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The Mental Health and Psychosocial Aspects of Disaster Preparedness

*Report of an Intercountry Meeting
Khao Lak, Thailand, 20-23 June 2006*



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1. Introduction

The Tsunami of 26 December 2004 caused death and destruction on an unprecedented scale in some Member countries of the World Health Organization's (WHO) South-East Asia (SEA) Region. Termed the worst disaster in recent human history, the number of people killed, displaced or affected by it was overwhelming. The impact of the Tsunami on individual lives, structures and health care systems was devastating. The five countries of the SEA Region that were worst affected happen to be diverse in many respects - geographical, cultural and economical. All of them were scarred by the Tsunami although the impact of the devastation and the response to it were manifest in different ways and in different degrees.

Different countries affected by the disaster responded in different ways and this response was based on a multitude of factors. Some of these factors operated at the societal and national level, such as having a disaster management plan in place which would allow state or local governments or affected areas to access help readily and appropriately. Other factors involved localized issues such as communication with the affected persons, setting up shelters for the displaced and providing them food, accommodation and clothing. The micro-level factors involved individual or family and kinship levels and concerned themselves with the individual's ability to look after immediate family members and friends. The experience of the tsunami provided an opportunity to review the lessons learnt in order to be better prepared to face future disasters.

It was clearly recognized in the aftermath of the Tsunami that any neglect of psychosocial support could impair efforts at physical rehabilitation. Providing psychosocial support to communities affected by disasters is a key component of WHO's strategy. Such support is crucial and has to be appropriate and culturally sensitive in order to be effective. WHO's policy requires that psychosocial support should be community-based, culturally sensitive and be provided by competently trained workers who understand the needs of disaster victims. It should also take into account the needs of special groups such as children and women, particularly widows and the elderly. To provide back-up for the community-level action, there is also a need to enhance mental health services in the countries of the South-East Asia Region.

The Tsunami experience revealed the fact that disaster preparedness plans of Member States to meet the mental health and psychosocial needs of the community were extremely limited. It also highlighted the need for every country, affected or unaffected by the Tsunami, must prepare a detailed plan to meet any contingent situation arising out of future disasters. Mental health and psychosocial relief efforts should be an integral part of disaster preparedness plans. The best levels of disaster preparedness can be achieved by having a strong community mental health system in place which can be rapidly scaled up to meet the needs of the affected people in case of disasters.

This intercountry meeting will further strengthen WHO's initiative in supporting the governments of the Member countries in their efforts to formulate plans for mental health and the psychosocial aspects of disaster preparedness.

2. Objectives of the workshop

2.1 General objective

The general objective of the workshop was to help countries to develop a plan for the mental health and psychosocial aspects of disaster preparedness based on the experiences of Tsunami-affected countries.

2.2 Specific objectives

The specific objectives were to:

- Share the experience over mental health and psychosocial relief efforts of Tsunami-affected countries;
- Discuss the mental health and psychosocial components of existing disaster preparedness plans of all participating Member States; and
- Develop a plan for mental health and psychosocial aspects of disaster preparedness which can be adapted by Member States.

3. Summary of proceedings

The workshop was inaugurated by Dr Somchai Chakrabhand, Director-General, Department of Mental Health (DMH), Thailand. The speech of Dr Samlee Plianbangchang, WHO South-East Asia Region, Regional Director, was delivered on his behalf by Dr Vijay Chandra, Regional Adviser, Mental Health and Substance Abuse.

Dr Vijay Chandra then introduced the “WHO Framework for Mental Health and Psychosocial Support” (MHPS) to the participants. This framework stipulates that no intervention is required in cases of mild psychosocial distress whereas only social intervention and psychological first aid is indicated in case of moderate distress. Mental health services could be accessed through the primary care services in cases of severe psychological distress. Severe psychiatric cases and those involving trauma will have to be dealt with through community mental health teams. The preliminary observations from the affected countries indicate that psychosocial support is an important component of management and the needs of vulnerable groups such as children, the elderly, the disabled and widows must be taken into account and accorded primacy. The cultural appropriateness of the relief efforts is also crucial.

Dr Myron L. Belfer, Professor of Psychiatry, Harvard Medical School, the United States of America, made a presentation on “Lessons Learned in Mental Health and Psychosocial Support for Children in Tsunami-Affected Communities”. It is crucial to have a broad perspective that integrates social needs into the mental health needs of children. It is particularly relevant when considering appropriate interventions in post-disaster situations such as aftermath of the Tsunami. Children represent a significant segment of the total population in the Tsunami-affected areas of the SEA Region. Children and adolescents are at particular risk and most vulnerable when they experience the death of family members, friends, teachers and others and/or are displaced from their homes, community and schools. These adversely impact on their growth and mental and emotional development. Coupled with the normal tasks of development the need for attention to child and adolescent mental health in considering comprehensive care of the community in the aftermath of a disaster also needs to be underscored.

3.1 Overview of mental health and psychosocial relief efforts following a disaster

Experts from Member States made presentations to provide an overview of the mental health and psychosocial relief efforts after the Tsunami.

In the aftermath of the disaster, ministries of health in the affected countries first attempted to restore the health services. Mental health and psychosocial support was not awarded a high priority initially but governments of the affected countries soon realized that this too was a crying need of the people. Every person from the disaster-struck areas, it was noted, had to some extent been directly or indirectly psychologically affected.

It was recognized that any neglect of psychosocial support could impair efforts towards physical rehabilitation. Psychosocial support became crucial, but to be effective, the support had to be appropriate and culturally sensitive. The immediate need after the Tsunami was to reach out to all those who had been affected. Appropriately trained community-level workers who understood the nuances of the local culture were effectively used to render psychosocial support.

In order to bolster the action at the community level, the affected countries enhanced their mental health services. One of the important recommendations of WHO is to have a strong community mental health system which would serve the immediate as well as the long-term needs of the community, provided it is sustainable and can become a part of the routine health care delivery system. Different countries have developed innovative methods of providing community mental health services. These efforts should be encouraged. At the same time, the impact of these services should be objectively assessed and changes made as necessary.

The interventions immediately following a disaster occur in four phases:

- (1) *The rescue phase*: This is the period immediately after the event and lasts about two weeks. On an emotional scale, this is also referred to as the 'Heroic Phase'. People, victims and others alike, join hands to do whatever they can to prevent the loss of life and property in a spontaneous display of altruism. There are

many accounts of people who have been in the forefront of relief work, often working for 48 to 72 hours at a stretch, and sometimes risked personal injury and suffering to help some others' lives. However, there is a dark side to relief efforts too and care must be taken to ensure that there is no looting, plundering or exploitation of the vulnerability of the victims.

- (2) *The relief phase*: This is the period lasting approximately two to six months after the disaster. This is the period when the huge outpouring of relief supplies and support from the community, voluntary agencies and from the government result in a high level of optimism about problems being dealt with and the situation improving. There is a wave of compassion, goodwill and care.
- (3) *The rehabilitation phase*: This period continues upto one to two years or more after the disaster. Disillusionment about the efficacy of the relief efforts sets in at some point of time during this phase. Bureaucratic delays and legal barriers in providing relief and promises that are not kept or those that fall short of expectations can lead to frustration. Victims realize that they have to give up the wait for help and solve their own problems.
- (4) *The rebuilding phase*: This may last years and sometimes even continue for life. Disaster preparedness, especially for high-risk and vulnerable areas, is also an integral part of this phase. Individuals and communities work together to restore normalcy. People begin to live life on their own terms and move on.

3.2 Country presentations on relief efforts and lessons learnt from the tsunami

Maldives

The government of Maldives launched a well organized community-based campaign to provide psychosocial support to the disaster-affected persons. The response at the island-level and the warm reception accorded by the host community clearly highlighted the need for developing community resilience, coping skills and promoting community relationships and harmony.

The government established a psychosocial unit in the country, indicating its recognition of the issue to be important for the community. All persons recruited and trained by the psychosocial unit were Maldivians who spoke the local language and were familiar with the native culture. All affected islands have been reached, and every affected person provided at least a modicum of emotional and psychological support through the Emotional Support Brigade. The technical content of the psychological first aid was appropriate and in keeping with WHO guidelines. The Government of Maldives requested support from select agencies only and denied access to numerous INGOs. This prevented problems of coordination between agencies, which have been reported from other countries.

Lessons learnt

- **Community cohesion:** The immediate response by the affected community itself in arranging for transportation of the injured or displaced from the affected islands to the unaffected ones was a good example of community mobilization. The warm reception accorded by the host islands also stood out as an exemplary example of mutual support within the community. Building community cohesion can be considered a vital aspect of disaster preparedness.
- **Psychosocial support by local workers:** The formation of the psychosocial unit and mobilization of the Emotional Support Brigade resulted in a substantial amount of psychosocial support being provided to far-off affected islands. This is commendable considering the fact that there are only two psychiatrists in Maldives and both are located in Male.

India

Health care in India is the responsibility of the state governments. Thus the governments of all affected states immediately mobilized their own resources to the maximum and called upon professionals and NGOs to assist in the relief efforts. These state-level efforts were strongly supported by financial and technical assistance from the Central Government.

In Tamil Nadu, the worst affected state, the Chief Minister personally took a keen interest in the relief operations. Senior administrative staff were

mobilized and given complete responsibility to implement whatever support they considered necessary. The most remarkable aspect of the Tsunami response effort in Tamil Nadu was the high level of coordination in all the activities with the focal point being the District Collectors. All activities in the districts were required to be cleared through the office of the District Collector.

The psychosocial relief efforts at the community level in the Tsunami-affected areas of Tamil Nadu were implemented by the Department of Social Welfare. Clinical support services for mental health were the responsibility of the Department of Health. Initially, mental health services were provided by clinicians of the Institute of Mental Health, government hospital psychiatrists and NGOs. These activities were welcomed by the community. Back up mental health services, however, remained limited.

Lessons learnt

- Need for effective local administration and coordination: As per Indian laws, the District Collector is the overall authority regarding all administrative issues in the district. An effective District Collector can be the key focal point in the launch and conduct of any relief efforts in a district. This was clearly exemplified in the Tsunami-affected districts of Tamil Nadu where all relief efforts were directed and coordinated by the District Collector and his office in the districts concerned. This effective control prevented disorganized activities at the community level, particularly regarding the coordination of NGOs which can sometimes be difficult as has been observed in Indonesia and Sri Lanka.
- The need for training all those involved in disaster relief work: The importance of trained Community Level Workers (CLWs) to implement an organized effort aimed at providing psychosocial relief was well exemplified.
- The need for involvement of local leaders and other influential persons, local NGOs and volunteers was also evident.

Indonesia

Indonesian government ministries such as Education, Social Affairs and Public Works started providing psychosocial support to the survivors with

the aid of international and national agencies in the immediate aftermath of the Tsunami. However, in the early phase of the emergency, the widespread devastation made coordination among different sectors weak. The collapse of the provincial government also created difficulties in service provision. Nevertheless, considerable efforts were made to address the situation during the emergency phase.

A mental health programme for Aceh was launched. The main component of the programme was the development of mental health service capacity at the primary care level and the provincial and district health offices, while at the same time strengthening capacity in the mental hospital. A curriculum and syllabus for a Community Mental Health Nursing (CMHN) course was developed by a group of mental health nursing teachers from the Faculty of Nursing, University of Indonesia. General Practitioners (GPs) in the primary health care centres (puskesmas) were also retrained in primary care psychiatry. Many public health centres allocated a specific day for treating mental health patients. The need for continuous consultation or supervision was identified after discussions with doctors. It was also felt that improvements in the training curriculum would be beneficial.

