

DEVELOPMENT OF THE RAPID ASSESSMENT TOOL FOR MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE PHILIPPINE HEALTH EMERGENCY SETTING

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Abstract. Mental Health and Psychosocial Support (MHPSS) is an important aspect of emergency and disaster management. This covers a wide-range of interventions and services and should be preceded by careful assessment and planning within the local context, which would include the local perceptions of distress and illness, coping mechanisms, and the mapping of the community's capacity to cope. In the Philippines, the National Disaster Coordinating Council MHPSS Sub-committee saw a need to develop a Rapid Assessment Tool for Mental Health and Psychosocial Support in Emergency Settings (MHPSS-RAT) which will provide immediate assessment of the vulnerable population and relevant resources in the first twenty-four hours of onset in mass emergencies and disasters. The tool was based on the Inter-Agency Standing Committee (IASC) guidelines and developed through collaboration with the Department of Health-Health Emergency Management Staff (DOH-HEMS) and consensus of national agencies involved in disaster response, with inputs from local experts and concerned stakeholders. It was designed to allow planners and analysts to easily identify priority areas and provide sufficient information to rapidly design appropriate interventions and programs. It is recommended that further validation and field testing be done once the final draft is approved for national use.

INTRODUCTION

The impact of armed conflict and disasters from natural hazards can be detrimental to livelihood, food security and the biophysical well being of the affected population. It can also undermine the acute and long-term mental health and psychosocial well-being of these populations. In turn, this may threaten peace, human rights and de-

velopment (IASC, 2007). A recent empirical review of the disaster-psychology literature classified the psychosocial outcomes of disaster into categories labeled as specific psychological problems, nonspecific distress, health problems and concerns, chronic problems in living, psychosocial resource loss, problems specific to youth. Some studies reported that more than half of disaster survivors might have mild to moderate psychological impairment while around 39% may report severe to very severe impairment, suggesting that a very substantial proportion of disaster survivors could benefit from mental health services and psychosocial interventions (Norris *et al*, 2002). Public aware-

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ness has recently increased regarding the psychological reactions that may develop among people affected by disasters, and mental health interventions have become a mainstay of the national and local disaster-response system (Reyes and Elhai, 2004). This makes Mental Health and Psychosocial Services (MHPSS) an important aspect of emergency and disaster management. Protecting and improving people's mental health and psychosocial well-being is a main priority in emergencies and these would require coordinated action among all government and non-government humanitarian agencies. MHPSS covers a wide-range of psychological and social services not just limited to critical incidence stress debriefing, as it is often misunderstood. Providing psychological support will involve dealing with the acute and ongoing stressors, recognizing particular vulnerabilities, and assisting and strengthening existing coping capacities. It should be noted that the need for external support might vary over time, as may the required support. Resources that are depleted are both physical and psychological. Designers of psychological and social support interventions may need to respond to these changing patterns, and should always be aware of the need to engage those affected in terms of their own strength and opportunities for adaptation (Sphere, 2004; Prewitt-Diaz *et al*, 2006). Correspondingly, interest in disaster mental health has rapidly increased with a call for greater availability of MHPSS training and for establishment of guidelines for models of service provision and employment of evidence-based interventions (Reyes and Elhai, 2004).

In the acute emergency phase, social interventions should not interfere with needs such as the organization of food, shelter, clothing, primary care services, and the control of communicable diseases. These

interventions and other services would include establishing and disseminating a flow of credible information, keeping temporary shelters organized with systems of registration for keeping families together and proper distribution of aid, assuring cultural space, and community participation in decision making, encouraging play and schooling for children, with a basic approach to foster an atmosphere of normalcy. Psychological interventions may also be needed in the acute phase, particularly for those with pre-existing psychological problems and may need immediate referral and management of psychiatric complaints. In which case, a proper system of referral to a mental health professional through the primary health care (PHC) or emergency care station in the area would be vital. Psychological interventions would also include "psychological first aid" both for the victims and for responders (WHO, 2001; IASC, 2007).

