**Older persons with mental health conditions in situations of risk and humanitarian crisis: contribution of the WPA-SOAP and IPA**

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**Introduction**

People across the world are living longer. The world’s population over age 60 years, estimated to be 1 billion in the year 2020, is projected to double by the year 2050, to reach 2.1 billion. People over age 80 years are the fastest growing age cohort and expected to triple between 2020 and 2050 to reach 426 million[[1]](#endnote-1), 2, 3. Of these, 20% are estimated to have a mental health condition and 60% live in low- and middle-income countries where barriers (stigma, poor access to social and health care systems, low awareness, lack of policy implementation) lead issues even during stable times4. A humanitarian crise is defined as a singular event or a series of events that are threatening the health, safety or wellbeing of a community or group of individuals and require action that is usually urgent and often non-routine5. There is an urgent need of an international commitment to plan for humanitarian emergencies that include individual and community psychosocial support for older persons with and without mental health conditions. The current lack of inclusion of older persons in a humanitarian response and related policies is dramatic and constitute a clear violation of their human rights. Governments and humanitarian actors need to do more during crisis to ensure that individual's specific needs are addressed. The CRPD6 clearly states this in article 11:

*“States Parties shall take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.”*

A humanitarian response includes the collective actions of actors responding to the global needs5. Each state has the responsibility first to take care of victims of emergencies occurring on its territory. Humanitarian actors must provide assistance in accordance with the principles of humanity, neutrality, and impartiality. Promoting and ensuring compliance with these principles are essential elements of effective humanitarian coordination, in respect of the Human Rights principles, when vulnerable people such older persons with mental health conditions are involved.

Despite the increased risks older persons face during humanitarian crisis, they often are less visible in assessment and planning processes and receive less attention than younger persons and therefore, are excluded of programmes of aid. No specific service provisions are available for them. Lived narratives of older adults during humanitarian crisis are often silent in literature.

This document outlines the views of two global organizations - World Psychiatric Association Section of Old Age Psychiatry (WPA-SOAP) and International Psychogeriatric Association (IPA) - on the need to protect older persons with mental health conditions and psychosocial disability during humanitarian crisis. This is a contribution of both associations to the call for input made by the Committee on the Rights of Persons with Disabilities, UN-OHCHR (<https://www.ohchr.org/en/calls-for-input/2023/day-general-discussion-and-call-written-submissions-article-11-convention>).

**General considerations**

1. *Dimension of the problem*

During the year 2017 alone, there were 335 natural disasters that affected more than 95.6 million people globally: 9,697 people were killed7, 8. In 2018, 68.5 million people had been forcibly displaced worldwide because of persecution, conflict, or generalized violence. These numbers include 20.2 million refugees, 3.2 million asylum seekers and 39.7 million internally displaced persons: 3 per cent of refugees were over 60 years of age in 2017. In 2018, 84 per cent of displaced persons were hosted in developing regions, where service systems, including services required by older persons are already limited during normal times and the capacity to scale them up to cope is reduced. Displaced older persons often face additional difficulties when trying to reintegrate host original communities: they have reduced opportunities to participate in or build social networks, such as through education or work7, 8, 9. It is important to note, however, that even though, older people do not constitute a majority of displaced persons by any means, one reason for that is their limited ability to relocate due to frailty and other psychosocial vulnerabilities. Hence, older persons often are particularly vulnerable even when they stay in their own home country. In summary, one in every 70 persons around the world suffer the consequences of humanitarian crisis and need urgent support and care10.

An update of WHO estimates for the prevalence of mental disorders in conflict-affected settings was recently made and the burden per 1000 population was calculated. Authors estimated that the prevalence of mental disorders (depression, anxiety, post-traumatic stress disorder, bipolar disorder, and schizophrenia) was 22·1% at any point in time in the conflict-affected populations assessed. The mean comorbidity-adjusted, age-standardized point prevalence was 13·0% for mild forms of depression, anxiety, and post-traumatic stress disorder and 4·0% for moderate forms. The mean comorbidity-adjusted, age-standardized point prevalence for severe disorders (schizophrenia, bipolar disorder, severe depression, severe anxiety, and severe post-traumatic stress disorder) was 5.1%. Unfortunately, no specific data concerning older persons were available.

