Ensuring care for patients in custodial psychiatric hospitals in emergencies

Long-stay custodial psychiatric hospitals, which often hold people with mental disorders for a lifetime, are of human rights concern at all times, but especially in war and other emergencies (panel 1). Large psychiatric hospitals tend to hinder rather than facilitate recovery from mental illness.[1] The failures of such hospitals include inadequate treatment services, repeated ill-treatment of patients, insufficient inspection and quality assurance procedures, and absorption of financial resources for mental health services. Many countries are gradually phasing out custodial psychiatric hospitals while strengthening community mental-health services.[1]

During emergencies, children, women, elderly people, and people with severe physical or mental disorders and disabilities are all rightly classed as vulnerable groups. Patients in custodial psychiatric hospitals are one of the most vulnerable of these groups for at least three reasons. First, they tend to live in physical isolation from their families, who may have lost the sense of responsibility or capacity to provide care. Second, they are less likely to receive help from community members because of social stigmas and misplaced fear of mentally ill people. Third, some may have lost survival skills due to illness and prolonged incarceration and have become too dependent on others to take any initiative during an emergency.

During emergencies, public-health officials—working under the final responsibility of the minister of health—have many tasks concerning reducing mortality, disease, and injury and ensuring a functioning health system. Yet health officials must not disregard the care and protection of patients in institutions—an issue that we think of public-health concern. With respect to custodial psychiatric hospitals, we perceive five core responsibilities for public-health officials in emergencies.

- Whether the emergency is a war, flood, or earthquake, all health facilities, including custodial psychiatric hospitals, and their staff and patients should receive special protection.
- Hospitals should have a crisis contingency plan that includes: a hierarchy of responsibility for keys so that doors can be unlocked at any time; and steps to be taken, such as securing stocks of psychotropic drugs, if there is advance warning of a crisis. In countries where emergencies are rare, health workers' interest in such preparation may be low, and impetus might need to be generated by drawing attention to reports of emergencies elsewhere.
- Patients' basic physical needs must be met: potable water, adequate food, shelter, and sanitation, and access to treatment for physical disease and injury (panels 1 and 2).
- Human-rights surveillance should be implemented or strengthened. During emergencies, when resources and staff numbers may be low, patients are at increased risk of neglect, punishment, and physical and sexual abuse. Increased surveillance, especially by senior staff, can reduce the risk of violations.
- At a minimum, basic mental health care should be provided throughout the emergency—essential psychotropic drugs and psychosocial support. Sudden discontinuation of psychotropic medication can be harmful and even dangerous. If the crisis creates staff shortages, family or community members, if available, may be recruited to assist in basic care.

Addressing these tasks during emergencies is complex. Many aspects of emergencies are difficult to predict, and strategies to protect patients need to be able to be rapidly changed. Health workers may feel torn between caring for patients and protecting themselves and their families. When needs are many, priorities should be set. Physical protection and ensuring adequate water, sanitation, nutrition, and very basic health care for inpatients can be regarded as fundamental priorities.[2] Nevertheless, ensuring protection and ongoing care can be an impossible feat for health officers, as was the experience recently in Baghdad (panel 1). The final responsibility for protection lies not with health officials but with security forces.

By focusing on custodial psychiatric hospitals, we do not wish to draw attention away from other institutions (eg, for elderly or physically disabled people) in which many of the same concerns apply. However, severely mentally ill people—in or out of institutions—are often forgotten in emergencies,[3] especially since mental health resources are directed most often to people who have been exposed to traumatic stressors.[4] The impetus to develop and implement new mental health programmes in the event of emergencies could be used to shift existing models of care and develop appropriate community services for people with severe mental disorders.[1]

Panel 1: **Al-Rashad Psychiatric Hospital, Iraq, 2003**

"ICRC staff visited the Al-Rashad psychiatric hospital in the east of Baghdad, where the situation was found to be very bad . . . Between 9 and 11 April waves of looters descended on the facility, burning everything that was not stolen. The hospital director reported that some patients had been raped. On 10 April, the 1050 patients fled the hospital—only 300 patients have so far returned but their living conditions are dire. The hospital lacks sufficient drinking water; it has no water for washing or cleaning, meaning it is extremely dirty; and only very limited food is available for patients. It also needs to be completely renovated since warehouses, offices, wards, residences, kitchens, workshops and laundries have all been destroyed. As a first measure, the ICRC provided nearly 30 000 litres of water for cleaning and drinking as well as food and fuel and oil for the generator."

Quote from International Committee of the Red Cross (ICRC) News. Iraq bulletin: April 17, 2003.

Panel 2: **Shtime/Stimlje Special Institute, Kosovo, 1999**

"During the war, most staff from Shtime/Stimlje Special Institute in Kosovo left the area and the institute was left to its own. Few staff members stayed behind. Patients were locked in their wards and rooms. An uncertain number of inmates died because of hunger, cold, and health complications due to the difficult conditions. The situation described is not dissimilar to the ones that occurred in some Bosnian and Croatian custodial hospitals during war in the 1990s."

Source: Urbina, L, WHO, personal communication, May, 2003.

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1 WHO. World health report 2001. Geneva: WHO, 2001.
2 Bise G. Les malades mentaux et la guerre. Geneva: ICRC, 2001.
3 Silove D, Ekblad S, Mollica R. The rights of the severely mentally ill in post-conflict societies. *Lancet* 2000; **355:** 1548–49.
4 Weiss MG, Saraceno B, Saxena S, van Ommeren M. Mental health in the aftermath of disasters: consensus and controversy. *J Nerv Ment Dis* (in press).