

Primary mental health care for disaster victims in developing countries*

Bruno R. Lima

Department of Psychiatry and Behavioral Sciences
Johns Hopkins University
Baltimore
MD 21205, U.S.A.

INTRODUCTION

Disasters, known to have significant mental health consequences (Kingston and Rosser, 1974), are frequent occurrences in developing countries (Kroeger, 1976), with heavy human casualties and property losses. On the other hand, primary care, the main strategy for attaining WHO's programmatic goal of "health for all by the year 2000," incorporates mental health as one of its essential components. In routine clinical practice, it has been fully recognized that mental health services in developing countries have to be provided at this level of care, as sixteen per cent of adult primary care attenders have emotional disorders (Climent *et al.*, 1980), and specialized mental health resources are blatantly insufficient to meet their mental health needs (Harding, 1978). A recent WHO collaborative study in seven developing countries has shown that primary care workers can be trained to carry out effective mental health interventions (WHO, 1984), highlighting the adequacy and the potential of their role.

Therefore in situations where the frequency of mental disorders is likely to increase — such as in disasters — the primary care worker will naturally bear the greater responsibility for identifying, managing and referring patients who present mental health problems. Nonetheless, no attention has been paid to the role of primary care workers in delivering mental health to disaster victims in developing nations, an area that needs to be the focus of greater research and training efforts. The volcanic eruption of November 1985 which destroyed the small town of Armero, in Colombia, has provided an opportunity for exploring these issues. The observations summarized in this

report were made when the author went to the area eleven days after the disaster, as a consultant for the Pan American Health Organization to the Division of Mental Health of the Colombian Ministry of Health.

THE CASE OF ARMERO

Armero, with a population of approximately 30,000, had a 160-bed general hospital and a psychiatric hospital. Both hospitals were lost in the tragedy that killed over 22,000 people and left 10,000 homeless, about half being injured. The psychiatric hospital had 5,000 yearly outpatient visits and ninety beds, representing eighty-seven per cent of the state's psychiatric beds. Over the past ten years, it had been upgraded from a custodial institution that operated with an occupancy rate of 205% into an efficient hospital with an average length of stay of twenty-six days. The current psychiatric facility is a twenty-bed unit in a general hospital located fifty miles away.

This disaster of November 1985 highlights the mental health role of the primary care workers for a variety of reasons:

- i. the survivors, mostly farm workers with a small repertoire of skills for alternative gainful employment, represent the usual attenders of primary care services;
- ii. a major regional psychiatric resource has been lost, and many of its professional staff died in the tragedy;
- iii. there are many people in temporary camps, in very poor living conditions, whose health needs are varied and complex, still preoccupied with immediate basic problems, but lacking clear longer-term plans;
- v. the threat of new eruptions or earthquakes continues, adding to the post-traumatic stress and rendering the survivors and the general population extremely anxious.

Even three weeks after the tragedy, primary care workers already reported a higher frequency of anxiety and depression among their patients, as well as of physical complaints of probable psychophysiological origin, such as headaches and backaches. In a follow-up consultation six months later, it was noted that the need for mental health care had increased with new problems such as severe depression, chronic anxiety, alcohol and drug-abuse, violence, marital problems and maladaptive behavior. These problems have clearly outstripped the already limited specialized mental health resources, transferring to the general health sector, and particularly to the primary health worker, the responsibility for meeting them. Patients are seen in the two health centers located in nearby towns that are staffed by a general doctor and auxiliary staff, with a weekly psychiatric consultation.

The mental health training of primary care workers in developing countries has included the management of conditions seen in routine clinical practice, such as first-aid in neuropsychiatric emergencies; maintenance treatment of the chronically mentally ill; advice and support to high-risk

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families; referral of mentally ill people in a nonacute or unclear state to the nearest health facility; family education about psychosocial development and the needs of the elderly and handicapped; support and education of the mentally ill about self-care; and collaboration of community leaders in activities aimed at protecting and promoting mental health (Harding *et al.*, 1980). Attention needs to be paid now to the special mental health needs of disaster victims and to the structural and procedural adjustments required from the primary care worker to meet them. Important areas in disaster education and training include: knowledge of disaster behavior (e.g. crisis/stress, loss and mourning, coping and adaptation); skills in the use of different treatment modalities (crisis counselling, group therapy, short-term focused therapy, psychopharmacology); understanding of the disaster aid system (e.g. shelter, medical care, home repairs, financial assistance) and ability to utilize available family and community resources (Cohen and Ahearn, 1980).

In order to adjust service delivery to meet the disaster victims' biopsychosocial needs, a variety of activities must be developed in the areas of training, education, research and planning in primary mental health care. Training and educational activities should concentrate on the development of the necessary methodologies adapted to a disaster situation and to the specific contents that need to be learned. For example, training should include the use of manuals and focus on the recognition and treatment of frequent psychiatric problems seen in disasters, such as depression and anxiety. Research should ascertain the frequency of psychiatric problems seen in primary care clinics located in the disaster area, and the primary care workers' deficiencies in identifying and managing patients with emotional problems and in referring them to the specialized mental health sector. The data generated will highlight the specific areas at which training programs should be targeted.

A collaborative research project is being carried out in the disaster area by the Johns Hopkins University, the University Javeriana in Bogota and the Division of Mental Health of the Colombia Ministry of Health to address these specific questions. From a planning viewpoint, the role of the specialized mental health sector in the comprehensive care of disaster victims should be of training, education and consultation to the primary care workers, rather than direct

service delivery. Ideally, a small national or regional mental health team specialized in disasters should develop the capability for training the mental health team local to the disaster area to provide basic training and continuing support to the front line primary care workers, who will in turn provide direct mental health care to victims, families and communities. The local mental health team will remain available for evaluation and/or treatment of referred patients with psychiatric problems that are too complex to be handled at the primary care level, but actual mental health care will be delivered to the disaster victims by the primary care workers.

It is expected that the lessons to be learned from the Armero tragedy will enhance the primary care worker's role in delivering mental health care in developing countries, and will permit a faster flexible and comprehensive response of the health system to the multiplicity of biopsychosocial problems disaster victims present.

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