1. *Defining the population concerned*

Data concerning older victims of humanitarian crisis is inadequate, partially due to challenges in defining old age and an older person. Older people are a heterogeneous group and part of society, not a distinct and homogenous group. Moreover, older persons with mental health conditions are not solely represented by their age or their mental health condition and a negative valence should not be automatically assumed12. Refugees and other displaced populations may in some cases be more likely to express attributes and be considered “older” at a much younger age. Age cannot be limited to just an arbitrary number. Notions of age may vary according to circumstances, conditions, culture and other considerations and factors, which are themselves subject to change. Ageing must be considered as a social contextual construct, involving far more life-course factors and conditions than just chronological or numerical age, such as biological and socioeconomic determinants, which are also subject to change7.

1. *Specificities of the older population in a humanitarian crisis context*

Older persons in emergency contexts may have intrinsic vulnerabilities (poor health, disability, or frailty), extrinsic (due to low income, low degree of literacy or the remoteness of the place of residence, risk of abuse, limited access to resources and rescue provisions) or due to systemic factors (lack of disaggregated data, or failure to assess needs correctly or to monitor the effectiveness of assistance provided)7. This may be explained by the heterogeneity of this group of persons and the other forms of vulnerability older persons may experience such stigma, discrimination in terms of gender, race, education level, income, health status, or access to justice – that have been accumulated during a lifetime. If older persons don’t have the possibility to enjoy their rights in normal times, the risk of their rights being violated during a humanitarian crisis will increase, in many ways including:

* Discrimination in access to basic needs for survival such as food, water, sanitation, shelter, health services, protection, and livelihood support
* Denial of the right to exercise legal capacity
* Lack of access to services for their specific needs
* Physical and sexual abuse, exploitation, violence, neglect and arbitrary detention
* Abandonment or separation from family during displacement
* Abandonment and neglect in institutional settings
* General age-based discrimination in refugee and rescue settings
* Imposition of choices, restricted autonomy and secondary preference for help-seeking

Physical and mental health conditions associated with the ageing process which are manageable under normal circumstances and do not compromise the older persons’ wellbeing or their activities of daily living, may become severe limitations during a humanitarian crisis. The loss of supporting devices (e.g. eyeglasses, hearing and mobility aides, etc.) may reduce their capacity to cope with changing situations (for example, during evacuation)7. Sensory deficiencies and cognitive impairment may affect their capacity to understand emergency instructions. Chronic and acute mental health conditions may cause older persons hardship affected by the emergency living conditions e.g. in shelters, where crowding, loss of intimacy, increased noise levels, and overcrowding cause a reduction of their autonomy and independence13, 14. Other difficulties are the limited digital literacy and impede awareness about help-seeking and legal provisions during such crises.

Older persons during humanitarian crisis are particularly vulnerable to violence, abuse, and exploitation. They may suffer from loss of social connectedness that helps to protect their health and well-being by providing emotional and practical, informational and appraisal support15, 16. This can be crucial during the crisis when they lose their family members or other caregivers that help them with their daily activities. Very often older persons remain in their places of origin even when their family and community evacuate because they are an impediment to rapid evacuation or because they retain a strong sense of attachment to their place of residence, and are left behind to look after the property. Equating older adults to “hazards” in migration can make them feel discriminated, lonely and left out which increases stress and trauma of such crises, increasing the risk of mental health conditions. In these conditions they are exposed to hazards and risks and have difficulties accessing support for their survival.

Later during the crisis, they may be excluded from programmes to rebuild the shelters or other facilities necessary for their livelihood, and from financial assistance, microcredits or other recovery schemes because of their older age7.The specific needs and human rights concerns of internally displaced older persons do not automatically disappear when a humanitarian crisis ends. In fact, they usually face continuing challenges requiring support until a durable solution has been found for their displacement17.

The generalization of older persons as a vulnerable group in need of protection during humanitarian crisis impedes the recognition of their important role and contribution in reducing the harmful consequences of disasters, both during and post-disaster as resources to cope with adversity. Older persons play an important role in displaced communities, including in preserving cultural heritage, social cohesion, and connection with their country of origin7. These skills should be assessed, recognized, and utilized . These older persons should be included in all decision-making processes that may affect their lives, their family, and their community. Reducing the vulnerability of older persons in humanitarian crisis does not primarily require creating special services for them: it is more important to ensure that they have equal access to the existing support services.