The experience of dealing with the Tsunami highlighted the necessity of developing a national disaster preparedness plan which would encompass mental health and psychosocial aspects. A quick response to any disaster depends on the existing mental health policy structure and mental health care system. The Government of Indonesia used the momentum gained in Aceh to reform the mental health system for disaster preparedness for the future. It was felt that a strong Community Mental Health System should be scaled up to prepare the needs of the community in case of another disaster.

Lessons learnt

- Role of external agencies: The role of external agencies becomes important if the magnitude of the disaster is overwhelming and the civil administration is incapacitated.
- Training of nurses and general practitioners: An innovative programme for training nurses and GPs for mental health and psychosocial support was developed to reduce the severe shortage of mental health

professionals. This helped in bridging the existing gap in the capacity to meet the needs of the community.

- Coordination: The problem of coordinating NGOs, INGOs and external agencies was an important administrative issue.

Sri Lanka

In the recent past, Sri Lanka has endured many natural and man-made disasters such as floods, landslides and also a 22-year-old lingering civil war. However, the need of psychosocial intervention was not recognized as a priority till the Tsunami happened. The President of Sri Lanka identified psychosocial support to the community as a top priority and established the National Psychosocial and Mental Health Committee to oversee these efforts.

The magnitude of the disaster in Sri Lanka was overwhelming. An important factor which hampered relief efforts was that many of the affected areas were situated in conflict zones. It took a while for the government and professionals to organize a large-scale programme as there were only 30 psychiatrists available, most of whom were based in Colombo, and virtually no other trained mental health professionals.

The initial response was spearheaded mainly by the affected communities themselves, NGOs and expatriate mental health workers. In the immediate aftermath of the disaster the emphasis was on social interventions. Soon INGOs arrived in large numbers and provided whatever support they considered appropriate.

Following a debate on the benefit of community-level work led by local WHO staff, a plan endorsing the mobilization of community-level workers was accepted by the Government of Sri Lanka, local technical experts, NGOs and international organizations. These community-level workers will link to a proposal to develop a community mental health system. A Senior Community Support Officer (SCSO) and Community Support Officers (CSOs) were appointed in each affected area. The number of CSOs appointed was based on the number of people affected in a particular community.

Pre-intern doctors were appointed and sponsored by WHO as senior community support workers with their numbers depending on the

population in each affected district. Paid volunteers have also been appointed from among the community as junior community support workers sponsored by WHO. All of them were imparted a brief training by psychiatrists.

Support from all possible sources was sought, especially in the identification and appropriate referral of persons needing psychosocial support. Teachers who would be able to deal with children were trained. Community leaders such as clergymen (*samurdhi niyamakas*) too were involved and imparted appropriate training. The media and information leaflets helped raise the awareness among the general public about possible psychological consequences of disasters.

Sri Lanka has a well-developed primary health care system. The primary health care teams consist of a Medical Officer, Public Health Inspectors, Public Health Nurse and Family Health Worker. These members were trained in recognizing disaster-related psychological problems.

Initially, teams including a psychiatrist, psychiatry trainees and nurses were sent to the camps in the tsunami affected areas. Psychotropic drugs were made available with the teams. Each of the affected districts was allocated a group of psychiatrists and their teams who would visit regularly and conduct the necessary training and management of patients referred.

Lessons learnt

- Despite the high priority awarded to psychosocial support by the President of Sri Lanka it took the government time to develop and operationalize a detailed plan for mental health and psychosocial relief efforts. This illustrates the importance of having a plan in place in advance as part of disaster preparedness.
- Coordination: The problem of coordinating NGOs, INGOs and external agencies was an important administrative issue.

Thailand

The community mental health service in Thailand is based on a pre-existing network of village health volunteers. Each volunteer is designed to take care of 8-15 families in the village. These volunteers who belong to the village,

donate time for social work. They are trained by the Department of Mental Health on basic issues of relevance to the community. A special programme was set up after the Tsunami to train these volunteers on issues specific to psychosocial relief efforts.

Sustainability of mental and psychological relief efforts in Thailand is being ensured through the establishment of the Mental Health Recovery Centre (MHRC). This centre is located in Phang Nga province, which was the most seriously affected by the Tsunami. The objectives of the centre are:

- Coordinating the work in the community of all departments of the Ministry of Public Health and of other organizations.
- Capacity building of the local community, e.g. training health workers and NGO staff.
- Establishing a mental health surveillance system.
- Facilitating community mental health work and extending support to the health network and village health volunteer.

Focus on vulnerable groups after the Tsunami in Thailand

Children and orphanages

The Tsunami affected millions of families and left many bereaved. Children were perhaps the most affected. Many thousands of children lost either parent or both. Many people lost their jobs or occupational equipment. Children could also not go to school because the school buildings were destroyed. A joint concerted effort was made by the Ministry of Health, Ministry of Education, Ministry of Interior and Ministry of Social Development and Human Security to ensure that the orphanages were registered, received scholarship and psychological support and that their other needs were met.

Children of school-going age

The Department of Mental Health (DMH) coordinated with the Ministry of Education to provide training courses for teachers to understand the needs of these children and provide them the appropriate assistance and basic psychological support. At the same time, the United Nations Children's

Fund (UNICEF) and the DMH developed through the Mental Health Team a body of knowledge and material for capacity building for teachers and health personnel. A School Advisory Programme exists in all schools and offers students the opportunity to share their concerns and enables teachers to identify children who need help. The MHRC also contributes with the deployment of its mobile van equipped with books, toys and drawing material to help affected children from the trauma.

Elderly people

The MHRC helped bolster, five clubs for the elderly and promoted social cohesion and social activities among them. These activities included religious sessions and discourses, group support, home visits to the elderly activities conducted jointly with other similar clubs and the like.

Disabled people

The Sirinthorn Rehabilitation Institute for Disabled People coordinated with the social welfare department, DMH and local health office to provide one-stop services that included providing registration, evaluation, treatment and equipment for the disabled. The local health office also surveyed for new cases after the Tsunami and offered compensation and other social support.

Lessons learnt

The strengths of the Thai response to the Tsunami were the following:

- A well established chain of command including at the political, bureaucratic and technical level.
- A well developed existing health and mental health care delivery system which could be rapidly scaled up to meet any eventuality.
- The existence of a comprehensive data and information gathering system which is optimally used by decision-makers.
- The ability of the mental health system to reach each and every village through its network of mobile teams and health volunteers.

- The participation of many other partners (teachers, monks etc) who could supplement the efforts of the health team.

3.3 Country presentations on current and proposed mental health and psychosocial aspects of disaster preparedness plans

Existing disaster preparedness plans in participating countries do not, as of now, have a significant component of MHPS support. The presentations at the meeting emphasized what they would like to include in the disaster preparedness plans of their respective countries. The key domains in MPHS disaster preparedness plans presented were: coordination, assessment, monitoring, and evaluation, human rights standards, human resources, community organisation and support for MPHS, protection, health services, education, information dissemination and social considerations.

Specific examples cited about what could be included in disaster preparedness plans were:

Bangladesh

Bangladesh has a Ministry of Disaster Management and Relief. Other government agencies dealing with disasters include: the Disaster Management Bureau, the Directorate of Relief and Rehabilitation, Disaster Management Committees at all administrative levels and the Emergency preparedness and response mechanism from health sector.

Disaster management strategy of the Government of Bangladesh

- After the devastating floods of the late 1980s and the killer cyclone of 1991, the concept of reacting to disasters was replaced by that of total disaster management involving prevention/mitigation, preparedness, response, recovery and development.
- The Government of Bangladesh (GoB) has, therefore, displayed total commitment towards reduction of human, economic and environmental costs of disasters by enhancing overall disaster management capacity.

- Efforts have been continuing for optimum coordination and best utilization of resources along with ensuring community involvement so that the people are aware of what they can do themselves to protect their lives and property against disasters.
- The plan and conduct of disaster management by the GoB involves disaster management practice, disaster mitigation and emergency preparedness and emergency response and recovery as the key aspects for building up self-reliance in the community.

Emergency preparedness and response (EPR) from health sector

Bangladesh has a well structured plan for relief for initiating efforts after any disaster which are regulated through an Incident Command Office headed by the Director-General of Health Services. The operations coordinator is the Director, Disease Control. In addition there is a director responsible for logistical support while various relevant agencies provide technical support. The authority responsible for implementation at each field level is clearly earmarked. Lastly, there is also a designated authority for supervision and monitoring.

Activities during emergencies

- Formation of Disaster Monitoring Cell (DMC) at DGHS.
- Round-the-clock control room at DGHS.
- District control room at Civil Surgeon's Office operational round-the-clock.
- Receiving reports on a daily basis from Upazila Health Complex (UZHC) and sending them to DGHS, DMC/control room on a daily basis.
- Upazila Control Room at UZHC operational round-the-clock to receive reports from Health Inspector/Assistant Health Inspector/Health Assistant and send them to the Civil Surgeon's Control Room on a daily basis to monitor any incident including disease outbreaks during and after the disaster.
- Operation of Rapid Response Team at all levels, including DGHS, Institute of Epidemiology, Disease Control and Research and the National Institute of Preventive and Social Medicine.

Co-ordination of activities during emergency

- Regular meetings at the Ministry of Health and Family Welfare along with other ministries concerned, including local government institutions and disaster management bureau.
- Daily meeting with DHGS operational staff for situation analysis, decision making and instant execution.
- Coordination and collaboration with social/political/religious leaders, local administration, NGOs, Community Based Organizations (CBOs) and other partner agencies.
- Dissemination of daily situation report explaining current updates and measures taken.
- Teleconferences with field-level executives for close supervision and monitoring.

Activities of existing mental health services

Currently, there is no special team or committee for the management of disaster-related psychosocial problems in the community. Psychiatric services are not yet incorporated in the existing health sector disaster relief plans and services.

The National Institute of Mental Health (NIMH) in Dhaka and all medical colleges have a Department of Psychiatry. One medical officer has been trained in basic mental health issues for the UHC (primary level). Trained field workers and imams (religious leaders) also help patients by providing psychological support and proper guidance and referral to seek medical care.

Evidence-based response

The importance of mental health and psychosocial needs of disaster affected communities was brought out in a study carried out by “Social Assistance and Rehabilitation for the Physically Vulnerable (SARPV) Bangladesh” that followed the violent tornado of 13 May 1996 which had struck Tangail district. The objectives of the study were:

- (1) To assess the extent of psychological effects/trauma among women and children and following the disaster.
- (2) To assess the need for psychological services for the affected population.

Important findings of the study include:

- (1) Women were more affected psychologically than men.
- (2) Two out of three people surveyed in the disaster area were psychologically traumatized and required emergency psychological services.
- (3) While 65% of the subjects of the survey aged 18 years and above living in the disaster area needed psychological services, 80% of those of below 12 years and 29% of children between the ages of 13 and 17 years needed such services.
- (4) While 60% of all males aged 18 and above in the disaster area were in need of psychological services, 80% of the females from the same areas required such services.
- (5) One psychiatrist was employed for diagnosis of psychiatric illness in 14 cases, of which four were in the moderate category and 10 severe.

Suggestions for the future for MHPS activities

Suggestions for the incorporation of mental health and psychosocial support activities for an emergency preparedness plan include:

- Mental health services should be provided in the community through a community mental health system which will include health workers, community leaders, religious leaders and GPs. A model for such a community-based system will be developed in four districts in the 2006-2007 biennium with WHO support.
- Development of psychiatric services in general hospitals.
- Rehabilitation for the community of chronically ill psychiatric patients, including social welfare, occupational therapy and liaison services.

