WHO Recommendations for Mental Health in Aceh

Contents

I. Background

Persons affected by a catastrophic event like the tsunami of 26 December 2004 are exposed to extreme stressors, immediately and over a period of years, and are vulnerable to the development of serious mental health problems and mental disorders. Psychosocial and mental health concerns should complement humanitarian work starting in the first days and weeks of the relief, but should continue and be translated into substantial interventions through the phase of rehabilitation.

The magnitude of the disaster is indicated by the following figures from BAKORNAS[1] (24 January 2005). Deaths: 170,000; Missing: 30,000; Injured: 8,500; IDPs: 394,285 in 10 districts of Aceh. Many of the displaced are currently in approximately 180 temporary settlements. Many IDPs are staying in the homes of relatives and friends in Aceh.

The population of Aceh is approximately 4 million. Banda Aceh, the capital city, has a population of 230,000. The population along the severely affected western coast of Aceh was approximately 450,000. Virtually all of those living in Banda Aceh and the western coast have died or been displaced.

The government's plans for housing of displaced persons include the construction of 24 semi-permanent 'barracks', each of which will house approximately 4,000 – 5,000 people. It is intended that there will be health services, a school and other social services attached to each camp.

Of approximately 150 *puskesmas* in Aceh 78 have been severely damaged and are not functional. In the remaining unaffected *puskesmas* a proportion of professional health staff are unavailable for active duty.

In general, public hospitals in Aceh still function although they face limitations. RS Zainul Abidin in Banda Aceh is the hospital most badly affected by the tsunami, there is a plan to speed up its recovery to 100 beds.

Mental Health

It is difficult at this stage to give precise figures concerning the psychosocial needs of the population. However, it is evident that all the population has been affected, directly or indirectly, by the disaster. Many children have lost one or both parents. Many tens of thousands of families have lost one or more family members, and hundreds of thousands have lost their homes and their livelihoods.

It may be expected that there will be a massive need for psychosocial support. Up to 50% of the affected population may be expected to experience significant psychological distress and 5-10% to develop a diagnosable stress-related psychiatric disorder. Many

---

[1] Bulletin No, 28, Badan Koordinasi Nasional – the National Coodinating Authority, under the Deputy President of Indonesia.

people will not manifest symptoms of mental disorder until a considerable time after the disaster.

Considering that approximately 1 million people may be considered to have been directly affected by the disaster, we may expect that 500,000 people will need psychosocial support, and up to 100,000 people will require skilled mental health intervention for trauma related stress disorders[2]. This is in addition to the pre-existing mental disorders in the community.

If we assume that in adults the prevalence of schizophrenia is 1%, the prevalence of major affective disorder is 1% , then there are already 60,000 adults with severe mental disorders in the population.

A substantial increase in need for psychiatric care may be expected as a consequence of the disaster. The pre-existing morbidity plus the additional morbidity due to the disaster will require a substantial enhancement of mental health system capacity. The numbers of mental health professionals per 100,000 population in Indonesia (WHO Atlas) and in Aceh (MOH figures) are shown in the table below.

---

[2] In estimating the extent of need for psychosocial support and mental health intervention we wish to express an important caveat concerning based on the particular socio-cultural circumstances of Aceh. There are several potentially relevant considerations.

Aceh is a deeply religious society, referred to by the Acehnese as the Verandah of Mecca. Syariah law applies in Aceh. Many individual people have expressed the conviction that the disaster, and the loss of loved ones, the destruction of houses and material possessions, and the resultant suffering, is the will of God.

Acehnese society has experienced many traumas – natural and man-made - over a very long period. The Acehnese are generally considered to be a particularly resilient people. They are said to be proud and self-reliant and have shown themselves to be resistant to outside 'interference', regardless of whether such outside intervention is with benevolent or malevolent intent.

