activities.</p>	<p>Mental health situation analysis (MHSA) available, together with an analysis of the services on hand. Determination of the actors involved.</p> <p>Operational case-management plan, including defined referral and counter-referral mechanisms. Number of services operating. Number of cases of mental disorders treated and analysis of other indicators.</p> <p>Training plans available. Number of staff trained and % thereof per category.</p> <p>Youth groups operating. Number of children taking part in group activities at school. Participants in educational awareness-raising activities involving community groups.</p> <p>Social communication plan for</p>	<p>Documentation relating to MHSA</p> <p>Documents relating to the Plan. Statistical reports.</p> <p>Documentation relating to the training plans and their implementation. Reports on the training sessions.</p> <p>Reports on activities involving schoolchildren and youth. Reports on activities involving community organizations.</p>	<p>Commitment at the political and technical level to undertake the work and ensure its sustainability.</p> <p>Expert advice in specific areas.</p> <p>Staff in the health services and other institutions contribute to the satisfactory implementation of the Plan.</p>

R. 5. The health sector advises and supports social communication activities.	the health-sector developed with the assistance of the mental health team.	Documentation relating to the social communication plan for the health sector and reports on its implementation.	
R. 6. Inter-agency coordinating board or group operating at the different levels to implement the mental health plan.	Operational tasks to be undertaken by the inter-agency group under way.	Reports and documentation on the formation of the group and its periodic meetings	
	Inter-agency agreements		

Suggested activities, by expected outcomes:

General and organizational activities:

- Incorporation of emergencies as a specific component of the National Mental Health Plan.
- Incorporation of the mental health component into the National Plan for the Management of Health risks.
- National plan to provide local health agencies with adequate guidelines to enable them to formulate their own plans.
- Development, with PAHO's assistance, of rapid and feasible mechanisms for mutual assistance and cooperation between countries in Central America and the Spanish-speaking Caribbean.

R. 1. Capacity rapidly to conduct a preliminary mental health diagnosis during an emergency.

Territories and /or countries must have a Mental Health Situation Analysis (MHSA); this will provide a basis for more efficient performance of the rapid diagnosis required in the immediate aftermath of the disaster.

General, social and demographic assessment of the community:

- General description of the territory (size, main towns or villages, routes of communication, economy, levels of poverty, etc.)
- Description of the population.
- Description of the main social and cultural characteristics of the population.
- Identification of organizations and networks providing support.

Identify the needs of and problems faced by the population affected and /or at risk:

- Physical and food needs.
- Main threats.
- Areas in which they are vulnerable.
- Social conflicts.

Evaluation of the health system:

- Health-sector institutions and resources. Levels of coverage and accessibility of services.
- Updating the inventory of specialized resources capable of immediate and timely mobilization.
- Identification of existing contingency plans and / or plans under preparation.

Determination of priorities and target groups for immediate action.

A tool or guide for rapid diagnosis of disasters or emergencies must be developed at the country and subregional levels.

R. 2. Availability of mental health care for survivors, with a suitable and effective model for intervention during crises (by non-specialized staff / direct specialized clinical care for persons with more complex mental disorders / priority for care for risk groups)

The first task is to make an inventory of specialized human resources, of the coverage they provide and of the existing support network. The mental health resources available for mobilization during disasters and emergencies should be evaluated together with the distribution of specialized and / or trained staff.

Psychosocial care (for individuals and groups by non-specialized staff (primary-health-care workers, community health promoters, schoolteachers, first-aiders, voluntary and humanitarian assistance staff) is a cornerstone of this activity:

- Organization, support and supervision of the work of non-specialized staff.
- Implementation of on-site emergency training plans alongside interventions.

Provision of direct specialized clinical care for persons with more complex mental disorders, implying the organization of services at the following levels:

- Psychiatric hospital or psychiatric department of a general hospital.
- Primary health care mental health services.
- Mobile teams or teams temporarily assigned to selected sites.
- Other mental health units or services in different institutions (governmental and nongovernmental organizations)
- Definition or updating of mechanisms for referral and counter-referral of cases.

Priority for care of highly vulnerable risk groups:

- Identification of specific highly vulnerable groups
- Care for deeply affected groups
- Care for women and the elderly
- Care for children and adolescents.
- Care for displaced persons, especially those living in shelters or refugees. Consideration should also be given to persons living in community centres or with friends and relatives.
- Care for initial response teams.