- Ensuring the availability of psychotropic medications at the primary and secondary level hospitals
- Increasing the number of mental health professionals being imparted training.
- A Mental Health Act should be enacted by the government. The draft of the same has been submitted to the government.
- National Mental Health Policy should be accepted and implemented by the government.
- Enhanced capacity for dealing with situations of acute crisis in emergencies such as disaster-related emergencies suicides etc. should be created.
- Exchange of knowledge and information with regional and global organizations for training and research, such as with WHO, Royal College of Psychiatrists in the UK, WPA etc., should be encouraged.
- Drills should be conducted to practice implementation of the MHPS disaster preparedness plans.

Bhutan

Although Bhutan has an overall disaster preparedness plan the same does not include a separate MHPS component. One of the biggest constraints for the health care system in Bhutan is the sheer lack of an adequate number of trained mental health professionals. The rugged geographical terrain and a population sparsely dispersed over mountains and valleys also throws up considerable transport, communication and logistical challenges. The lack of other resources such as funding also compounds the problem in times of disasters

It is proposed to include a separate MHPS plan to make the disaster preparedness plan and policy holistic and comprehensive so as to be able to address the psychosocial needs of victims. This plan should include a well-developed community mental health system which can serve the needs of the community at any point of time and can be readily mobilized in the event of a disaster. This plan should also include empowering the community to launch the first response to a disaster and developing

community resilience, building coping skills and promoting community relationships and harmony. A plan for assessment of psychosocial distress in the community should be in place and roles and responsibilities of community-level workers should be clearly defined. Accordingly, a four-tier service delivery system as recommended by WHO is being proposed so that people can find solutions to all their mental health needs within the communities they live.

Specialist mental health and psychosocial counselling team

This team at the national level consisting of a psychiatrist, a clinical psychologist and two or three trained mental health nurses will form the core technical team to advise the National Disaster Risk Management Committee on psychosocial issues as well as train and supervise the work of the district-level community teams and primary health care workers. This team will also screen and organize referral to the regional and national referral hospitals for severe cases which cannot be managed at the community level.

Current situation

Currently, there is one trained psychiatrist and five trained psychiatric nurses in the country working in the referral hospitals. One more trained psychiatrist has completed his training abroad and is due to join service very soon. One of the trained mental health nurses is based at the Health Ministry and is working as the Programme Manager for the National Mental Health Programme. There is no clinical psychologist available but there are plans to train some of them in the future. This group of mental health professionals is based in the referral hospitals and manages severe disorders referred from the peripheral health facilities. They also travel around the country to train and supervise the peripheral health workers on mental health. In addition, they also participate in teaching mental health subjects to students at the Royal Institute of Health Sciences, which trains all categories of paramedical personnel in Bhutan. To date, about 50% of the peripheral health workers have been trained by this team in the management of common mental disorders in the community.

District mental health and psychosocial counselling team

A district mental Health Team consisting of a medical officer with mental health skills, a district health supervisory officer endowed with management skills and three to four trained nurses or health workers including one or two trained in psychosocial counselling can provide services through mobile and outreach facilities or through the primary health care network in the community. Though this team is usually based in the district hospitals, it can be activated when the need arises to become a mobile or a community mental health team. The primary function of this team is to manage cases admitted in the district hospitals. But, it also has additional responsibilities to train and supervise primary health care workers and community-level workers including village health workers.

Current situation

Short and medium-term training on mental health is offered on a regular basis to general doctors and health workers based at the district hospitals. On account of the rapid turnover of general doctors in the country, it has become mandatory to impart training to them in the districts annually. A few selected medical officers and assistant clinical officers also participate in three-month attachment courses at institutions such as (NIMHANS), Bangalore, India. These selected medical officers and assistant clinical officers form the core team of trainers at the district level. The specialist team from the centre will shortly train about 20 new doctors on basic psychiatric skills and psychosocial rehabilitation. Hospital-based nurses also get a shorter version of training on mental health with the emphasis on communication and management skills.

Community mental health and psychosocial counselling team

This team consisting of health assistants and auxiliary nurse midwives (ANMs) are based in the basic health units in the community. They can operate from their bases or go mobile through their outreach clinics or at disaster sites. Their primary responsibility is to provide psychological first aid and identify and refer people who need additional psychosocial help. They also work closely with community-level volunteers and assist in conducting training for them.

Current situation

This group, based at the Basic Health Units in the country, forms the backbone of the nation's primary health care system. Since this category of health workers did not receive considerable pre-service training on mental health issues, efforts are now made to train them on basic psychiatric skills and psychosocial rehabilitation. To date, health workers in eight of the 20 districts in the country have been trained. The pre-service training curriculum for this group of workers has also now been revised to include mental health and psychosocial rehabilitation.

Community volunteers and psychosocial support team

This group comprises religious leaders, teachers, extension workers, village health workers and other volunteers in the community who will take on the responsibility to provide psychological first aid and other psychosocial support to the victims of disasters. They will work closely with the community mental health teams as well as the community leaders.

Current situation

Traditionally, Bhutanese enjoy close family and strong community support through the extended family system. Families, however, are becoming increasingly nuclear especially in the urban areas with development and modernization. Therefore, there is the need to develop new community support systems in towns and cities. Teachers, agriculture extension workers, village health volunteers, traditional healers and religious and community leaders can be mobilized and trained to provide psychosocial first aid in times of disasters.

There is an ongoing programme on training village health volunteers on health matters including psychosocial rehabilitation and sharing ideas and information on mental health between modern health workers and traditional and religious healers. The school health and youth scouts programme also incorporates training in basic psychosocial counselling and rehabilitation. Efforts are being made to train policemen and other community-level workers on psychosocial counselling and rehabilitation.

Challenges

One of the biggest constraints for the health care system in Bhutan is the lack of an adequate number of trained mental health professionals. There exists the need to train more many mental health professionals as well as offer short-term courses on mental health and providing psychosocial counselling and rehabilitation in times of disasters to all categories of health workers. The rugged geographical terrain and low population density in the mountains and valleys pose huge transport, communication and logistical challenges. Lack of other resources such as funding also adds to the challenge in times of disasters.

India

India has been struck by numerous disasters in the recent past including, among the major ones, the Bangalore circus tragedy (1981), Bhopal gas tragedy (1984), Gujarat cyclone (1998), Orissa supercyclone (1999), Gujarat earthquake (2001), annual flooding in large parts of the country during the monsoon, and the tsunami of 2004. The response to disasters has gradually improved over the years as lessons have been learnt from each disaster and adapted.

Factors that have inhibited the response to disasters in the past include the lack of a national- level plan policy, absence of an institutional framework at the centre/state/district level, poor inter-sectoral co-ordination, lack of an early warning system, slow response from the relief agencies, lack of trained/dedicated search and rescue teams, and poor community empowerment.

There are also certain legal impediments to relief efforts. Disaster relief is not directly included in the Union, State or Concurrent list of legislative subjects of India. There is no Central legislation in force except for the Environment Protection Act of 1986. In the federal system of governance, the primary responsibility for conducting rescue, relief and rehabilitation operations vests with the state governments. The Centre plays only a supportive role in terms of providing physical and financial resources.

The supercyclone in Orissa (1999) and the Gujarat earthquake (2001) led to some re-thinking of government policy. These disasters underscored the need to adopt a multidisciplinary, multisectoral, multi-hazard approach.

It was realized that mitigating the impact of disasters should be an integral component of development planning. Vulnerability analysis and risk reduction should be incorporated in the developmental plans and strategies. This rethinking has led to a paradigm shift from rescue and relief to disaster preparedness, mitigation, robust response, reconstruction and sustainable development.

The Ministry of Health (MoH) is the nodal ministry for biological disasters and plays a supportive role for all other disasters. The current role of the MoH includes formulation of policy guidelines, health sector disaster planning (hospital structural mitigation, hospital preparedness/ clinical management, immediate medical care (including trauma care and medical supplies), capacity building in the health sector (disaster prevention, mitigation, preparedness, response and early rehabilitation) and instituting public health measures including disease surveillance and epidemic response. It also plays an advisory role to state governments, in advocating for health in other sectors and for inclusion of disaster reduction/mitigation measures in development activities.

A National Health Policy was developed in 2002. It has a section on dealing with disasters which calls for “an adequately robust disaster management plan (has) to be in place to effectively cope with situations arising from natural and man-made calamities”. The Plan describes Disaster Mental Health as “a service that focuses on the mental health needs of those directly affected by a disaster (primary victims), relief personnel, and those indirectly affected (secondary victims)”.

The current primary objective of the Disaster Mental Health service is to restore the normal way of life in the community after the occurrence of the tragedy. It works towards restoring the psychological and social functioning of individuals and communities. It also attempts to limit the occurrence and severity of adverse impacts of disaster related mental health problems. The specific objectives are to provide counselling for survivors, screening for those who need specialized care, group therapy, capacity building through training (master trainers, health professionals, health workers, teachers, anganwadi staff, volunteers, NGOs, CBOs), planning and sensitization of officials.

Disaster mental health is an emerging issue in India. Three phases are proposed for the development of Disaster Mental Health services:

preparation, direct services and operational research. Three specific tasks envisaged for MHPS services are psychological first aid, triage of those who need specialized services and assessment of the magnitude of psychological distress.

The proposal calls for the psychosocial interventions with disaster-affected populations to be social and culturally sensitive. Mental health workers need to set aside traditional medical methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully in the aftermath of disasters. The detailed plan outlines specific activities to be conducted at specific times after a disaster.

Indonesia

A National Disaster Preparedness Plan (NDPP) has been developed but MPHS aspects are not included in the plan and MPHS programmes not integrated into disaster preparedness and contingency plans.

Experts from Indonesia have recommended that the MHPS disaster preparedness plans should include:

- (1) Mapping and assessment of the MHPS needs of the affected community.
- (2) Collaboration and coordination between all stakeholders.
- (3) Integration and access to mental health services for all into the primary health care system.
- (4) Capacity building through training and supervision of health staff to increase competency.
- (5) Monitoring and evaluation of MHPS services to ensure that the objectives are being met.
- (6) MHPS services should be decentralized up to the local level of the administration

The suggested MHPS preparedness at different levels of the administration include:

National level

- I. Develop policy, standard and guidelines:
 - (1) To develop policy and guideline on prevention and management of MHPS problems in affected communities.
 - (2) To develop guidelines of information and IEC materials about MHPS problems for the community.
- II. Advocacy and facilitation:
 - (1) To facilitate intersectoral meetings with community elements at the national level.
 - (2) To conduct campaigns on prevention and management of MHPS problems for affected communities.
 - (3) To encourage growth and development of MHPS network at the local, national and international level (which involves health, social, religious education, and security sectors and media, donor agency and community elements).
 - (4) To impart training to trainers at various levels on early detection and management of MHPS problems.
- III. Monitoring and evaluation:
 - (1) To develop an information network system on MHPS problems at the local, national and international levels by coordinating with the MoH.
 - (2) To arrange formal and informal coordination meetings on prevention and management of MHPS problems.
 - (3) To encourage educational institutions to incorporate MHPS issues in their curriculum for health personnel (*nurses, midwives, public health officers, analysts, doctors*), psychologists and social workers.
 - (4) To develop instrument for RAMH.