As a result of the military conflict between the Aceh Fredom Movement (GAM) and the Indonesian authorities, Aceh has been closed for a number of years.
These observations may have a number of implications for planning.
- The disaster has been invested with religious meaning and is understandable, and manageable, in that context. As a result, the prevalence of trauma-related psychiatric disorder may be substantially less than that which would be expected based on the international literature.
- Attempts from outside Aceh to 'train' various community leaders in how they might respond to widespread psychological distress at a community level, using western constructs of community reconstruction and development, may be misguided and will probably be unwelcome.
- The religious construction of meaning surrounding the disaster may mean that efforts to deal with psychological and social consequences of the disaster in ways that are not consonant with such religious and cultural values and beliefs (e.g. trauma-focused counselling, psychiatric approaches) will be both ineffective and unacceptable.
- Control of rehabilitation and reconstruction from outside Aceh, including from Jakarta but particularly by international agencies and organizations, may result in many problems.
- The Acehnese may wish to see outsiders leave Aceh earlier rather than later. There may be a rise in tensions and there is the possibility of a serious deterioration of the security situation, particularly for foreigners.

Discipline	Indonesia: Number per 100,000	Aceh Number	Aceh: Number per 100,000
Psychiatrists	0.21	5	0.13
Psychiatric nurses	0.9	90	0.72
Psychologists	0.3	3	0.075
Social workers	1.5.	5	0.13

The figures in the above table demonstrate that the number of mental health professionals per 100,000 population in Aceh has been substantially below the mean for Indonesia. In addition it should be noted that most of these staff are concentrated in the psychiatric hospital of Aceh and therefore not serving the entire population of Aceh. The fact that Aceh is among the four poorest provinces in Indonesia (BPS-Statistics Indonesia) represents an additional reason for national authorities to invest in strengthening the mental health system in the province.

There are many agencies that are currently providing, or that intend to provide, psychosocial support in Aceh. A coordination meeting was held on Friday 7 January 2005 to collect information and to begin to coordinate the efforts. The following agencies and NGOs are already involved in the coordination process established by the MOH: PMI, IPSI, Yay Pulih, MSF Belgium, Save the Children, Mercy Corps, International Medical Committee, Care International, IFRC, WHO, UNFPA and UNICEF.

An advance team was fielded to Aceh in the first week of January to conduct a qualitative rapid assessment. Most of the survivors showed symptoms of fear, panic, helplessness, emotional numbing, disbelief, confusion, nightmares and flashbacks, hyper-activity, fear of returning to the original place, fear of water, fear of being inside a building, restlessness, and fatigue. The team also found that first responders were mentally distressed and that people on active duty, such as soldiers and police, are distressed because they have lost members of their family or colleagues in the disaster.

In conclusion, the mental health needs are expected to increase substantially while mental health system resources are substantially less than in the rest of Indonesia. Investment in strengthening the mental health system is essential.

II. Rationale for the strategic plan

The present plan is intended to address the entire population of Aceh with a particular focus on disaster survivors. Effective social and mental health interventions are available and should be implemented through the present strategic plan.

It is the responsibility of the Government of Indonesia to protect the health and wellbeing of the people of Aceh. Due to the complexity of the issues, the number of people affected, the number of local and international players, it is essential to establish a clear and comprehensive strategy. A comprehensive strategic plan will assist in avoiding

fragmentation of efforts in achieving the most effective and efficient use of limited resources. This will also serve as a framework for the coordinated actions of government, non-government and international agencies.

III. Principles

The strategic plan is based on the following principles:

1. Psychosocial support programs and mental health care should be provided **equitably** to all in need, even if location is remote or demand is not actively expressed.
2. Particular attention should be paid to the protection of **human rights** due to the vulnerability of people suffering from severe psychological distress and mental disorder.
3. A **public health orientation** requires that the well-being of the entire population is addressed and psychosocial support and mental health programs are integrated into the overall health system. All new human resources and expertise, and mental health infrastructure created in response to the disaster , should be integrated into the health system in order to ensure sustainability.
4. To ensure that the broader needs of all sub-groups are considered all activities should be undertaken in **consultation and partnership** with all interested sectors and their stakeholders.

