LONG TERM PLANNING FOR RECOVERY AFTER DISASTERS: ENSURING HEALTH IN ALL POLICIES (HiAP)

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INFORMATION SHEET 6
Mental Health issues

What is the aim of this series of documents?

This document aims to show what can be learnt from previous disasters about the impact of decisions and actions taken that have affected people's wellbeing during the recovery period.

The document is written from a public health perspective but draws from the **literature of many disciplines.**

The key challenge and aim is to gain a place in the recovery planning effort and ensure that health and wellbeing is recognised as a key factor to be considered in all decisions and actions, rather taking a narrow view of "health" as being limited to health protection and disease control functions, vital though they are.

It aims to show that recovery takes place in several phases, from immediate response to long term rebuilding, with transitional phases in between. These phases overlap and the stages of recovery may be of longer or shorter duration for particular groups of people within the affected area.

It highlights that there is always tension between acting speedily and taking time to plan well. Pre-disaster planning is the best means of avoiding short term decisions that create or exacerbate long term problems.

Why is the HIAP approach so relevant?

Health in All Policies (HiAP) is an approach which emphasises the fact that health and wellbeing are largely influenced by measures that are managed by government sectors other than health. HiAP seeks to highlight the connections and interactions between health and other sectors. The health sector's role is to support other sectors to achieve their goals in a way which also improves health and wellbeing.

What are the Mental health issues?

Although extreme distress is common in the immediate aftermath of a disaster, most survivors recover spontaneously without the need for professional help. Intervention in the form of "stress debriefing" is unsupported by the evidence and may even exacerbate distress (Gheytanchi et al. 2007).

Focussing on fostering a belief in self-efficacy, adaptive coping and problem solving skills of survivors has consistently been found to be a buffer against persisting distress and postraumatic stress disorder.

Survivors from a number of serious disasters in the US were found to have severe distress in the immediate aftermath but those who believed in their ability to cope with events and exercise control over their lives did not experience long-term symptoms (Benight and Bandura 2004),.

However, a small proportion of people who believed they were at the mercy of circumstances and could not turn off "perturbing ruminations" were still be experiencing elevated distress years later (p. 1136) .

A random dialling survey of adults in New York at one, four, and six months after the 9/11 terrorist attacks (Galea et al 2003) found that the prevalence of self-reported symptoms of post traumatic stress disorder declined from 7.5% at one month to 0.6% at six months, suggesting that there was a rapid resolution of symptoms in the general population.

Although reassuring on a population level, the authors reported that some people were still experiencing clinically meaningful mental health consequences after six months. Service providers had also reported an elevated rate of mental health use.

Children and young people - Increased levels of long-term stress, behavioural and emotional disturbance, and psychiatric illness after disasters are more likely under particular circumstances. Children and young people are particularly vulnerable. A cohort study of children in Louisiana and Mississippi found that some suffered long term persistent stressors and symptoms over the following four years and that they were nearly five times as likely as a pre-Katrina cohort to suffer serious emotional disturbance even after controlling for parental mental illness and social adversity (Abramson 2010).

Another study of health care needs in New Orleans six months after Hurricane Katrina (Springgate 2009) noted that many psychiatrists had left town, psychiatric services had all but disappeared, and there were suicidal and psychotic patients waiting for days to be seen.

Primary care - Primary care services also reported that around 90% of the patients they saw were reporting very high levels of stress from a range of causes including homelessness and from insurance issues. It is also important to consider the emotional impact on those giving the help during disasters, who may be working outside their normal area of expertise and not trained to deal with people under extreme stress (Quarantelli 1999, p.8).

Displaced families living in mobile homes and other temporary housing after Hurricane Katrina were found to have high levels of both medical and mental health problems exacerbated by poor living conditions (Madrid 2008; Jacob 2008).

In the haste to evacuate during Hurricane Katrina, those people who were not able to go to family and friends by themselves and had to rely on emergency transport out of the city were taken to totally unfamiliar locations, and some families were separated from one another and not reunited for a long time. Evacuees in temporary housing reportedly moved an average of 3.5 times, adding to the burden of stress and disruption (Jacob 2008).

There were frequent disruptive behaviour disorders, and learning problems, anxiety, depression, and stress in children, with addiction and mood disorders most common among adolescents and adults.

Other studies of displaced people six months after the disaster showed high rates of domestic violence and suicide (Larrance et al. 2007), as well as substance abuse in adolescents (Rowe and Liddle 2008).

Moreover, services were ill equipped to cope with co-occurring substance and traumatic stress reactions. Several authors report on family-based interventions as being a preferred approach in such circumstances to support resilience in families and communities (Rowe & Liddle 2008; Landau 2008), but avoiding the extent and duration of displacement from social networks altogether may potentially have been a better approach.

HIAP messages:

"Health begins where we live, learn, work, and play"

Health starts – "long before illness – in our homes, schools and jobs"

Health in All Policies (HiAP) is an approach that acknowledges the causes of health and wellbeing lie outside the health sector and are socially and economically formed.

HiAP highlights the connections and interactions between health and other sectors and how they contribute to better health outcomes.

Health Impact Assessment (HIA) is a tool to meet HiAP goals.

Other Information Sheets in this series

Information Sheet 1: Background and key areas of health

Information Sheet 2: Introduction, Recovery phase and Lessons from Napier Earthquake of 1931

Information Sheet 3: Immediate response phase

Information Sheet 4: Equity issues

Information Sheet 5: Housing issues

Information Sheet 6: Mental Health issues

Information Sheet 7: Social cohesion and resilience

Information Sheet 8: Community participation issues

Information Sheet 9: Economic recovery

Information Sheet 10: Sustainability: mitigating future disasters

Information Sheet 11: Heritage buildings

Information Sheet 12: Reflections on literature for Christchurch recovery

Information Sheet 13: Limitations to consider

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For more information visit

http://www.cph.co.nz/About-Us/Health-in-all-Policies/Default.asp

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