Provincial level

- (1) To prepare implementation and technical guidelines on prevention and management of MHPS problems.
- (2) To map areas that face a high risk of disaster occurrences by identifying types, characteristics and locations of disasters, local socio-cultural conditions and possible points of evacuation.
- (3) To provide information and education to communities about the possible situation in the aftermath of a disaster through the media or group approach.
- (4) To impart training to personnel in the provinces and at the district level (programme managers, health personnel in hospitals, PHCs and in the communities).
- (5) To develop a network in the provinces that includes various sectors and community elements.
- (6) To develop an information system about MHPS support in the provinces and districts.
- (7) To periodically organize coordination meeting among government offices, private institutions, organizations, universities and community elements.

District level

- (1) To identify areas that are high risk or prone to conflict, vulnerable groups such as children, adolescents, women, elderly and the disabled, sociocultural situation and possible sites for evacuation in the event of a disaster.
- (2) To impart psychosocial education to the community and deliver information about mental health and psychosocial services that are available to them.
- (3) To organize MH teams for prevention and management of MH and PS aspects in PHCs after disasters. These teams should be mobile and ready to take action in the community (mobile teams).

- (4) To train potential work force in the community such as villagers, religious leaders, women leaders and teachers to conduct education sessions on prevention and management of MH and PS aspects following disasters.
- (5) To periodically organize coordination meeting among government offices, private institutions, organizations, universities and community elements.

Maldives

No emergency preparedness and response plan existed in the Maldives prior to the Tsunami but, for an airport contingency plan. In July 2005 the Ministry of Health developed a draft health sector EPR plan supported by WHO. It is expected that the health sector EPR will become part of the Health Master Plan as well as of the National Disaster Management Plan. The plan contains components of MHPS based on recommendations of the National Workshop on Current Status and Future Preparedness in Mental Health and Psychosocial Aspects in Disasters held in Male, Maldives, on 14–15 September 2005. Recommendations to be included in the Health sector EPR plan for MHPS aspects of disaster preparedness in Maldives include:

- The national disaster preparedness plan should include MHPS aspects of a disaster.
- One ministry should be designated as the lead ministry for MHPS support in any future disaster. The Ministry of Health was recommended for the role.
- Coordination mechanisms and responsibilities between ministries at the ministerial level with a clear chain of command and responsibility for MHPS should be in place. A good example for interagency coordination for disaster preparedness could be the coordination of ongoing activities on MHPS between various agencies such as MoH, WHO, UNFPA, Ministry of Planning, American Red Cross and NGOs.
- All stakeholders interested in MHPS should be identified and a list prepared.

- Every project related to MHPS now and after any future disaster should be implemented after clearance from the lead ministry and be a part of the overall strategy.
- The role of external international organizations, particularly INGOs should be carefully considered now and in the future.
- Training workshops and periodic drills of all stakeholders should be carried out to implement the MHPS component of the disaster preparedness plan.
- Technical material such as training material for community-level workers, survey instruments to be used, guidelines for NGOs and the media etc. should be validated for use in Maldives and be made readily available.
- Communication equipment should be installed/upgraded regularly.
- A 'risk communication' strategy for disseminating essential information during emergencies should be prepared.
- Efforts in empowering the community to launch the first response to a disaster and developing community resilience and coping skills and promoting community relationships should be encouraged
- A well-developed community mental health system is the best form of disaster preparedness. This can serve the needs of the community now and can be readily mobilized during a disaster. Details of such a system are provided in the proceedings of the national workshop.

Myanmar

Myanmar has a disaster preparedness plan with a component of MHPS issues. Psychiatrists are almost always involved in relief programmes after any disaster. However, the psychosocial component of the plan is not very detailed. Some technical documents for MHPS are available but more are needed.

Myanmar also has a National Emergency Health Care Plan for Disasters. Its objectives are to reduce burden and vulnerability in a disaster; to prepare a plan for emergency health measures, and to promote health

infrastructure. The National Health Committee guides the Emergency Health Care Committee which comprises representatives from the Ministry of Health, Myanmar Red Cross, NGOs, Department of Administration, Department of Relief and Resettlement and two nominees of the President. The main committee implements programmes before, during and after a disaster. The functions of the committee are to:

- Draw up an emergency health plan for a disaster.
- Mobilize medical teams, including teams, for psychological support.
- Provide for health personnel.
- Procure items needed for relief to victims.
- Promote disease surveillance and prevention of communicable diseases.

The community-level response is led by the state/division level team which includes a psychiatrist as one of its members. The functions of this committee are to:

- Collate information from disaster areas and promptly send emergency teams there.
- Provide access to adequate water, sanitation and safe food.
- Record and report all loss of livelihood to the central level.
- Provide emergency clinic and health education to the community.
- Allocate manpower and support for technical, logistics, environmental health, media operations, food safety, epidemiology, disease control, surveillance and emergency preparedness and response operations.

Specific activities conducted on MHPS

- (1) Training of psychiatrists and TMOs from states and divisions on mental health and psychosocial aspects of disasters. The content of the training included:

- (a) Psychological consequences of disasters
 - (b) WHO guidelines for intervention strategies for health officials in the field, and
 - (c) Disaster management (World Psychiatrists' Association).
- (2) Training course on mental health and psychosocial relief after the tsunami (mental health nurses and MOs) and multiplier courses - in the states and divisions.
 - (3) Training on disaster preparedness to medical officers from various regions (course content includes stress management and PTSD prevention and management).
 - (4) A Community Mental Health Programme was launched in 1990 and psychiatrists were posted in all states and divisions. The Community Mental Health programme is integrated into the PHC programme.

Activities proposed for MHPS

- (1) A national workshop on psychosocial aspect of disasters in September 2006
- (2) Development of technical material for counselling in psychosocial aspects of disasters (included in WHO country budget 06/07)

Nepal

Nepal has a high degree of vulnerability to natural disasters compounded by the ongoing violent civil conflict that affects almost all districts of the country. Emergency preparedness and response is not adequately addressed by the Ministry of Health in its policies and planning. There is also a scarcity of financial resources and limited capacity and expertise.

The combination of topography and weather conditions makes many parts of the country inaccessible during the winter and rainy season. This creates logistical problems in accessing potential disaster sites in remote areas. Floods and landslides are the most regularly occurring and most threatening water-induced hazard in Nepal.

Epidemics are a major health concern in Nepal. The transmission route relates to contaminated water and food, person-to-person contact and various type of vectors. Morbidity and mortality from diseases of epidemic potential are likely to continue to rise in the near future due to the increase in population density combined with a lack of safe drinking water, sanitation facilities and basic health education.

Fire poses a serious threat in many areas in Nepal, especially in the Terai. In areas of high population density what starts as a small kitchen fire can quickly spread and become a major disaster in the neighbourhood. The immediate human fallout includes deaths and burn injuries, damage to property, disruption of life and loss of valuable documents.

Mass casualty influxes by conflict situation, both intentional and non-intentional, are increasing due to rapid changes in political, social and economic scenarios in the country and the region. Conflict situations have become a regular feature in recent times. War or war-like situations are the worst-case scenario in this category. Other complex mass casualty incidents can be caused by mob dispersal methods such as *lathi charge*, firing of rubber bullets and tear gas shells used during riots. The experience of the emergency imposed in February 2005 showed that the emergency preparedness plans in general have not been prepared well enough but the health system was able to cope well due to prior training.

In 2003 a set of guidelines for district health workers was developed by the Department of Health Services, Epidemiology and Diseases Control Division, in collaboration with WHO. This could be adapted for training health workers in psychosocial relief efforts.

Evidence-based planning

The Kathmandu Earthquake Risk Management Project had estimated the magnitude of the aftermath of an earthquake as severe as the one in Bihar, India, if such a one occurred in the Kathmandu Valley at this point in time. The estimates of deaths, injuries and damage were:

- No. of deaths: 40 000
- No. of injured: 95 000
- No. of buildings destroyed: 60% of existing buildings, many to the point beyond repair

- No. of people rendered homeless: 60 000 to 900 000
- Estimated damage to the water supply system: 95% of length of water pipes and 50% of pumping stations and treatment plants, etc. will be affected, disrupting water supply for several months.

Table 1. Anticipated disasters

| Hazard | Potential scale | Likelihood* | Early warning | Potential human effect |
|--------------------|-----------------|-------------|---------------|--|
| Earthquakes | Small to large | 4-5 | No | Up to 40 000 deaths, 95 000 injured and 600 000-900 000 homeless |
| Conflict situation | Small to large | 4-5 | Yes | Up to 10 000 deaths, 100 000 homeless |
| Major epidemics | Small to medium | 3 | Yes | Up to 5000 deaths |
| Flood & landslides | Small to medium | 4-5 | Yes | Up to 10 000 deaths, 10 000-20 000 homeless |
| Fires | Small to medium | 4-5 | No | Up to 500 deaths, 5 000 homeless |

* The likelihood of occurrence in the near future is rated by the following criteria: 5 suggests that the disaster is very likely to happen, 4 suggests that it is likely to happen, 3 suggests that it may happen, 2 implies that it can happen, and 1 reflects that it is unlikely to occur at all.

The need for integrating mental health and psychosocial relief efforts

The term *psychosocial*, introduced by international organizations working in the field of disaster mental health, is used to indicate a commitment to non-medical approaches and distinct from clinical of mental health services which is seen as too controlled by physicians, too closely associated with diagnosis, medications with an overly bio-psychiatric approach. However, the term psychosocial may have created an impression among some policymakers and planners that they are faced with choosing between setting up a vertical psychosocial care programme outside existing systems or ignoring it altogether in favour of clinical mental health services.

Suggested activities for inclusion in a disaster preparedness plan include:

(1) Social interventions:

- Continue social intervention launched during the emergency phase: family tracing, temporary shelter, documents, food, injuries, etc.
- Organize outreach relief efforts and psychoeducation.
- Encourage application of pre-existing positive coping values.
- Encourage economic development initiative (income generation activity).
- Establish information centre.

(2) Psychological interventions

- Ensure education of community leaders (village head, teacher) in core psychological care skills (such as emotional support, psychological first aid, sympathetic reassurance) to raise awareness and community support and to refer person to PHC when necessary.
- Train and supervise PHC workers in basic mental health knowledge and skills (such as use of psychotropic medication, psychological first aid, supportive counselling, working with families, suicide prevention, management of somatic complaints, substance use issues and referral).
- Ensure continuation of medication to psychiatric patients who may not have access to medication during the acute phase of emergency.
- Train and supervise community workers (e.g. support workers, counsellors) to assist PHC workers with a heavy case load. Community workers may be volunteers, paraprofessionals or professional depending on the context. Community worker need to be thoroughly trained and supervised in a number of core skills such as assessment of individual, family and group perception of problems, psychological first aid, emotional support, grief counselling,

stress management, problem-solving counselling, mobilizing family and community resources and referral.

- Collaborate with traditional healers if possible.
 - Facilitate creation of community-based self-help support groups for problem sharing, brainstorming for solution, effective ways of coping, emotional support, and generating community-level initiatives.
- (3) Development of community mental health services
- The interventions listed above are suggested for implementation with ongoing mental health system development.
- (4) Disaster preparedness plans must feature the following:
- The preparedness plan should include a disaster management strategy for hospital and community field-based medical services, and the line of communication and coordination among the key actor in the district.
 - The emergency preparedness plan should, furthermore, include assessment format and prioritization of existing health facilities, local resources and capacities.
 - The mechanism for early warning and reporting a potential disaster should be strengthened in coordination with government agencies such as NRCS Nepal Scout, Nepal Police, Army and other institutions.
 - Training should aim at enhancing the level of emergency preparedness and capacity for disaster response.
 - A minimum stock of medical supplies and equipment to be used after the declaration of an emergency must be prepared?
 - Environmental health aspect such as safe water supply and sanitation facilities should be considered. At the same time sanitation programmes should be prepared for an emergency.