IV. Goals

The goals of the plan of action are to:
1. provide immediate and long-term psychosocial support to the population of Aceh
2. strengthen the health care system to take adequate care of people with newly-developed mental health needs and people with pre-existing mental and substance abuse disorders.

The plan consists of five components.

V. Components

Component 1: Assessment and Monitoring

Assess and monitor psychosocial needs and psychiatric morbidity in the population in order to plan appropriate responses.

It is important that such assessment should be as methodologically sound as the situation will allow. Brief screening instruments that enable accurate estimation of the rates of mental symptoms and disorders. These instruments can be used for initial and periodic assessments. Examples of such instruments include The Self-Reporting Questionnaire, the Kessler K-10, etc. Brief instruments are also available that enable assessment of the stress related disorders.

What is Post-Traumatic Stress Disorder?

Soma clarification of posttraumatic stress syndromes is required due to the widespread use and sometimes abuse of the term PTSD. This condition is diagnosed only when the following symptoms have been present for longer than one month:
- *Re-experiencing the event (e.g. in nightmares,*
- *Routine avoidance of reminders of the event*
- *General lack of responsiveness*
- *Diminished interest and engagement*
- *Increased sleep disturbance and poor concentration*

Other symptoms, such as depression and anxiety, should not be considered as indicators of the presence of PTSD. Rates of PTSD following severe trauma vary widely – from 2% - 28% It is likely that the development of PTSD is more likely after violent episodes of trauma than after natural disaster. Rates of PTSD also vary widely in different countries and cultures and. Therefore it is advisable not to focus exclusively on the notion of PTSD or, even worse, consider separate treatment approaches, techniques and settings. It is essential that PTSD be considered as only one of the many possible psychological or psychiatric consequences of trauma exposure. For these reasons treatment of PTSD must be part of the normal treatment system rather than establishing parallel services that are focused only on trauma.

Actions	Phase
1.1 Carry out rapid assessment of the magnitude and distribution of psychosocial and psychiatric needs and their geographic distribution.	Emergency
1.2 Create a mental health surveillance capacity This may consist of routine collection of data of the following types: • Record of new psychiatric cases in specialised psychiatric care • Psychotropic drug prescription • Rates of development, emotional and behavioural problems in schools • Rates of domestic violence • Rates of substance abuse	Rehabilitation
1.3 Conduct studies on the long-term effects of the disaster on affected populations	Reconstruction

Component 2: Coordination

In order to ensure more effective and efficient use of resources, and to prevent fragmentation and duplication of efforts, it is essential that the activities of all local, national and international organizations be coordinated. Activities/interventions must be appropriately linked to population need, informed by the best available evidence, and distributed geographically on the basis of need

Why is coordination essential?

The generosity of the Indonesian and international response to the suffering of the people of Aceh whom have been affected by the tsunami has brought into Aceh multiple agencies, many of which have already commenced or are planning psychosocial and mental health activities and programmes.

Among the risks of multiple agencies operating independently of each other in this domain include :
  • *uncertain quality of interventions*
  • *fragmentation and duplication of efforts*
  • *lack of sustainability of response*
  • *inequitable distribution of programs*

Both psychosocial intervention and mental health services should be considered part of the health sector response which should include health protection as well as management of mental disorders. Therefore all activities related to psychosocial support, trauma

> *response and mental health service provision should be coordinated at district and provincial health authority levels and integrated into the existing health system.*

Actions	Phase
2.1 Establish effective mechanisms for coordination. This is the responsibility of the Ministry of Health through provincial and district health authorities.	All phases
2.2 Map of all NGOs, local and international agencies. This includes: a. Data on the background of the organization, b. their specific plan, c. how long will the program last, d. geographical coverage e. target population subgroups (women, children, elderly etc)	Emergency
2.3 Establish procedures for accreditation of programs and interventions, to ensure that only interventions that produce benefit, and that do no harm, are supported.	All phases
2.4 Within 60 days MOH and WHO to convene a two day meeting of all major stakeholders in Banda Aceh to assess the implementation of the action plan and the effectiveness of coordination mechanisms.	Emergency

Component 3: Evidence-based Interventions

Ensure that all individuals and organizations (local, national and international) providing psychosocial support use interventions based on the best available evidence.