**Human rights of older persons during humanitarian crisis**

Humanitarian crisis are occasions when human rights are particularly vulnerable. The respect of basic human rights is not only essential: they should guide all strategies to support and care the people in need. The essential rights mentioned as follows summarize the most important ones, but they are not exclusive.

The right to housing: older persons may wish to remain at the place where they have lived besides the risks that this option may represent for their security. Their wish must be considered. Adequate housing means accessibility, affordability, habitability, security of tenure, cultural adequacy, suitability of location, safety and access to essential services including to health care7. Older persons with disabilities should have access to facilities that address their needs and limitations. Older persons displaced because of a humanitarian crisis should have access to their properties once back to the place where they lived. They should be protected from discriminatory practices that prevent older widows from owning or inheriting property, which is a violation of their right to property7.

The right to social security: it is a duty of governments to ensure the right to social security when individuals or groups are unable to realize that right themselves, within the existing social security system with the means at their disposal. The social security system is supposed to respond in time

of humanitarian crisis. During these crises older persons may face several difficulties to access to social support as their pensions. Older refuges may be at risk to have no more access to their respective pensions. The loss of identification documentation may be a cause of a particular difficulty to have access to social rights. For refugees, mobility difficulties can hinder access to the administration to regulate their situation. All kind of access to social support may represent a particular risk of poverty with consequence to the food intake and to the continuation of health care7.

The right to work: during a humanitarian crisis older persons may often be excluded from the right to work because of discrimination based on both age and status as a refugee. The housing accommodation may let older persons unable to access of economic centers where they may find work. Discrimination also excludes older persons from the recovery efforts and their skills are not recognized. They may be also excluded of job rehabilitation programmes, income-generating activities or food-for-work programmes and from obtaining microcredit7. There is a risk of older persons need to find a place in the informal economy where they are victims of exploitation, poor working conditions or other abuses7.

The right to food and to health: older persons may need specific dietary requirements that are difficult to fulfill during humanitarian crisis. If their mobility is reduced, access to proper food may also be difficult. Access to care \ can be also a challenge. If the majority of older persons are in good health, the stress during the period of humanitarian crisis may be a factor for the onset of several health conditions or change the follow up of chronic conditions. A humanitarian crisis may reduce access to medical care, and to relevant medical records necessary for deciding on appropriate treatments and what treatments can be suspended. Moreover, even the daily routines relating to health care and nourishment can be interrupted. In the context of a humanitarian crisis, specialized access to geriatric staff become very difficult. The care most often needed by older persons, such as to prevent and treat non-communicable diseases, and access to assistive devices may also not be prioritized during a humanitarian crisis7.

**The mental health of older persons during a humanitarian crisis**

1. *Humanitarian crisis and mental health*

Mental health during a humanitarian crisis is always a concern: new mental health conditions may appear; pre-existing conditions may change their expression and increase in intensity and number, and as noted, existing conditions may hamper the ability of older persons to face the crisis. Assessment tools are virtually never designed to recognize anxiety and depression in older persons; the early stages of dementia in older persons may remain unrecognized5. The interruption of social networks and social support during a humanitarian crisis may result in limited acknowledgement of the mental health needs of older persons. There is a risk of weakened mental health infrastructure, and difficulties in coordinating facilities and staff providing mental health support. Funding for mental health and psychosocial support is often limited, and where such services are in place, younger age groups are usually prioritized7.

Humanitarian crises pose a set of challenges to the mental health care response, including (1) heightened urgency to prioritize and allocate scarce resources which depend on political will and proper governance, (2) limited time to train health-care providers, (3) limited access to specialists (for training, supervision, mentoring, referrals or consultations), (4) limited access to medications due to disruption of usual supply chain, and (5) the risk to disrespect deontological and ethical care values18, 19.

But a humanitarian crisis may also be an opportunity to improve the mental health care provision for all persons with mental health needs. Such crises also help to revisit and revise existing mental health related policies during disasters. It was the psychological impact of the world wars that supported the effectiveness of psychological interventions during the first half of the 20th century. The differences in the presentation of the psychological symptoms among the officers and the soldiers opened new ways of understanding the psychiatric reactions to stress. It was the need to support older veterans of the WW II that in UK, psychiatrists observed the need to created specific mental health facilities during the 1950’s decade. During and immediately after a humanitarian crisis, the media often rightly focus on the plight of surviving people, including their psychological responses to the stressors they face19. This as well can increase attention to mental health issues and to the impact of humanitarian crises on people’s mental health and wellbeing. Even the lessons taught by the COVID-19 pandemic suggest that mental wellbeing needs to be an inevitable component of disaster management healthcare planning.