Conclusions and recommendations

- (1) Nepal is a developing country with a weak health system and a high risk of disasters. Mental health is not regarded as a priority in its public health programme.
- (2) There is an emergency preparedness and disaster response plan albeit with limited concerns to mental health
- (3) There is a need to integrate mental health and psychosocial support.
- (4) There is a possibility to further develop the emergency preparedness and disaster plan with more specific focus on mental health and psychosocial aspects
- (5) The programme on psychosocial support should be structured as follows:

Step A: State-level coordinating mechanism should be established.

- Meeting of all stakeholders should be held at the national level.
- Appropriate strategies should be established.
- Mapping of service providers in affected geographic areas should be done.
- Trainers for the districts should be identified.

Step 2: District-level training and service delivery should be conducted.

Step 3: The monitoring and evaluation process should be conducted.

Sri Lanka

Sri Lanka has now established a Disaster and Risk Management Ministry headed by a Cabinet Minister. The disaster and risk management policy of the country envisages the protection of human life, property and environment from natural disaster through awareness, prevention, preparedness, mitigation and co-ordination”.

Sri Lanka Disaster Management Act

The newly formed Disaster and Risk Management Ministry has passed a Sri Lanka Disaster Management Act. There are many important tasks which have been listed in this Act enacted in mid-2005. Some of the tasks are appointment of a Disaster Management Council headed by the President. The Leader of the Opposition and select Cabinet ministers are also members of the Council. Each ministry has to prepare its own disaster preparedness plan.

The Act also has a provision for establishing a Disaster Management Centre. Implementation of plans and co-ordination of various ministries will be the main tasks of the Disaster Management Centre. Protection of the life of affected people and the environment, effective use of resources for preparedness, mitigation, relief reconstruction and rehabilitation, raising public awareness levels to protect themselves from disaster and capacity building of relief workers in prevention and mitigation of risk and disaster management are among the planned functions of the Disaster Management Centre. Pre-disaster planning, preparedness and relief and reconstruction will also be the tasks of the Centre.

To provide a legal framework to mental health activities, a new Mental Health Law has also been formulated and passed by the Parliament of Sri Lanka.

Disaster preparedness of Ministry of Health

The Ministry of Health has the experience of handling the huge number of casualties in the 22- year-old civil war and has also over the years developed a disaster management plan. However, previous disasters have been of a relatively smaller magnitude compared to the Tsunami and entailed mainly of dealing with physical trauma. Though the plan recognizes the need for psychosocial support to disaster-affected victims, this has not been included.

Disaster preparedness in the field of mental health should essentially include improvement and expansion of existing mental health services, capacity building of mental health professionals, appointing mental health professionals to the deprived areas and inclusion of MHPS in the disaster management plan of the Ministry of Health.

Implementation of the new mental health policy will be a big step forward in the development of mental health services in the country. The appointment of psychiatrists for each district, setting up of acute psychiatric units and psychiatric rehabilitation units in each district, development of community psychiatric services by appointing community mental health workers, ensuring that all necessary drugs are available throughout the country, and the establishment of a National Institute of Mental Health are the important proposals in the new policy.

Capacity building in relation to post-disaster psychiatric sequelae

The apex body of mental health programmes in the country should be the National Mental Health Council with a secretariat to support its activities. This Council should be appointed by the Minister of Health. The new National Mental Health Policy and the disaster preparedness plan for MHPS support will be implemented through the secretariat. Other functions of the Council would include the allocation of funds, coordination with agencies such as WHO, World Bank and other donors, advocacy on the impact of disasters on the psychological well-being of affected people, advocacy on enhancing the number of trained mental health professionals, development of infrastructure, and ensuring the proper availability of medication.

Mental health needs of the community should be met by establishing community mental health teams. One such team should be appointed in each Medical Officer of Health (MoH) jurisdiction. These teams should be headed by a Medical Officer for Mental Health (MoMH) and include one Community Psychiatric Nurse (CPN) and two Community Mental Health Workers (CMHW). Such teams should be attached to MoH offices and be provided transportation to visit field areas and provide services to the community. Psychotropic medications should be available to the team. The functions of the community mental health team should include not only delivering mental health services in the community but also early identification of illness and referral, training of health workers, assuring continuing care, raising the awareness of mental health and services and assessing the needs of disaster victims.

Capacity building in mental health care should also be accomplished by training of trainers in training other staff in the management of disaster-related illness, training of MoH staff, training of Community Mental Health

Workers, training of Public Health Staff (Public Health Nurse and Family Health Workers) and training of volunteers and community leaders in recognizing the need of care. Creating awareness among the general public is equally important in preparedness planning for disaster management and the mass media can be used effectively for the same. Another important aspect in capacity building is the availability of training and educational material, technical expertise and facilities to train.

Thailand

Mental Health and psychosocial aspects are included in the national disaster management plan. The Department of Mental Health is the nodal agency for mental health issues and collaborates with the Department of Disaster Prevention and Mitigation, other government organizations, NGOs and the private sector through partners. All stakeholders are identified and listed. There is a clear chain of command and demarcation of responsibility among stakeholders. Lessons learnt during previous disasters reveal that failure of communication systems aggravates the situation and hampers relief. Thus all disaster preparedness plans now include installation of communication equipment (internet, satellite communication etc.). Mental health care is also being integrated into the local health system. This integration will strengthen the local health system in service delivery and monitoring. The Department of Mental Health also facilitates support for the development and implementation of preparedness in mental health related issues during disasters at the level of local government policies and encourages communities to set up their own local plans as needed. At the local administrative level, a community mental health plan is integrated into the provincial plan. Mental health related statistics are compiled and distributed to the health authority in each catchment area.

A multifaceted approach is needed for effective disaster management. Facilitating exchange of disaster risk management expertise, experience and information among potentially affected provinces at the local, national and international level helps in knowledge management. In order to broaden the skills for disaster management, workshops for participants from all affected areas should be held to impart in-depth training in disaster psychology, especially facilitating learning lessons from local knowledge and their transfer to the community. Preparedness should include capacity building and developing manuals/guidelines on clinical interventions for

mental health professionals, general health staff, teachers, religious leaders and village health volunteers. While victims suffer directly, the public are also concerned about the possible fallout of such disasters. They can be better informed through dissemination of information for awareness and preparedness.

Considerable emphasis is placed on disaster preparedness by Government agencies, weather forecasters, the media and non-profit organizations, including the Red Cross and NGOs. However, not everyone is convinced about the pressing need for disaster preparedness. Lack of awareness of the enormity of the risks and belief that no tangible threat exists are the commonest reasons for not preparing for potential disasters.

Plans for MH response

Crisis management policies have been put in place in all 17 mental hospitals under the jurisdiction of the Department of Mental Health. Each team develops their own action plan. Each mental health team collaborates with local health officers to develop skills, resources and networks in support of mental health services in the aftermath of a disaster. Lists of all trained staff are maintained in order to ensure that personnel can be rapidly mobilized and assigned to crisis management teams. Tools to be used for immediate care and locally validated assessment instruments are available. Efforts are being made to build a strong mental health system in the community. This will be useful in helping members build their own resilience. Policies for stress management of relief workers are also being developed.

Monitoring changes, early warning, and taking urgent action will strengthen mental health surveillance systems, particularly in the identification of special needs and where these needs lay.

Thailand's plan for MHPS aspects of disaster preparedness is based on the following principles and strategies for mental health intervention in disasters:

- (1) *Capacity building*: This includes guideline development and training on mental health aspects of emergencies and disasters at all levels, from the community to the tertiary, of the health sector.

- (2) *Service delivery*: The aim is to provide timely, appropriate, and holistic (Keeping in mind the social and mental aspect) services in the emergency phase, post-impact phase and rehabilitation phase. Outreach and awareness programmes are important to ensure the treatment of vulnerable groups within the general health services and other community services.
- (3) *Health information and advocacy*: These activities aim at informing the public on prevention and preparedness for mental health emergencies and disasters. Efforts will be made to empower communities through health education and promotion.
- (4) *Networking and social mobilization*: The aim is to network and collaborate with various sectors the government and private organizations for advocating and implementing the objectives and activities of mental health in emergency management. Inter-sectoral response and community participation should be encouraged in all phases of disasters.
- (5) *Resource mobilization*: The aim is to mobilize all resources of the health sector in order to achieve the maximisation of response and equitable distribution of resources. Furthermore, it encourages generating only the appropriate resources required.
- (6) *Information management and surveillance system*: This emphasizes the importance of using information optimally in mental health emergency management for service delivery and to assist in decision-making.
- (7) *Research and development*: The importance of research cannot be over-emphasized as this serves as the inputs and feedback mechanism for policy and programme development.
- (8) *Standards and regulation*: This is needed to put all the different aspects in management in order. Efforts will be made to improve preparedness and response to mental health emergencies. In so doing, standards will be set and regulations will be reinforced.
- (9) *Monitoring and evaluation*: Activities should be monitored and evaluated through key indicators. Emphasis will be made on documenting events, lessons learnt and sharing rewarding

experiences at special forums and conventions. All events will be documented in the form of final reports that will serve as inputs for policy- making and improvement of response.

A clear line of command for management of MHPS programmes in the chaotic situation after a disaster can reduce confusion among workers. Thus a command line in mental health intervention, from local to national levels, has been established.

The Department of Mental Health has set the policy and direction for ways to support and provide treatment to the survivors. The Mental Health Operations Center (MHOC) has been established at the Department to supervise and cooperate with other concerned organizations at the provincial, ministerial, and national levels. The Frontline Operations Center will be established at the disaster-affected site and will be responsible for the Mobile Mental Health Teams working closely with other teams under the authority of the Provincial Operations Center. The following two flow charts illustrate the organizational structure and duties.