> *What is Psychosocial support?*
>
> *Psychosocial support consists of strategies and interventions that do not require medical expertise but require certain capabilities. The interventions should be based should be based on evidence of effectiveness. The interventions are intended to have both psychological and social impact, and include:*
>
> *Social interventions include:*
>
> *The re-establishment of normal cultural and religious events (including grieving rituals*

in collaboration with spiritual and religious practitioners).
Activities that facilitate the inclusion of orphans, widows, widowers, or those without their families into social networks.
The organization of normal recreational activities for children.
Starting schooling for children, even partially.
Involving adults and adolescents in concrete, purposeful, common interest activities (e.g., constructing/organizing shelter, organizing family tracing, distributing food, organizing vaccinations, teaching children).
Wide dissemination of uncomplicated, reassuring, empathic information on normal stress reactions to the community at large. Brief non-sensationalistic press releases, radio programmes, posters and leaflets may be valuable to reassure the public. The information should emphasise an expectation of natural recovery.

Psychological interventions include:

Most acute mental health problems during the acute emergency phase are best managed without medication following the principles of 'psychological first aid' (i.e., listen, convey compassion, assess needs, ensure basic physical needs are met, do not force talking, provide or mobilise company from preferably family or significant others, encourage but do not force social support, protect from further harm).

Psychosocial support for children

All children who have been exposed to the disaster or who have lost parents or other family members will display distress. This may include withdrawal, behavioural problems, nightmares, developmental regression, etc. For most children these problems will recede when they are in a safe environment and in the care of family or relatives. It is most important that children should be with members of family and relatives and other familiar members of community at the earliest opportunity. It is important to restore a sense of order and predictability in the child's life. The routines of daily life – meals, sleep patterns, schooling, opportunities for play, and so on – should be restored as quickly as possible. Whether to encourage expressions of distress, and the most appropriate forms of such expression, will depend on many factors - the child's age, the presence or absence of supportive family members, the culturally sanctioned forms of such expression, and the extent to which expression of negative emotions is consonant with cultural values and practice.

Actions	Phase

3.1 Identify, adapt and develop a limited set of guidelines on
   a. community based psychosocial support
   b. management of psychiatric conditions
   c. development of mental health system
	Emergency

3.2 Identify existing resources from international organizations, professional organizations and academic centres	Emergency
3.3 Adapt and translate existing resources in order to ensure that they are culturally appropriate and relevant to local needs	Emergency
3.4 Develop new guidelines (where appropriate guidelines do not exist) using local expertise and international technical advice	Emergency

So far, WHO has produced resource materials that should become part of the recommended guidelines. They are the following:
a. Mental Health in Emergencies (2003)
b. Mental Health and Psychosocial Care for Children affected by Natural Disasters (2005)
c. Manual for Community Level Workers to provide Psychosocial Support to Communities Affected by the Tsunami Disaster (draft, SEARO)

Component 4: Strengthening Capacity of Communities and Health System

Strengthen the capacity of community organizations and community leaders in provision of psychosocial support, and strengthening the capacity of health workers to identify and provide appropriate management for mental disorders at all levels of the health system.