In the wake of large-scale disasters (*eg*, hurricanes, earthquakes, refugee crises), identifying which individuals are most at risk of becoming or remaining symptomatic is a high priority. Inquiries may also be undertaken to determine exactly what happened, such as to help prevent repetition of the disaster, identify deficiencies in the relief efforts or even reveal human rights violations in some situations (Ehrenreich, 2001). Whatever these interventions may be, they should be preceded by careful assessment and planning within the local context and the mapping of the community's capacity to cope. Assessment before intervention, being one of the basic principles of mental health in emergencies, should cover the sociocultural context (setting, culture, history and nature of problems, local perceptions of illness, and ways of coping), available services, resources and needs (Van Ommeren *et al*, 2005). It has been suggested by the

Department of Mental Health and Substance Dependence of the World Health Organization that in emergency settings, the type of assessment should be qualitative for assessment of context and quantitative for measurements of disability or daily functioning; and when the assessment uncovers a broad range of needs that will unlikely be met, assessment reports should specify urgency of needs, local resources and potential external resources (WHO, 2006).

Depending on the emergency context, particular groups of people are at increased risk of experiencing psychological and mental problems. In general, those with the least power and resources are most exposed to the adverse effects of the disaster and its aftermath and have a harder time recovering from it (Ehrenreich, 2001). The Inter-Agency Standing Committee Task Force on Mental Health and Psychosocial Support in Emergency Settings (2007) identified the following groups of people who have been shown to be at increased risk of various problems in diverse emergencies which include women, men, children, elderly, extremely poor people, internally displaced persons, rescue and relief workers, armed groups, survivors of sexual violence, and indigenous people. Although many key forms of support should be available to the general population affected by the disaster, good assessment and programming specifically include the provision of relevant mental health services and psychosocial support to people or groups at risk, who need to be identified for each specific crisis. Moreover, certain vulnerability factors are also identified such as experiencing tremendous loss through the death of loved ones, loss of body parts, loss of homes, markers of heritage, sources of livelihood, and other extreme stressors, which increases the risk of an individual to experience social and mental health prob-

lems, including common mental disorders. People directly exposed to the traumatic stressor or elements of disaster are likely will be most affected (Van Ommeren *et al*, 2005).

In planning an appropriate emergency response to the disaster-affected population, it is also important to know the nature of local resources, whether they are helpful or harmful, and the extent to which affected people can access them (Weine *et al*, 2002). Organizational capacities and activities include structure, location, staffing, and resources for mental health care in the health sector (including policies, availability of medications, funds/finances, etc) and mapping of potential partners, human resources, and MHPSS programs available in the affected area. A key to organizing mental health and psychosocial support is to develop a layered system of complementary supports that meet the needs of different groups, which include basic services and security, community and family supports, focused non-specialized supports, and specialized services. Basic services and security refer to the establishment of security, adequate governance and services that address basic physical needs (food, shelter, water, basic health care, control of communicable diseases). Response in accessing key community and family support may help victims maintain mental health and psychosocial well-being and prevent problems arising from displaced social networks and family separation due to the disaster. Focused and non-specialized support refers to focused individual, family or group interventions by trained and supervised workers, such as psychological first aid and basic mental health care by primary health care workers. Specialized services comprise of psychological and psychiatric assistance for people with severe mental disorders, which may require referral to a mental health in-

stitution or initiation of longer-term training and supervision of primary health care providers (IASC, 2007).

In the Philippines, until recently the lead agency for psychosocial interventions has been the Department of Social Work and Development but in early October 2008, the National Disaster Coordinating Council (NDCC), through Memorandum Circular No. 15 s. 2008, created a specific cluster for MHPSS and designated the Department of Health (DOH) as lead. Also under this memorandum, the task of consolidating reports was put on the Health Emergency Management Staff (HEMS) of the DOH. With this task, the MHPSS cluster found a need to develop assessment and reporting tools for MHPSS for emergencies and disasters within the local context of the country.