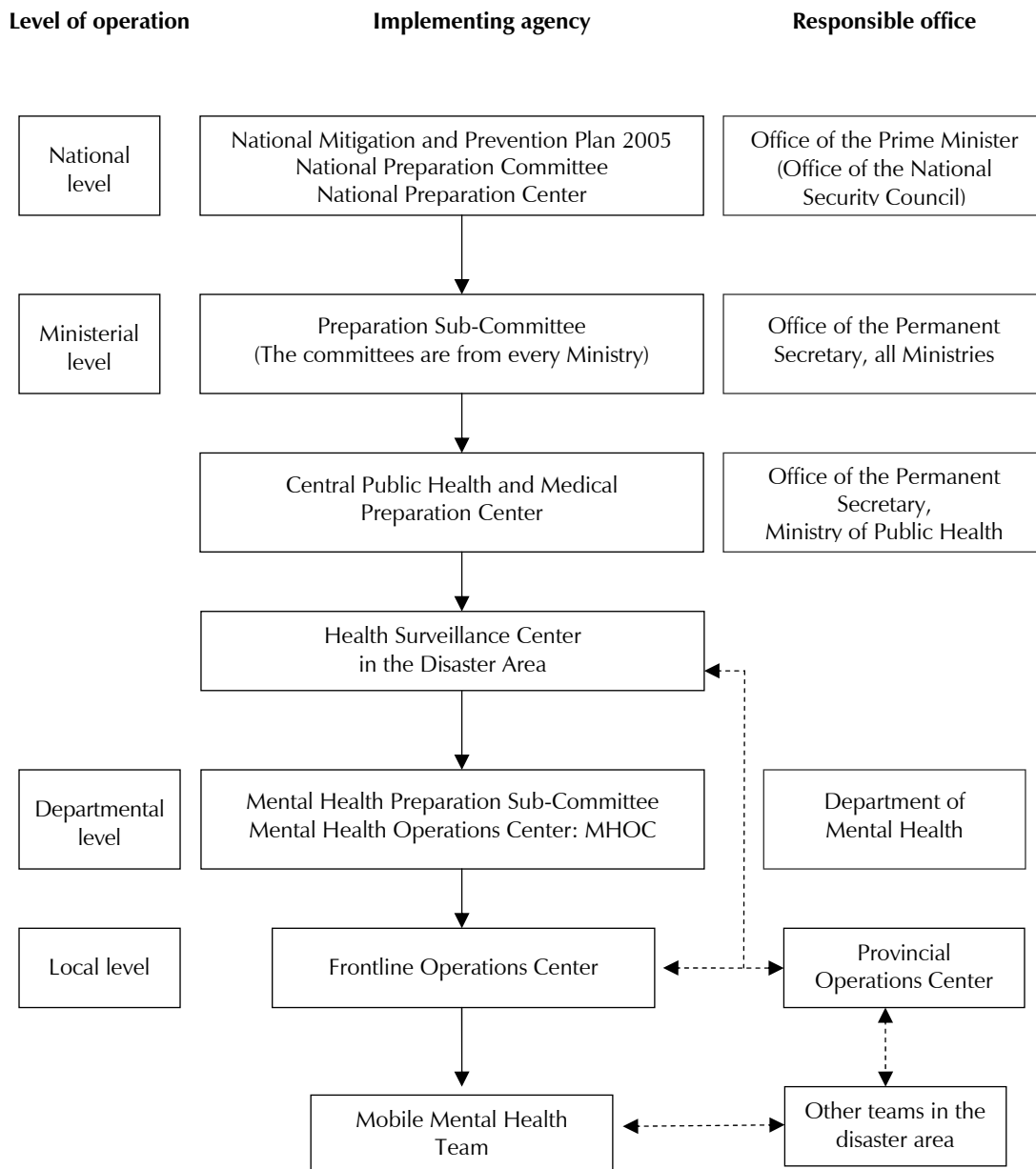
4. Field visit to affected sites and recovery programmes in Khao Lak, Thailand

Khao Lak was one of the regions most severely affected by the Tsunami in Thailand. A field visit was arranged for visiting delegates to ascertain the extent of damage caused and observe the ongoing recovery programmes. The sites visited included:

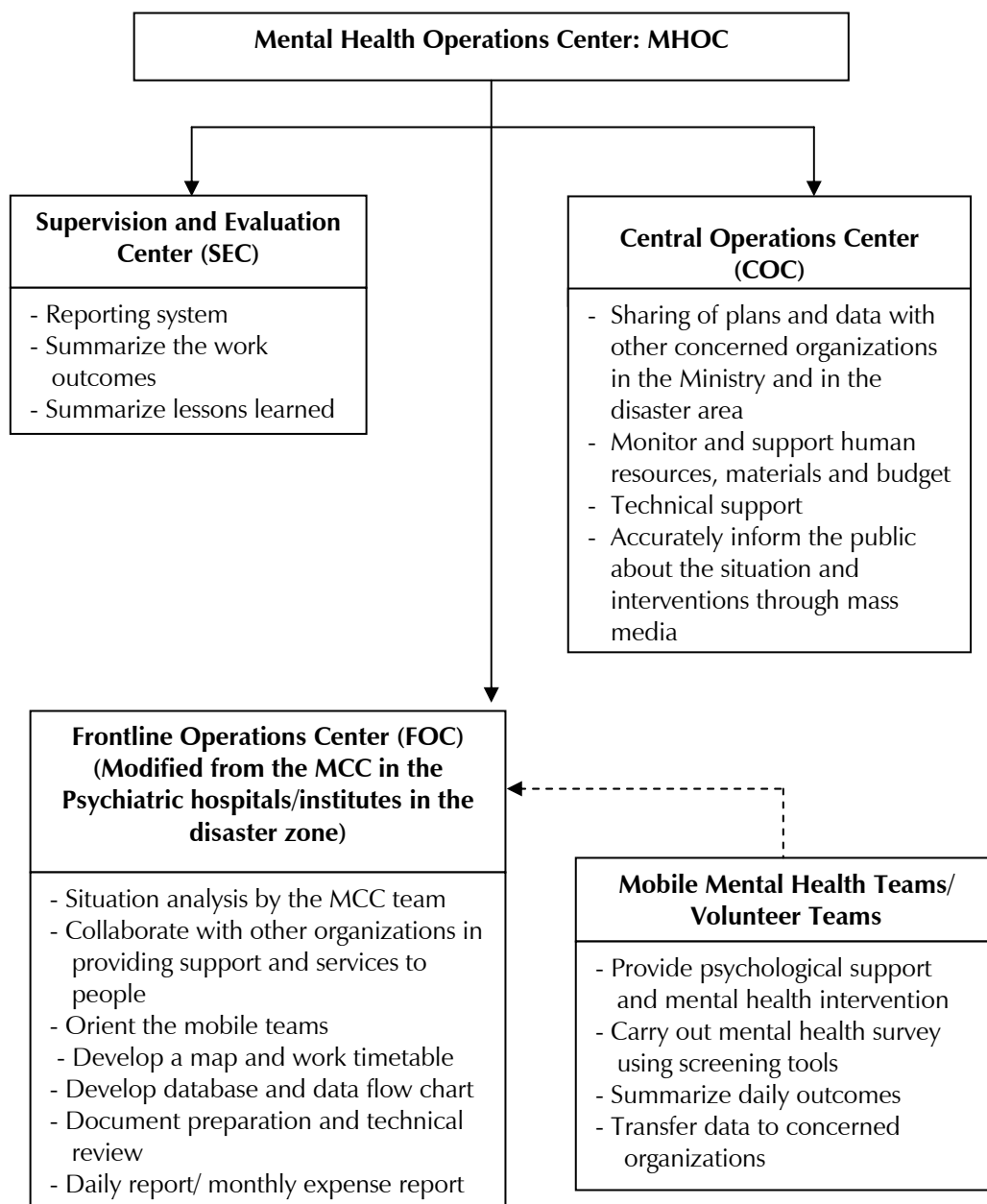
- A beachside hotel which was almost completely washed away despite being made of bricks and concrete on account of the sheer force of the Tsunami. The scars of the tidal onslaught were visible to the visitors.
- A large naval vessel and many large fishing boats had been washed from the ocean on to dry land about 1 km inland. The colossal force of the wave can be estimated from the fact that an entire naval vessel was virtually lifted off the waters and thrust one kilometre inland.

- A Mental Health Recovery Centre has been established. This will remain in place for at least two years till experts conclude that the community has fully recovered. This centre provides MHPS support to the entire affected region. It is called a recovery centre to convey a positive image about the rehabilitation process.
- A school for orphaned children has been established by donations from the King's Foundation. All expenses of each child is borne by the foundation. A detailed academic and psychological profile of each child is maintained.
- A rehabilitation community was visited where survivors were engaged in income generation activities such as the production of clothes, handicrafts etc. Another community which had constructed new houses for resettlement was also visited. Although the reconstructed houses had better and more advanced facilities than the old village, residents still preferred the old culture and surroundings in their native village. Delegates interacted with the residents who said that though their basic physical needs were met they still could not completely get over the loss of their loved ones and being uprooted from their traditional way of life. They expressed appreciation of the MHPS support by the Department of Mental Health., Thailand, and the Mental Health Recovery Centre.
- A community radio station which broadcasts health and mental health promotion messages was visited. Locals could call in with their problems (such as problems of adolescence) and obtain expert advice from the mental health expert. This was effectively used after the Tsunami.

Flow chart 1. Line of command on mental health intervention in natural disasters



Flow chart 2. **Mental health management structure under the Department of Mental Health**



5. Discussion on issues related to mental health and psychosocial aspects of disasters in SEA Region Member States

Participants held intensive discussions on issues related to mental health and psychosocial aspects of disasters in Member countries of the SEA Region. Dinesh Bhugra, Professor of Mental Health and Cultural Diversity, Institute of Psychiatry, the United Kingdom, facilitated this discussion. A summary of the discussions is provided below.

5.1 Unique MHPS linked issues affecting the response to disasters

There were detailed discussions among the participants about the unique aspects of communities of the SEA Region which influences their response to suffering, ability to cope with loss, time of recovery, etc. The importance of local culture in rehabilitation efforts was repeatedly emphasized. Any relief effort and disaster preparedness plans must take into consideration ethnic and cultural aspects and needs. It was also recognized that culture varies from community to community and that only those familiar with the local culture can appreciate its role and relevance.

Cultural response to suffering

The culture of most communities in the SEA Region is deeply embedded in religion, traditions and faith. Included in these traditional beliefs is the law of "karma". In Buddhist teaching, the law of karma says: "*for every event that occurs, there will follow another event whose existence was caused by the first, and this second event will be pleasant or unpleasant based on the quality of the first*". There is also a sense of fatalism with the transcending belief that God's will must prevail. Collecting experience and sharing of grief is most commonly observed than an individual's expression of distress. Such cultural moorings make suffering easier to tolerate for local communities in contrast to other communities where anger directed at the failure of the civic administration is often prominently in evidence after a disaster.

Previous experiences of the community

Several communities in the Region have endured previous disasters, either manmade (prolonged civil conflict) or natural (earthquake, flooding or cyclones). There have also been deaths due to high infant or maternal mortality, and from infectious or chronic diseases due to inadequate health services. Such experiences have built a natural sense of resilience within the community that enable it to come to terms with a disaster and learn to cope with its aftermath.

Mode of expression of psychological distress

The most common term to refer to the expression of distress in western literature is “post-traumatic stress disorder”. Several research studies in the SEA Region have revealed that this is, however, not the most common form of expression of distress in this Region. In most cases, people present with somatization of psychological distress or with dissociative and conversion symptoms. Sleep problems, irritability, aggression (particularly against women and children), agitation, suicidal tendencies and alcohol and substance abuse are also common. It is important for relief agencies to recognize these symptoms as a manifestation of psychological distress.

Role of cultural factors in help seeking behaviour

Most people in the SEA Region will not seek help or medical assistance for their psychological distress but expect it to be given to them without their asking, unlike western societies where help is directly sought more often. There is also a tendency to seek the guidance of religious, traditional or faith healers. The training of such healers in dealing with psychosocial issues was extensively discussed.

The low levels of literacy and lack of awareness also make it difficult for people to access the help available to them.

Grieving process

Grieving for the loss of a loved one is a normal phenomenon in most communities. Communities have many pre-established rituals that make the grieving process easier. Many of these normal rituals, however, are not

adhered to due to the exigencies of a disaster. For example, the elaborate rituals that have to be performed with the dead body cannot be expected if the corpse is not available leading to a sense of loss and confusion about what to do. Many of the bereaved continued to hunt for the remains of their family members even one year after the Tsunami. There was also a dilemma on how to dispose the large number of dead bodies after the Tsunami and whether to opt for man burial or cremate these according to religious beliefs. Efforts at reuniting families, re-establishing pre-existing community structures and helping people resume a normal routine in life can help mitigate the grieving process.

Extended family support

Communities in the Region have enjoyed strong family relations and share their joys and sorrows. The burden of widows, widowers, orphans and injured persons is borne by the extended family. A good example is in Thailand where almost all orphans are cared for by the extended families within the community.