1. *The mental health care of older persons during a humanitarian crisis*

There is limited research on how to deliver specific mental health care for older persons during a humanitarian crisis. Nevertheless, the WHO has published a Humanitarian Intervention Guide20 which offers a framework that may serve to respond to most of this population needs.

The document starts with some advice for clinical managers. According to this document the integration of mental, neurological and substance use conditions in general health care needs to be overseen by a leader who is responsible for designing and coordinating care in several health facilities, based on relevant situation analyses. Each facility has a clinic manager with specific responsibilities, and with the need to consider the following points (1) environment, (2) service model, (3) staffing and training, (4) conditions for referral, (5) raising awareness around available services, (6) on how managing medicines, and (7) the conditions for the clinical information management.

The WHO Humanitarian Intervention Guide20 proposes the general principles of care for people with mental, neurological and substance use, including (1) principles of communication, (2) principles of assessment, (3) principles of management, (4) principles of reducing stress and strengthening social support, (5) principles of protection of human rights, and (6) principle of attention to overall well-being.

Finally, the guide offers clinical recommendations to manage 10 common mental health conditions. None of them specifically addresses working in old age mental health and how to manage people with dementia is missing. It is imperative to understand that individuals living with neurocognitive disorders (like dementia) and their caregivers will face specific challenges in humanitarian crisis. Besides gradual worsening of cognitive abilities and behavioral and psychological symptoms of dementia (BPSD), such crisis may also lead to caregiver burnout, limited institutional care and restricted help-seeking that propagates sufferings of the family21. Fortunately, the Global Alzheimer’s and Dementia Action Alliance, Alzheimer’s Disease International and Alzheimer’s Pakistan have published a document addressing dementia in a humanitarian response21. The document recognizes that addressing the needs of people living with dementia during emergencies is a humanitarian and public health blind spot and it makes a list of recommendations as follow:

1. *“Ensure accessibility by eliminating the physical, communication, social/attitudinal and institutional barriers to the inclusion of those with dementia in humanitarian action.*
2. *Develop and universally use fully inclusive frameworks, standards and tools to ensure support for people with dementia in a humanitarian emergency response.*
3. *Create dementia awareness initiatives to aide disaster preparedness, humanitarian workforce understanding and community resilience in humanitarian emergencies.*
4. *Collect, analyze, report, and utilize disability disaggregated data which includes cognitive disability, and ensure the data are accessible to all humanitarian actors.*
5. *Widen the evidence base on the impact of dementia in humanitarian settings and solutions to support people living with the condition.*
6. *Foster collaboration between humanitarian agencies and dementia specialists via local, national and global NGOs/DPOs and people living with dementia, to provide specialist input across the humanitarian programme cycle, from preparedness plans to evaluation.*
7. *Monitor the inclusion of people living with dementia as part of improved inclusive action for those with cognitive and psychosocial disabilities in humanitarian programming.*
8. *Invest in an inclusive humanitarian action ensuring data collection and monitoring for cognitive and psychosocial disabilities are included within funding requirements to ensure that those living with dementia are not left behind.*
9. *Dementia-focused NGOs and organizations of people with disability develop processes for emergency preparedness and response and advise humanitarian actors on dementia-specific needs and best practice”.*

**Conclusion**

Older persons with mental health conditions are extremely vulnerable to the consequences of humanitarian crises. They have unique vulnerabilities and unmet needs. The number of victims among this population risks to increase during the next years because of the increase in size of the global older population and also of the increasing number of humanitarian crises. To let older people be forgotten in a crisis is unacceptable and it is our duty to be vigilant at all levels that older people’s needs and human rights, including in terms of mental health, are addressed Their lived experiences during humanitarian crises need to be heard out at community level and included at policy levels. Humanitarian emergencies create a human rights crisis for the older adults especially those with mental health conditions. A collective responsibility is warranted at all levels for awareness, promotion, protection and implementation of their human rights, dignity and autonomy in such conditions. This needs more research, training and policy provisions tailored for the older adults guided by the principles of the WHO Humanitarian Intervention Guide.20 and adequate response included in all policies and strategies.

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1. [↑](#endnote-ref-1)