MATERIALS AND METHODS

Uses and Benefits of the Rapid Assessment for Mental Health and Psychosocial Support in Emergency Settings

The Rapid Assessment for Mental Health and Psychosocial Support in Emergency (MHPSS-RAT) is the first and initial form to be used in event of disaster and *ideally* should be carried out within the first 24 hours upon onset of disaster, or as soon as possible after the disaster occurs. The tool aims to: 1) identify those who need MHPSS services and interventions, and are at increased risk of mental health and psychosocial problems, 2) check previous psychosocial interventions or mental health services provided, and 3) assess mental health resources and psychosocial support available in the affected area, within 24 hours of onset of emergency or disaster. It does not attempt to cover all domains of mental health and psychosocial support rather focus more on the capabilities of the affected community to provide psychosocial interventions and

mental health services for victims needing MHPSS attention. Its format and content should allow planners and analysts to easily identify priorities and provide sufficient information to rapidly design appropriate interventions and programs. The tool is designed to be user-friendly and comprehensible for local health and social workers, volunteers, trained staff, and others concerned with MHPSS. The layout is mostly in checklist and inventory format for ease in data collection and assessment.

Development of the MHPSS-RAT

The IASC Guidelines in Mental Health and Psychosocial Support in Emergency Settings served as the foundation of the tool. These guidelines enable humanitarian sectors and communities to plan, establish, and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergency. The focus of the guidelines is on implementing minimum responses, which are essential, high-priority actions that should be implemented as soon as possible in an emergency (IASC, 2007).

An initial rapid assessment tool was drafted by the National Center for Mental Health, with the team headed by Dr Bernardino Vicente. The tool was in the form of guide questions such as description of the event and affected population, availability of human service providers and facilities for psychosocial services, coordination/organization, other issues, and concern. Major changes were done regarding the format of the tool and organization of mental health services and psychosocial support. A simple checklist format was suggested for ease in data gathering. Operational definitions of key terms with concrete examples were discussed with the team, and those agreed upon were included in the instructional manual.

Upon presentation of the initial draft of the rapid assessment tool to the NDCC MHPSS Sub-committee, members noted the information needed should focus on the MHPSS situation alone and not the overall disaster situation that is already included in the NDCC report.

In order to standardize the tool for national use, assessment and reporting forms were collated from various member agencies such as the Department of Health (DOH), Department of Social Work and Development (DSWD), Department of Education (Dep Ed), and Philippine National Red Cross (PNRC). Apparently, most of the forms gathered focus on the assessment of the general emergency setting with limited emphasis on mental health and psychosocial support. The DOH-HEMS utilized a rapid health assessment form with basic information about the event, magnitude (tally of persons affected and evacuation centers), health consequences (mortality and morbidity), health facilities, lifelines, and status of essential drugs in the affected areas, actions taken, problems encountered and recommendations. The DSWD produced assessment and reporting forms that focus on the status of disaster operations, status of evacuation centers, master list of casualties, and augmentation for supplies. The PNRC furnished a field action guide based on the UNICEF Handbook on Psychosocial Assessment of Children and Families in Emergencies. However, forms were not received from the Department of Education.

Consultations with other stakeholders including a consultant psychiatrist from the East Avenue Medical Center and a psychologist from the Médecins Sans Frontières were also done. They agreed that the mental health services and psychosocial interventions provided should be organized based on the IASC Guidelines. Response from this

sector was greatly considered in the revision for that particular part of the tool, yet the remaining portions were still retained based on utilization and adaptation for local use.

The MHPSS-RAT together with its instructional manual was subsequently presented in the NDCC MHPSS Sub-committee meeting. The working group facilitated by DSWD Undersecretary Celia Yangco and DOH-HEMS Director Carmencita Banatin collaborated in editing the instructional manuals, specifically the introduction, flowchart of MHPSS interventions, and operational definitions. Members were furnished with copies of the tools and instructional manuals and were tasked to provide further inputs and recommendations for the final draft.

RESULTS

The MHPSS-RAT

The tool is divided into seven sections, namely 1) brief description of the event or disaster, 2) at-risk groups or affected population, 3) inventory of services and interventions already provided, 4) mental health resources and psychosocial support available, 5) priority issues, concerns, and problem areas, 6) recommendations and suggestions, and 7) assessor details.

The first section of the tool refers to a brief description of the event pertaining to its title, location and date of occurrence. Date, time and area covered by the assessment, as well as main source of information or key informant, are also indicated in this part. The second part of the tool identifies the affected population and vulnerable factors that increases the risk of concerned groups from that particular event or disaster. At-risk groups identified by the IASC and included in the tool comprise of women, men, children, elderly, disabled, internally

Table 1
MHPSS-RAT inventory of services and interventions already provided.