Community cohesion (resilience)

In any disaster, the community is the first to respond to its needs. The level of organization present in a community is crucial for its success in withstanding the immediate aftershocks of a disaster. Communities, particularly in rural areas, are bound by common religious beliefs and rituals, extended families, collective celebration of festivals, etc. Conflict with neighbours and other ethnic groups are, however, also common.

An emerging belief is that building cohesion and harmony among members makes the community better prepared for and more resilient to disasters. Various strategies have been proposed, such as regular meetings, assigning responsibilities, establishing a hierarchy of command, skill-building camps, music and sport events.

Role of alternative systems of medicine and local healers

There are many practitioners who deliver health care to the communities in the Region. Some of these are affiliated to recognized alternate systems of

medicine (ayurveda, unani, homeopathy, etc), others belong to a group of non-formal health-care providers including religious healers, faith healers and traditional practitioners. There was an intense discussion on the role of the non-formal health-care providers particularly in relieving psychological distress. Generally, these practices are time-tested, well developed, easily accessible, cheaper, culturally sensitive and acceptable with no stigma. The overall opinion was that these practitioners could be trained on what to do and what not to do in disasters and what role they could play as partners in the health system.

5.2 Implementation of MHPS programmes in communities

Types of personnel

The wide range of persons providing MPHS support in times of disasters was discussed. It is important to recognize, identify and list all such personnel for a coordinated effort and ensure that they are adequately trained for the appropriate activity. Relief efforts can be provided by:

- Non-medical personnel: Community leaders/volunteers (teachers and religious leaders), community-level workers and relief workers, including the police, fire services and NGOs defence forces should be trained in basic psychosocial relief methods and be under the supervision of the mental health team. Such personnel can be trained to provide psychological first aid, identification and referral of those who need specialized care.
- Medical personnel: Staff of primary health care, nurses and medical officers can provide medical treatment.
- Mental health personnel: Community-based mental health units integrated into the general health service and mobile mental health teams consisting of psychiatrist, clinical psychologist and psychiatric social workers can provide expert mental health services to the community. They can also provide training to non-medical personnel, assist in capacity building, conduct a needs assessment, maintain a daily log of cases with interventions used, prepare summary reports and conduct monitoring and evaluation of programmes.

- Mental hospital: Staff of the mental hospital can serve as the tertiary care back-up for training, policy-making and providing advice to the government.

Role of community-level workers

Community-level workers played an important role in the Tsunami relief effort. This is the first time that they were allotted such an extensive and organized role for disaster relief and rehabilitation. They were very effectively deployed in Maldives, Sri Lanka, India and Thailand. Although the parameters varied from location to location, their performance and effectiveness was uniformly welcomed by the community. The role of CLWs could include providing psychological first aid, identification and referral, minimizing harm, facilitating recovery, raising public awareness and the administration of a needs assessment questionnaire such as GHQ 12.

Special attention to vulnerable groups

Certain segments of disaster affected communities need focused and sustained attention. This should be culturally appropriate and keep in mind age, gender and appropriate needs. These groups include children (infants, children aged 1-5 years and 6-12 years and orphans), adolescents (particularly orphans), women (widows, pregnant and those with infants), the elderly, widowers, people with physical disability, people with pre-existing medical and psychiatric conditions, and those who abuse alcohol and other substances. Relief workers of all kinds also themselves need to practice stress relief. There should be a clear government policy on adoption of orphans of disasters preventing and preventing of exploitation of young destitute women and widows.

Appropriateness of MHPS interventions

MHPS interventions implemented should be technically and culturally appropriate. Inappropriate interventions can be harmful. Psychosocial care being a long and continuous process, long-term projects should be emphasized.

5.3 Policy issues for MHPS support to the community

Managing NGOs and INGOs

Nongovernmental organizations, both national and international, play an important role in relief efforts and primarily in community-based work. NGOS have some advantages in relief work over government organizations such as flexibility in operations, quick decision-making and rapid mobilization of funds. However, it should be noted that many NGOs have a personal agenda to uphold and their own chain of command to which they respond, making it difficult to monitor their activities. Some suggestions to better manage the activities of NGOs discussed were:

- Governments should have a registry of credible and transparent NGOs and INGOs who work without prejudice and respect local sentiments and culture.
- The work of NGOs and INGOs should be coordinated through the local and national government.
- There should be an initial briefing of the organizations and subsequent periodic monitoring of their activities through local MHPS committees.
- The government should prioritize needs and indicate the same to NGOs and INGOs.
- NGOs should pool resources and network with other agencies to avoid duplication.
- INGOS should, as far as possible, operate through local networks (local NGOs and government agencies).
- Identify external agencies who plan to for the long term and enter into an MoU with them to ensure commitment and accountability.
- NGOS should not insist that affected persons accept their relief supplies.

Management of the community

Addressing the needs of the community is crucial in relieving their psychological distress. The real needs of the community should be kept in

mind as opposed to the needs perceived by external agencies. Identification of community needs should assume priority over individual needs. Issues to be kept in mind are:

- The pre-existing community structure should be maintained as far as possible and restored to its original form if damaged. Residents of the same village and community should be placed together.
- Community and religious leaders should be identified, their guidance sought and a prominent role in relief efforts assigned to them.
- A clear chain of command should be established for decision-making and coordination. Decision-making should be democratic and participatory.
- Locals should be involved in projects including relief efforts and other productive activity. Skill development abilities and income generation means should be encouraged. Self-help groups can be established in the community.
- The Physical security of vulnerable groups such as young girls and women should be ensured.
- Respect for privacy, dignity and confidentiality is important. Privacy at places to sleep and bathe must be ensured.
- Children should be stationed at “child-friendly” places and kept involved with games and playful activity. Schools should be started for them as soon as possible after their dislocation. Children at risk of exploitation or deprivation such as orphans, children with single parents and adolescents should be kept under observation.
- Optimum nutritive food, water and sanitation for all must be ensured.
- An information centre should be established from where reliable and unbiased information can be made available. The information should be periodically disseminated in easily understandable format and orally for the unlettered. A simple pamphlet listing ‘Dos’ and don’ts is usually welcome. Caution must be exercised to prevent the spread of rumour.

Documentation

Documentation of current needs can help policy-makers decide on resource allocation and professionals plan service delivery. Written documentation of experiences is vital for future disaster preparedness and for sharing of information. Unfortunately, local experts in SEA the Region tend not to write reports or document their experiences, leading to paucity of published papers. Verbal transmission of knowledge and information as is the case with communities usually has very limited reach. .

Problems with aid

Aid from any external source should be managed in a way that it should not foster dependency. Sometimes, local resources are sidelined by over-enthusiastic external agencies, thus limiting their local capacity. Resources donated should be appropriate and must match the local needs - it has been observed that surplus items available with donors is sometimes dumped in disaster-affected areas regardless of need, or that clothing is inappropriate and drugs close to the expiry dates are distributed. At the same time it must be ensured that there are as unnecessary administrative delays in clearing the aid and routine customs procedures may be waived.

VIPs and media

VIPs, particularly politicians, often visit disaster-affected areas in large numbers and have an important function. These visits create management and security problems and distract aid efforts. Sensitizing VIPs and developing a protocol for their visits can serve their need for information and yet not disturb on-going work.

The media should be made aware of psychosocially-sensitive disaster reporting and urged to refrain from any kind of sensationalisation. Particular attention must be paid to ensure that victims are not harassed or inconvenienced in any way.

Coordination

Coordination of activities at every level is usually a difficult issue. Multiple ministries of national governments along with multiple departments,

multiple agencies and several NGOs rarely work together in a coordinated manner. The proper and efficient coordination of agencies was noted to be a significant problem in most Tsunami-affected countries. Some successful methods for coordination discussed were:

- A strong civil administrative set-up which effectively controls the activities of all agencies for instance, the District Magistrate is the highest civil administrator in every district of India with powers to control the activities in the districts. In India's Tamil Nadu State, all unwanted agencies in the affected areas were asked to leave by an order from the district magistrate which could be enforced by the police if needed.
- Restricted entry to affected areas was put to good use in Maldives where visas and entry permits were issued only to selected agencies after careful screening.
- A categorical announcement that no external assistance is needed as was the case with India and Thailand, helps in limiting the influx and interference of NGOs.
- If the response of local governments and agencies meets all perceived rehabilitation needs, as was the case with Thailand, there is nothing left for external NGOs to do. This will help restrict their entry and hasten departure.
- If the scale of the disaster is such that the indigenous resources of the country find it impossible to cope, national and district coordinating mechanisms need to be put in place as soon as possible and UN agencies need to work closely with local and international NGOs.

5.4 Technical evaluation of MHPS programmes

Evaluation of any activity or programme can take the form of process evaluation or impact evaluation. Process evaluation includes assessment of activities conducted and the budget spent. However, even the successful implantation of the activity does not guarantee that the overall objective of the programme will have been met. Impact evaluation of the activity is done to assess whether the objective of the programme has been met.

An independent person not involved in planning or implementing the activity should conduct the evaluation. The evaluator should not only be technically competent but also familiar with the local culture and needs of the community. A structure format should be used preferably be used for the evaluation to avoid subjectivity.

6. Essential components of the mental health and psychosocial aspects of a disaster preparedness plan

These can be adapted by countries for inclusion in their disaster preparedness plans.

- (1) A national disaster preparedness plan should be developed. Mental health and psychosocial aspects of a disaster should be included in the plan.
 - Mental health and psychosocial programmes should be integrated into the disaster preparedness and contingency plan.
 - Training workshops and periodic drills to implement the disaster preparedness plan should be considered.
 - All stakeholders and resources for mental health and psychosocial support should be identified and listed.
- (2) One ministry should be designated the lead ministry for mental health and psychosocial aspects in any future disaster.

Every activity and project related to mental health and psychosocial support should be implemented after clearance from the lead ministry and be a part of the overall strategy.

- (3) Coordination mechanisms and responsibilities between ministries at the ministerial level with a clear chain of command and responsibility for mental health and psychosocial aspects should be in place.
 - The lead ministry should be responsible for developing a plan and determining coordination mechanisms and

responsibilities in consultation with other relevant stakeholders at the senior level with a clear chain of command and earmarked responsibility for mental health and psychosocial emergency response.

- (4) Technical material (such as training material for community-level workers, survey instruments to be used, guidelines for NGOs, guidelines for the media etc.) should be translated and validated for use in countries and be readily available.
- Availability and dissemination of the following guidelines or manuals on clinical/psychological interventions should be ensured:
 - for mental health professionals.
 - for general health staff (doctors, nurses, community level health workers, etc).
 - for human resources outside the formal health sector (e.g. teachers, religious leaders, volunteers) .
 - Information documents for the media and general public on mental health/psychosocial problems, coping, sources for social support, and available care should be widely available.
 - Plans on specific problems like family tracing and reunification, preventing child abuse, and gender-based violence during and after a disaster should be available.
 - Guidelines for care of children, who are a particularly vulnerable group, should be available.
 - Widows and the elderly may experience disproportionate stress due to loss of support systems, and particular attention has to be paid to their case.
 - Availability of ethical guidelines for post-disaster research should be ensured.
- (5) A plan for assessment of psychosocial distress in the community should be in place.