Design and implementation of a plan for psychosocial and self care for members of the initial response teams.

R. 3. Members of the response teams, PHC staff and community health workers trained on psychosocial issues.

- Availability of support- and teaching tools and books
- Distribution of publications on mental health.
- Refreshing the skills of and training health personnel, community leaders and workers while circumstances are normal. The most important target groups for training are:
 - a. Primary health-care workers.
 - b. Staff responsible for the management of shelters and refuges.
 - c. Volunteers, first-aiders and humanitarian assistance staff.
 - d. Teachers.
 - e. Community leaders and health promoters.
- Continuity and follow-up of the training process.

R. 4. Implementation of health promotion and education activities, with a focus on groups of children and adolescents and in schools. Participation of community organizations in educational activities.

Ensure easily understandable educational material is available, graded by age group and level of vulnerability.

Group awareness-raising educational activities during emergencies, involving:

- Groups and families deeply affected by the disaster
- Evacuees and shelter dwellers.
- Children and adolescents.
- Women's groups.
- Members of initial response teams.
- Other organized community groups.

Actions in support of community organization, social participation and self-help.

- Identifying community organizations and leaders.
- Encouraging and organizing the population to help themselves and each other.
- Encouraging the population to take part in planning and implementing actions during emergencies.

R. 5. The health sector advises and supports social communication activities

- Advising the authorities on how to set up a coherent and efficient social communication system.
- Informing key political players.
- Informing and motivating direct service providers about psychosocial issues.
- Helping to design messages directed at different population groups.
- Dispelling and managing rumours.
- Evaluating the response by the population in order responsively to organize (appropriate) immediate social communication activities.
- Organization, during times of risk, of campaigns in the community (e.g. during the rainy season or hurricanes, etc.).

R. 6. Inter-agency coordinating mechanism operating at the different levels to implement the mental health plan.

- Identifying and strengthening organizations and institutions acting both directly and indirectly in the mental health field.
- Enhancing the Ministry of Health's stewardship in this field.
- Joint activities by the National Mental Health Programme and institutions responsible for disaster management.
- Definition and enhancement of cooperation mechanisms and establishment of networks and different levels.
- Commitment by organizations to implementing and following up plans.
- Periodic assessment meetings for different national players.
- Exchange and systematization of experience.

Other recommendations:

Circumscribing actions, within the plan, in terms of the time or phase of the emergency:

- Preparation.
- Critical phase, or emergency proper
- Post-crisis period
- Psychosocial recovery, linked to regular plans

Organization and structure of the Plan: It must be consistent with the health sector's mental health plan and with the National Emergency Programme. It is also necessary to determine actions to ensure continuity and sustainability.

Clear follow-up and supervisory mechanisms:

- Set up an information system to evaluate the ongoing process.
- Minimum indicators for evaluation.
- Periodic meetings of players to ensure coordination and provide information on progress.

V. SCHEDULE OF WORK

The proposed schedule for advancing with or strengthening national plans for mental health during disasters is as follows:

1. Revision, at the country level, of the document setting out methodology and identification of the key players and counterparts who will work on the design or reformulation of plans: First quarter / 2004.
2. Activities at the national level, beginning with a workshop in February 2004.
3. Subregional workshop to enable countries to exchange their experience:
4. Presentation of the framework plan for Central America and the Spanish-speaking Caribbean:

VI. FINAL REMARKS

Challenges:

- There are not enough mental health specialists in our countries to provide care for all those affected by disasters. However, on the other hand it is neither necessary nor desirable to rely solely on professional or specialized medical staff to provide all mental health care.
- Technology transfer is of huge strategic importance.
- In many instances, the structure of mental health services does not match the needs that arise during emergencies.
- Under normal circumstances and before disasters strike, the mental health care model should be reinforced on a community basis.
- A change in focus and in the boundaries of the skills of mental health professionals
- Fostering a focus on risk with community participation.
- Putting mental health on the agenda of the health sector during emergencies.
- Influencing collective behaviour and establishing a clear relationship between human rights and mental health.
- Commitment to provide support to those affected.