Actions	Phases
4.1 Training to enable community organizations and community leaders to provide psychological first aid and psychosocial support. The purpose of the training is to enable community leaders to provide effective psychosocial support in particular to: a. Affected adults b. Affected children c. High risk populations (children who have lost both parents, women without immediate family and destitute elderly)	Emergency
4.2 Training to enable community leaders to establish and support self-help groups	Rehabilitation

4.3 Training to enable teachers, and all kinds of organizations dealing with children, to provide psychosocial support to children and adolescents. An important element in teacher training is to enable teachers to recognise developmental, emotional and behavioural problems in children so that appropriate specialised intervention may be sought when it is required.	All phases
4.4 Training to enable primary health care workers to identify and provide appropriate management of mental disorders and, when necessary, to refer to specialized services. Training should focus on early detection of mental disorders, management and referral if needed.	Emergency and Rehabilitation
4.5 Training to enable mental health workers to recognize and treat psychiatric consequences of trauma.	Emergency and Rehabilitation
4.6 Training to enable mental health workers to work effectively at community level, and in collaboration with primary health care and with non-health sectors.	Emergency and Rehabilitation
4.7 Training to enable health system managers to design and effectively manage a comprehensive mental health system that provides continuity of care across community and hospital levels.	Reconstruction
4.8 Widely disseminate uncomplicated, reassuring, empathic information on normal stress reactions to the community at large. Focus of public education should primarily be on normal reactions because widespread suggestion of psychopathology during the emergency phase may lead to unintentional harm. The information should emphasise an expectation of natural recovery.	Emergency

Component 5: Building a Comprehensive Mental Health System

To build a comprehensive mental health service that is patient-needs oriented and community focused.

> *What is a comprehensive mental health service?*
>
> *The need to rebuild the mental health system of Aceh following the disaster represents an opportunity to move towards a more comprehensive mental health system in the province, in line with Ministry of Health policy to shift from a hospital based to a community-based mental health system.*
>
> *The traditional mental health system is focused on psychiatric hospitals, which*

consume the majority of human and financial resources. However, only a small minority of people in need of mental health care reach the psychiatric hospital. In addition, psychiatric hospital settings generally do not offer optimal care or protection of citizen's rights. A comprehensive mental health system is one in which there is well-developed community capacity for enhancing mental health and self-help among the population; the primary health care system is capable of detecting and effectively managing the majority of mental disorders, and there are effective referral mechanisms to community mental health centres. If this system is well developed the need for hospitalisation is decreased thereby reducing the need for investment in psychiatric hospitals. While remaining an essential component of the mental health system the psychiatric hospital should not be the main mental health resource consumer.

In the current situation of Aceh activities intended to deal with the mental health consequences of trauma, and the resources and skills that are available for this purpose, should be integrated into the comprehensive mental health system, specifically within community mental health teams.

Actions	Phase
5.1 Re-start clinical activities in the psychiatric hospital, including the supply of essential psychotropic drugs.	Emergency
5.2 Establish 4-6 community mental health teams (for example in Banda Aceh, Meulaboh, Lhok Seunawe, Kota Langsa), based in *puskesmas*, with each team having a geographic area responsibility (including the residents of IDP camps). Each team should be composed of a minimum of one psychiatrist, one psychologist, 4-8 psychiatric nurses, and 1-2 social workers. The community mental health teams are responsible for outreach activities of the mental health service and must be provided with vehicles. These teams should also be responsible limited numbers of patients admitted to district hospitals for psychiatric care.	Emergency
5.3 Re-balance the number of inpatient psychiatric beds in Aceh, reducing the number of beds in the Aceh psychiatric hospital and establishing inpatient beds in district hospitals – for example in Banda Aceh, Meulaboh, Lhok Seunawe, Kota Langsa.	Rehabilitation
5.4 Integrate within the community mental health teams all human resources providing psychological care to trauma survivors in order to integrate manpower and expertise.	Emergency
5.5 Establish referral procedures from primary health care worker to community mental health teams	Rehabilitation

5.6 Allocate responsibility for decisions concerning admission to psychiatric beds to community mental health teams	
5.7 Establish mechanisms that will enable mental health professionals working in the community mental health teams to provide supervision and consultation to primary health care workers.	Rehabilitation

VI. Implementation

This plan should be under the authority of the Ministry of Health. The plan should be coordinated by the provincial health authority and implemented by district health authorities. The coordinating group at provincial level will need to be substantially strengthened in order to undertake this responsibility. The activities should be undertaken in coordination with, or delegated to, professional organizations, national, local and international NGOs, and UN and international agencies. The coalition of professional mental health association should play a particularly active role in the implementation of this plan. There should be active participation in all elements of the further planning and implementation of the plan by Acehnese community leaders. The World Health Organization will provide technical and, where possible, financial support including deployment of mental health professionals in Aceh to assist in coordination.