- A clear plan should be in place to determine which instruments will be used, when and by whom in case of disasters in the future.
 - Instruments to be used in assessment must be culturally appropriate and locally validated.
 - Qualitative information on mental health and psychosocial aspects, resources and ways of coping should be collected on a regular basis and linked to quantitative assessments.
 - Validated quantitative questionnaires for needs assessment and mental health status of the affected population should be readily available to all partners.
 - Rapid assessments (when made) should be interpreted carefully within the social and cultural context of the event.
- (6) The roles and responsibilities of community-level workers in times of disasters should be clearly defined
- Manuals and guidelines for training CLWs should be translated and adapted to the local culture. As far as possible, a set of manuals dealing with overall psychosocial support activities should be prepared. To this each agency can add a section of specific interest to them such as children's programmes, women's programmes, etc.
 - The lead ministry should be responsible for coordinating activities such as framing of standard curriculum for their training, deployment, supervision and monitoring.
 - Support from mental health professionals for persons identified by CLWs as needing specialized care should be readily available.
 - Organizational policies should be developed for the prevention and management of stress in all relief workers including CLWs.
 - The role of external international organizations, particularly INGOs, should be carefully monitored.

- (7) Communication equipment should be installed/upgraded regularly.
- Modern communication equipment should be installed/upgraded regularly.
 - Use of modern technology such as e-mail, webcam, wireless and satellite communication at regional, atoll and island levels should be made available.

- (8) A 'risk communication' strategy for disseminating essential information during emergencies should be prepared.

Reliable information should be provided on time by senior officials. This can help reassure the public and prevent the proliferation of rumours.

- (9) Efforts to empower the community to launch the first response to a disaster, develop community resilience and coping skills and promote community harmony should be encouraged.

Considering the fact that in most disasters it is the community itself that must respond in the most crucial first six to 12 hours, community resilience and preparedness is crucial.

- (10) A community mental health system should be developed as it is the best form of disaster preparedness. This can serve the needs of the community in the aftermath of a disaster and can be readily mobilized during one.

- A quick and appropriate response to a disaster depends on an existing policy structure and system.
- The best form of disaster preparedness in mental health and psychosocial needs is to have a strong community mental health system in place into which additions in terms of personnel, skills and required resources could be incorporated rapidly should the need arise.
- All aspects of mental health and psychosocial services should be developed with a long-term perspective. These include:
 - Formulation of mental health legislation.
 - Development of mental health policy.

- Development of community mental health services.
- Enhancing the administrative structure for mental health in the country.

7. Recommendations

The following recommendations were made for overall disaster management

- (1) There should be a national policy on appropriate management of aid, coordination between different agencies and evaluation of the role of external agencies prior to their deployment in the field.
- (2) Impact evaluation of activities should be conducted.
- (3) Keeping in mind the possible negative role of the media in some times magnifying the horrific and tragic aspects of disasters through repeated broadcast of images of destruction or loss of life, a “code of conduct” on reporting disasters should be developed. This could be used at the country level to reduce the exposure of children and others to the repeated transmission of reports of traumatic events.
- (4) A mapping of the degree of vulnerability of the community in different risk categories (housing, injury, death, risk of type of possible disasters, etc) in the time of a disaster must be conducted.

Recommendations specific to mental health and psychosocial relief efforts were:

- (1) All Member States should have a disaster preparedness plan which should include a mental health and psychosocial relief component.
- (2) Member States should develop baseline data on mental health resources and on the capacity to respond to mental health and psychosocial needs of the community in emergencies.

- (3) Regional exchange of information on “best practices” for dealing with post-disaster interventions in mental health and psychosocial relief efforts should be encouraged. At the regional level there is likely to be a greater sensitivity to culturally acceptable interventions. A web-based best practices publication (updated regularly) would help to influence the use of accepted techniques for interventions. This document would provide for children and adolescents examples of work with schools, vocational training, and programmes to help those with previously diagnosed mental illness in the aftermath of disasters.
- (4) Cultural sensitivity and appropriateness in diagnosis, management and delivery of services is essential, with the focus on the unique aspects of the Region.
- (5) Unconventional and unproven therapies which have no evidence to substantiate them should not be used. A position paper on “harmful” or unsubstantiated interventions that are currently being used should be developed.
- (6) Consideration must be given to ways of determining increase, if any, in alcohol abuse and suicide rates after a disaster.
- (7) A workshop on the technique of needs assessment which will include a section on issues regarding the mental health of children should be conducted.
- (8) Particular attention must be paid to children and adolescents in times of disasters. Member States should also be encouraged to include child mental health in country-level mental health policy development. The WHO/HQ Guidance Manual on Child and Adolescent Mental Health Policy is a key resource for this initiative.
- (9) Recognizing the limitations of schools in reaching those who do not have access to schools and are a most vulnerable population group, innovative means for providing child mental health services for such children should be developed.
- (10) WHO should provide technical assistance to Member States in developing their mental health and psychosocial components of disaster preparedness plans.

Annex 1

Programme

Tuesday, 20 June 2006

- 08:30–09:00 Registration
- 09:00–10:00 Inauguration
- 10:15–10:45 WHO Framework for Mental Health and Psychosocial Support in Tsunami-affected countries – Dr Vijay Chandra, RA-MHS.
- 10:45–11:15 Overview of mental health and psychosocial relief efforts in emergencies – Dr John Mahoney, STC, WHO Country Office, Sri Lanka

Session I

- 11:15–11:45 Overview of mental health and psychosocial relief efforts after a disaster: Introduction/Historical aspects - Dr Harjeet Singh (IND)
- 11:45–12:45 Overview of mental health and psychosocial relief efforts after a disaster: Psychosocial support to disaster-affected communities - Dr Kiran Rao (IND), Dr Benjaporn Panyayong (THA)
- 13:30–14:30 Overview of mental health and psychosocial relief efforts after a disaster: Mental health care of disaster-affected communities - Dr Harjeet Singh (IND), Dr Harischandra Ghambeera (SRL) Dr Pattama Sirivech (THA)
- 14:30–16:00 Overview of mental health and psychosocial relief efforts after a disaster: Administrative issues after a disaster - Dr Jagdish Kaur (IND), Mr Abdul Hameed (MAL) Dr Terrence de Silva (SRL), Dr Suparat Ekasawin (THA)
- 16:30–17:30 Discussions - Dr Bhugra (UK)

Wednesday, 21 June 2006

Session II

- 08:30–10:30 Presentation on lessons learnt in mental health and psychosocial support to the community in Tsunami-affected countries
Dr Kiran Rao (IND), Dr. Prasetiyawan (INO), MAL, Dr Harischandra Ghambeera (SRL)

- 10:30–11:00 Presentation on lessons learnt in mental health and psychosocial support to the community in Tsunami-affected countries
Dr Benjaporn Panyayong (THA)
- 11:00–11:30 Presentation on lessons learnt in mental health and psychosocial support children and adolescents in Tsunami-affected communities
Dr Myron Belfer (USA)
- Session III
- 11:30–12:30 Existing disaster preparedness plans (mental health and psychosocial component) of each Member country - Dr Chowdhury (BAN), Dr Chencho Dorji (BHU), DPRK and Dr Jagdish Kaur (IND)
- 13:30–15:30 Existing disaster preparedness plans (mental health component) of each Member country - Dr Eka Viora (INO), MAL delegate, MYA, Dr Terrence de Silva (SRL)
- 16:00–16:30 Existing disaster preparedness plans (mental health and component) of each Member Country
Dr Lumeshor Acharya (NEP), Dr Suparat Ekasawin (THA)
- 16:30–17:30 Discussions – Dr Bhugra

Thursday, 22 June 2006

- 09:00–17:00 Field visit to disaster affected-communities

Friday, 23 June 2006

Session IV

- 09:00–12:30 Group work on development of plan for mental health and psychosocial aspects of disaster preparedness
- 13:30–14:30 Presentation of the outline of plan for mental health and psychosocial aspects of disaster preparedness – Dr Rajesh Pandav
- 14:30–15:30 Discussions - Dr Bhugra
- 16:00–17:00 Open discussion and future plan -
Drs Bhugra, Belfar, Chandra, Mahoney and Pandav.

Annex 2

List of participants

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Annex 3

Address by Dr Samlee Plianbangchang Regional Director, WHO South-East Asia Region (Read by RA MHS, Dr Vijay Chandra)

Distinguished participants, dear colleagues, ladies and gentlemen,

I have great pleasure in conveying greetings from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, to the organizers and participants of the Intercountry Meeting on Mental Health and Psychosocial Aspects of Disaster Preparedness. As Dr Samlee is unable to be here today, I have the honour to read out his address. I quote:

It is with great pleasure that I welcome you all to this important Intercountry Meeting on Mental Health and Psychosocial Aspects of Disaster Preparedness.

Eighteen months have passed since the Tsunami of 26 December 2004, which caused death and destruction on an unprecedented scale. It is now time to see what we have done, what we have learnt and how we can be better prepared to face future disasters.

Following the tragedy, WHO was requested by affected Member States to support the respective ministries of health in restoring health services. Mental health and psychosocial support were among the top priorities. Each and every person in the disaster-struck areas was, to some extent, psychologically affected. In terms of numbers, therefore, the magnitude of the problem of psychological trauma in the disaster-affected population could be said to be as large as the size of the population.

It was clearly recognized that any neglect of psychosocial support could impair efforts in physical rehabilitation. Providing psychosocial support to communities affected by the tsunami was a key component of WHO's short, medium and long-term strategy. Such support was crucial, but to be effective it had to be appropriate and culturally sensitive. WHO's

policy has been that psychosocial support should be community-based, culturally sensitive and provided by appropriately trained workers who understand the needs of disaster victims. It should take into account the needs of special groups such as children and women, particularly widows and the elderly.

To back up the community level action, affected countries enhanced their mental health services. In this context, I would like to highlight that one of the important recommendations of WHO is to have a strong community mental health system to serve the immediate as well as the long-term needs of the community. Of course we need to ensure that it is sustainable and can become a part of the routine health care delivery system. Different countries have used different approaches in building their community mental health systems, some traditional and some innovative: for example, the mobile mental health team in Thailand, training of monks in Sri Lanka or the training of the general practitioners (GP++ Programme) in Indonesia.

Ladies and gentlemen,

As we are aware, the tragedy of the Tsunami resulted in urgent action by some governments which will have a long-term beneficial impact on the development of community-based mental health systems. For example, Sri Lanka developed a mental health policy which has been passed by Cabinet. The Government of Maldives has also decided to develop a mental health plan and review its Health Act to incorporate a section on mental health.

Another lesson of the Tsunami has been the importance of partnerships in dealing with tragedies where huge numbers of people are affected. No single agency can perform all that is needed by itself. Thus, meaningful collaboration with appropriate coordination between all stakeholders, including NGOs, is extremely important.

The experience of dealing with the tsunami highlighted the fact that disaster preparedness plans of Member States to meet the mental health and psychosocial needs of the community were extremely limited. Every country, affected or unaffected by the Tsunami, should prepare a detailed plan to meet any situation which may arise in future disasters. Mental health and psychosocial relief efforts should be an integral part of disaster preparedness plans.

The best form of disaster preparedness is to have a strong community mental health system in place. This can be rapidly scaled up to meet the needs of the community in case of disasters.

I am sure this intercountry meeting will further strengthen WHO's initiative in supporting the governments of Member States more efficiently and effectively in their efforts to develop plans for mental health and psychosocial aspects of disaster preparedness.

In conclusion, I wish you all fruitful deliberations and a pleasant stay in Khao Lak.

Thank you. Unquote.

I shall, of course, be apprising the Regional Director of your deliberations and the outcome of the workshop. I too would like to take this opportunity of wishing you all success and a comfortable stay in Khao Lak.

Thank you.