The psychosocial impact of a disaster is the outcome of several factors which need to be dealt with appropriately; they include the nature of the event, the extent to which an individual is affected and the

nature of the losses. It will also be necessary to ensure continual monitoring to determine the medium- and long term repercussions.

Facing up to a disaster or an emergency is not solely a problem for the health sector; it also involves other players, including government agencies, NGOs, local authorities and the community itself. In most cases, the institutional response relies on individual psychiatric care and reaches only a small number of those affected; there is a need for a paradigm change in this respect so as to provide genuine and comprehensive health care during emergencies.

The immediate general measures which help to establish a climate of order and calm include:

- An appropriate and orderly response by the authorities.
- True and timely information.
- Encouragement for inter-agency cooperation and community participation.
- Ensuring basic health services and mental health care for survivors. Making provision for an increase in the number of persons presenting grief-related or psychiatric disorders and for their proper care.
- Giving priority to the most vulnerable groups and taking into consideration differences of sex and age.
- Ensuring careful and ethical handling of corpses by the response teams, the authorities, law-enforcement and other personnel and providing an orderly and personalized means of notifying deaths and disappearances.
- Avoiding burial in common graves. Encourage proper identification and registration of corpses and their handing over to families.

Traumatic experience and grief need to express themselves in different ways depending on each culture. Performance of the last rites for loved ones is an important means of accepting and coming to terms with what has happened.

Where armed conflicts are concerned, the need for medium-and long-term measures to rebuild the social fabric should be emphasized:

- Compensation (material and financial).
- Humanitarian assistance and respect for the human rights of survivors.
- Encouraging respect for international humanitarian law.
- Restoring the collective memory and ensuring the dignity of victims.
- Exhumation may help to set the record straight and help families and communities with grieving.
- An active role by the different players (Government and civil society).
- Encouraging peaceful coexistence.
- Communication and family reunion.
- Social and political changes as a contribution to general well-being, building peace and democracy.

Throughout their history, many Latin American countries have been beset by traumatic events such as armed conflicts and natural disasters, against a background of deep social and economic adversity. There has been enormous loss of life and property; this make it imperative to address the problems of psychosocial rehabilitation of the populations concerned, as a matter of State policy within the framework of comprehensive health care.

ANNEX 1

GENERAL REMARKS REGARDING INDICATORS

This is a topic of considerable interest. Follow-up and evaluation of a plan largely depends on the use of reliable indicators and the determination of a baseline which makes it possible to monitor progress.

A valuable foundation on which to develop indicators for mental health during emergencies would be a reliable prior system (during normal times) of surveillance and data collection. Unfortunately, it is common for health systems to have no satisfactory mental health information systems, making it harder to set them up or strengthen them during emergencies.

In view of the circumstances of the emergency and the situation in which care is provided, most indicators will essentially relate to structure and processes. It will be possible to evaluate impact indicators over the medium and long terms and these are occasionally obtained by ad hoc research or specially designed studies.

The sources of basic information are primary health care (PHC), which is the cornerstone for the provision of health care, and the community, in which many of the actions are carried out directly. Data available from hospitals is of little value and fundamentally measures the increase in the caseload during emergencies and morbidity on account of the demand satisfied by hospitals, but does not genuinely reflect the true scale of the psychosocial problems besetting the affected population.

A large part of the information available during emergencies is qualitative, and is obtained by means of rapid interviews with key informants or community meetings. The information concerns not only current morbidity, but also the whole range of psychosocial problems affecting people at such times and which affect their very survival.

A list of the possible indicators for evaluation, in accordance with the type of action required, is given below:

Indicator	Method of collection
<p>General information and information on the structure of services:</p> <p>Estimated population, by sex and age group</p> <p>Population estimated to be directly affected</p> <p>Displaced persons (in shelters, hostels and other premises such as homes), their origin and destination. Number registered by the State and total estimated by other sources.</p> <p>Number and location of PHC resources and staff on the territory</p> <p>Number and location of PHC mental health services on the territory affected</p> <p>Population per PHC mental health service</p> <p>Psychiatric hospitals or services on the territory</p> <p>Available specialized human resources and their breakdown:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Psychiatrists <input type="checkbox"/> General practitioners with mental health training <input type="checkbox"/> Psychologists <input type="checkbox"/> Nurses with mental health experience <input type="checkbox"/> Occupational therapists 	<p>Preliminary and ongoing community psychosocial diagnosis to monitor changes in certain indicators.</p>