Category	Sample items
Basic Services and Security	Reestablishment of security Provision of basic services (food, water, shelter, and basic health care)
Community and Family Supports	Family tracing and reunification Assisted mourning and communal healing ceremonies Mass communication on constructive coping methods Supportive parenting programs Formal and non-formal educational activities Livelihood activities
Focused, Non-specialized Supports	Activation of social networks Briefing/Disaster orientation Debriefing Defusing Crisis counseling Grief counseling Stress management
Specialized Services	Assessment and referral Psychotherapy Hospitalization

displaced persons (IDPs), rescue and relief workers, military, survivors of sexual violence, and ethnic or linguistic minority. Approximate numbers of individuals are given for direct and indirect victims. Individuals identified to have such vulnerability factors (eg those who were trapped inside fallen buildings, entombed for hours or caught in a near death situation, etc) are also indicated in this section.

The third section of the tool is an inventory of services and interventions already provided in the affected area which comprise a layered system of complementary supports that meets the needs of different groups, including basic services and security, community and family supports, focused and non-specialized supports, and specialized services. Categories and sample items are based on the MHPSS pyramid of interven-

tions from the IASC guidelines. An overview of MHPSS-RAT inventory of services and interventions already provided is shown in Table 1.

The fourth part of the tool is an assessment of mental health resources and psychosocial support available. Checklists for infrastructures, facilities, logistics, and equipment are provided in this part. Availability of calamity fund and finances, as well as psychotherapeutic medications, are also asked in this part. Questions regarding coordination and organization identify the person or organization in-charge, availability of a functional MHPSS team and inclusion in the disaster management plan, accountability on human service provides, and presence of a referral system. The last part of this section pertains to an inventory of human resources and partnerships available in the affected area.

Human resources categories include human service providers, health workers (BHWs, midwives, sanitary inspectors, nurses and doctors), MHPSS trained staff (social workers, nurses, psychologists and psychiatrists), and others. Approximate numbers or counts for each area or classification (local, regional, national, international, NGO/volunteers, media, military, and others) are asked to be provided for identified human resources in the affected area.

The fifth part of the tool refers to priority issues and concerns experienced by the affected population with the corresponding actions taken. The sixth part of the tool tackles recommendation and suggestions of the assessor. The last section of the tool pertains to the information about the assessor including name, designation, office and contact details, and approval of the authorized head.

DISCUSSION

A rapid assessment tool for mental health and psychosocial support in emergencies and disasters should generally provide an understanding of the emergency. It should provide an analysis of threats to and capacities for mental health and psychosocial well-being, and an analysis of relevant resources to determine, in consultation with stakeholders, whether a response is required, and what will be nature of the said response (IASC, 2007). The MHPSS-RAT attempts to accomplish these goals with its given objectives, as well as to collect and analyze key information relevant to mental health and psychosocial supports. It also aims to address both the needs and resources of different sections of the affected population. The development of this tool will ensure that assessments are coordinated among local government agencies and organizations involved in disaster response. Coordinating assessments among involved

agencies and concerned stakeholders is essential to ensure efficient use of resources, achieve the most accurate and comprehensive understanding of the MHPSS situation and avoid burdening a population, especially the disaster survivors, unnecessarily with duplicated assessments (WHO, 2003; UNICEF, 2005).

Practical experience and empirical findings are generating a growing consensus regarding several general principles that should guide the delivery of MHPSS in the Philippines. The development of the MHPSS-RAT will pave the way to a more standardized assessment and subsequent efficient delivery of mental health services and psychosocial intervention to the disaster-affected population. Moreover, the MHPSS-RAT is still a work in progress and needs to be continuously updated based on the dynamics of the Philippine health emergency setting. Validation and field testing of the tool should be done once the NDCC MHPSS Sub-Committee comes to a consensus for this to be utilized for national use. Reviews and revisions will be done based on feedback, as implementation will also give evidence to the effectiveness of this tool. Effectiveness of the MHPSS-RAT in the Philippine health emergency setting may facilitate its adaptation and use in other counties. Furthermore, international organizations should get involved and have a representative in the NDCC MHPSS Sub-Committee meetings in the coming months to help facilitate adapting the IASC guidelines into the country's local context.

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