VII. The Next 60 Days

Urgent action is required during the next 60 days.

1. Re-start clinical activities in the psychiatric hospital.

2. Activate at provincial level effective coordination mechanisms, with the support of the World Health Organization.

3. Carry out rapid assessment of the magnitude and distribution of psychosocial and psychiatric needs.

4. Widely disseminate uncomplicated, reassuring, empathic information on normal stress reactions to the community at large.

5. Deploy a minimum of 4 psychiatrists, 4 psychologists, 16-24 mental health nurses, 4-8 social workers in order to establish 4-6 community mental health teams.

6. Integrate psychological trauma response activities into the newly establish community mental health teams.

7. Identify, adapt and develop a limited set of guidelines on community based psychosocial support, management of psychiatric conditions, and development of mental health system.

8. Identify capable training organizations to train community leaders to provide psychological first aid, psychosocial support and self-help.

9. Within 60 days MOH and WHO to convene a two day meeting of all major stakeholders in Banda Aceh to assess the implementation of the action plan and the effectiveness of coordination mechanisms.

VIII. Resources

Armen K. Goenjian AK, Molina L, Steinberg AM, Fairbanks LA, Alvarez ML, Haig A. Goenjian HA, Pynoos RS. Posttraumatic Stress and Depressive Reactions Among Nicaraguan Adolescents After Hurricane Mitch. *Am J Psychiatry* 2001; 158:788–794)

Centre for Health Emergency MOH Indonesia, WHO Indonesia. *Emergency situation report number 25*. 19 January 2005.

Dharmono S, Maramis A. Country Report: Indonesia. International Mental Health Leadership Program Working papers (Unpublished)

Kokai M, Fujii S, Shinfuku N, Edwards G. Natural disaster and mental health in Asia. *Psychiatry and Clinical Neurosciences* (2004), **58**, 110–116.

Munir K, Ergene T, et al. A window of opportunity for the transformation of national mental health policy in Turkey following two major earthquakes. *Harvard Review of Psychiatry*. 2004; 12:238-251.

National Institute of Mental Health. *Helping children and adolescents cope with violence and disasters: Fact sheet*. NIMH, September 2001.

SHERE Project. *Humanitarian charter and minimum standards in disaster response*. Geneva, 2004; SPHERE Project.

Van Emmerik A, Kamphuis J, et al. Single session debriefing after psychological trauma: A meta-analysis. *The Lancet*. 2002; 360 (September 7): 766-771.

Van Ommeren M, Saxena S, Saraceno B. Amental and social health during and after acute emergencies: Emerging consensus. *Bulletin of the WHO*. 2005; 83 (1): 71-77.

Wang X, Gao L, Shinfuku N, M.D., P Zhang H, C, Shen Y, Longitudinal Study of Earthquake-Related PTSD in a Randomly Selected Community Sample in North China. *Am J Psychiatry* 2000; 157:1260–1266.

Weine S, Danieli Y. et al. Guidelines for international training in mental health and psychosocial interventions for trauma-exposed populations in clinical and community settings. *Psychiatry*. 2002; 65(2):156-164.

WHO. *Atlas: Country profiles of mental health resources*. Geneva, 2002.

WHO. Mental health and psychosocial care for children affected by natural disasters. 2005. (www.who.int/MSD)

WHO. *Mental health in emergencies*. Geneva, 2003.

WHO. *Rapid assessment of mental health needs of refugees, displaced and other populations affected by conflict and post-conflict situations: A community oriented assessment*. Geneva, 2001.

WHO/Ministry of Health, Republic of Indonesia. *Report of mental health team, Banda Aceh*. 5-10 January 2005.