<ul style="list-style-type: none"> <input type="checkbox"/> Social workers with experience of mental health <input type="checkbox"/> Psychology students <input type="checkbox"/> Medical students <input type="checkbox"/> Trainee social workers <p>Number and make-up of the mobile teams formed by specialized staff or staff with training in mental health</p> <p>Institutions or organizations from which mental health services and resources are available</p> <p>Population affected for whom mental health services are available (%) and those without coverage</p>	
<p>Qualitative appreciation of existing psychosocial problems:</p> <p>Identification by the community, by means of qualitative procedures, of the main psychosocial problems that exist:</p> <ul style="list-style-type: none"> • Emotional distress and reactions • Mental disorders • Situations of violence • Excessive consumption of alcohol or other psychoactive substances • Others <p>Main reasons why people are distressed</p> <p>Risk factors and social groups most vulnerable to psychosocial problems.</p> <p>Evaluation of the information being received by the population at the different levels: mass media and information for groups and individuals. Information on unconfirmed rumours and gossip etc. should be included.</p> <p>Perception of the level of organization, quality and effectiveness of services by users and providers.</p>	<p>Psychosocial diagnosis</p> <p>Use of qualitative techniques (interviews with key informants and focus-group meetings)</p>

<p>Process: Cases treated by PHC. Cases with psychosocial disorders treated by non-specialized PHC staff and number referred to a psychologist or psychiatrist Cases treated by specialized staff</p> <ul style="list-style-type: none"> • Broken down by sex and age • Broken down by place of care provision (hospital, PHC centre, school or community premises). • Broken down by provider: psychiatrist, psychologist, paramedic or technician, medical or psychology student, etc. <p>Group therapy: number of sessions and cases treated. Index of number of consultations for mental disorders per population (x 10,000 inhabitants) Morbidity records using ICD-10. Meetings in the community of groups of victims who have received assistance from the health services: number of sessions and of participants Group meetings of child and adolescent victims who have received assistance from the health services: number of sessions and of participants Health education activities covering mental health issues: number of sessions and participants. Care for members of the response teams: cases dealt with, group therapy, etc. Training:</p> <ul style="list-style-type: none"> • Training sessions • Number of participants, by category of staff or groups having received training • Extent of coverage in mental health training: % of specialized staff, PHC workers, teachers and members of the response teams trained. 	<p>Ongoing records</p>
<p>Prevalence of mental disorders and psychosocial problems among selected samples of the population affected, and identification of those persons requiring medical care from the PHC network</p>	<p>Application of screening and diagnosis tools. Clinical interview with possible cases</p>

Remarks with regard to impact indicators

A reliable information system on the situation prior to the emergency or research allowing a baseline to be determined is valuable; this serves as a yardstick for determining the changes that may be ascribed to the actions carried out.

- Changes in the indicators of incidence and prevalence of specific disorders (depression, suicide, alcoholism, etc.). It is only possible to measure this as an impact indicator if a reliable baseline has previously been determined, otherwise, as is often the case, morbidity appears to have increased because access to services has improved or recording systems have been enhanced.
- Evaluation of the changes in the knowledge, attitudes and practices of those trained (health workers and others).
- Evaluation of changes in the knowledge, attitudes and practices of the community.
- Changes in how the population views the organization and efficiency of the health services.
- Indicators from schools (pupils repeating a year or going up a year)
- Improvement of the population's quality of life and other indirect indicators (quality of life, socioeconomic, etc.).

Some indicators of impact could be obtained from regular registers (provided they are properly kept, detailed and cover a long enough period); however, in most cases, they will be obtained from ad hoc studies or sentinel sites.

Indicators of sustainability:

Several questions are suggested, the answers to which might offer satisfactory indicators with which to measure the sustainability of the actions carried out:

- How many of the services and processes instituted during the emergency plan are sustainable? Which is it impossible to maintain, despite their being useful and necessary?
- Have PHC and mental health services been enhanced at the local level and have their levels of coverage increased? Will it be possible to maintain these improvements?