

Psychosocial Support for tsunami affected population in India



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Country Office - India
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RESOURCES FOR PSYCHOSOCIAL SUPPORT IN DISASTER MANAGEMENT

World Health Organization
Country Office - India
August 2006

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Foreword

Communities facing disasters have to deal with mental health issues in addition to loss of life and property. Psychiatric personnel are usually deployed as part of emergency medical relief and there have been attempts to provide long term mental health support in some settings.

The Tsunami, which hit the coast of India in December of 2004, left a trail of devastation and a huge population vulnerable to psychosocial issues. WHO India country office joined hands with the UN team for recovery support in the Tsunami affected areas and established a new paradigm for community based psychosocial support. In collaboration with State Governments, UN partners (UNDP, UNICEF, UNODC and UNFPA), WHO collaborating centers, national centers of excellence and NGOs, the WHO country office initiated low cost community based and sustainable support system for the affected populations. The various agencies and partners in different States and Union territories provided an opportunity to study the training needs, modalities and operational aspects.

The WHO India country office (WCO) has developed a series of manuals and modules with the support of its partners and they have been extensively used in psychosocial programme. They include a facilitator's manual, manual for community level workers, self help pamphlet, manual for children and adolescents and manuals for prevention and management of alcohol abuse.

The resource kit presents the work of WCO and its partners in the field on psychosocial support and a set of training modules which can be used in training for disaster preparedness and in post disaster management.

This compilation is divided into four sections. The first section is a comprehensive report on WCO supported psychosocial activities in the tsunami affected states and the Generic Model that has evolved. It also includes work done by two leading mental health institutions – SCARF, Chennai and NIMHANS, Bangalore in partnership with WCO to train PSS personnel and provide psychosocial care. Section II, III and IV contain manuals for training community level workers for providing psychosocial support, manual for helping children, and training manuals for providing alcohol abuse interventions in disaster situations, respectively. The entire compilation is also available in a compact disk version.

WCO would like to acknowledge all its partners in this endeavour and hope that this resource kit will serve as a useful repository for those who are involved in disaster mitigation and management.



Dr S.J. Habayeb
WHO Representative to India

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I. Psychosocial Support

for Tsunami affected populations in India

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Abbreviations

ADIC	Alcohol and Drug Information Centre, India
ASD	Acute Stress Disorder
BMO	Block Medical Officer
BDO	Block Development Officer
CLW	Community Health Worker
CBO	Community Based Organization
CDPO	Child Development Project Officer
DSWD	District Social Welfare Department
DDHS	Deputy Director Health Service
DSWO	District Social Welfare Officer
EOW	Extension Officer Social Welfare
GOI	Government Of India
ICDS	Integrated Child Development Services Scheme
IMH	Institute of Mental Health
JIPMER	Jawaharlal Nehru Institute of Postgraduate Medical Education and Research
MCH	Maternal and Child Health
MHPS	Mental Health and Psychosocial Support
MSW	Masters in Social Work
NSS	National Service Scheme
NCC	National Cadet Corps

NYK	Nehru Yuva Kendra
NIMHANS	National Institute of Mental Health and Neuro Sciences
NGO	Non Government Organization
NPO	National Professional Officer
PSS	Psychosocial Support
PTSD	Post Traumatic Stress Disorder
PHC	Primary Health Centre
RHA	Rapid Health Assessment
RWO	Rural Welfare Officer
SCARF	Schizophrenia Research Foundation of India
SEARO	South East Asia Regional Office
SMHA	State Mental Health Authority
SHG	Self Help Group
TOT	Training Of Trainers
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
VIMHANS	Vidyasagar Institute of Mental Health and Neuro Sciences
VHN	Village Health Nurse
WCO	WHO India Country Office
WHO	World Health Organization

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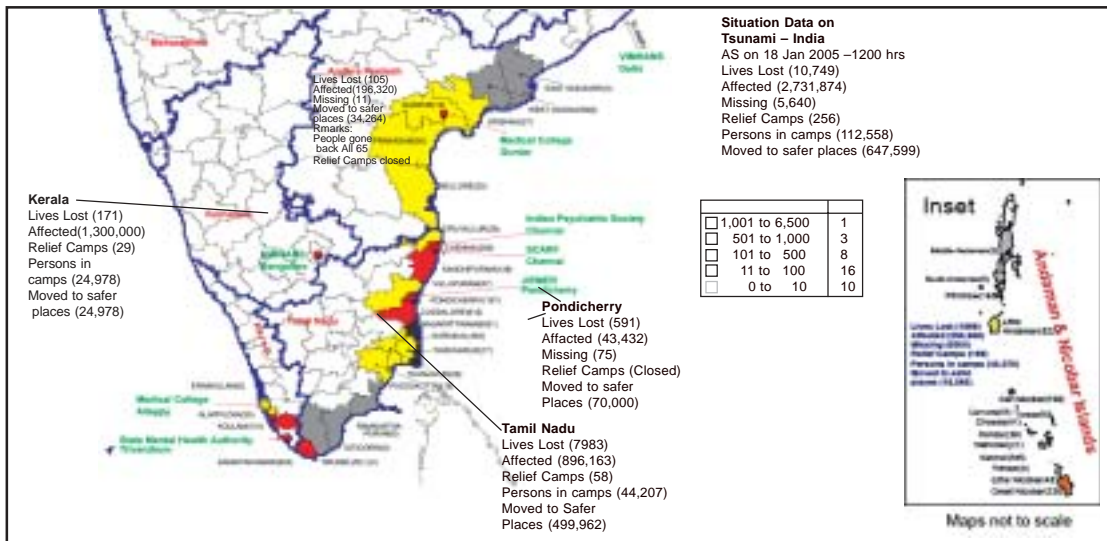
Psychosocial Support For Tsunami affected populations in India

I. Introduction

The tsunami tidal waves that swept the countries of South and South East Asia on the morning of 26th December 2004, affected 2260 kms of the Indian coastline. There were 10,749 deaths while 5,640 were reported as missing. More than 600,000 people were internally displaced and sheltered in temporary camps. Fig.1 gives areas affected by the tsunami and lives lost in India.

Besides the massive physical loss of lives, means of livelihood, property, agricultural land and crops, the mental trauma and agony of survivors has been immense. People lost their entire families and loved ones and watched their life's belongings disappear. Children were orphaned and women widowed in one stroke.

Fig. 1. Areas affected by Tsunami - India



Intensely traumatic events like the tsunami can lead to acute and long-term mental health and psychosocial consequences. In the initial stages after a disaster, trauma related psychological and behaviour responses like acute stress reaction, disaster syndrome, grief reactions, withdrawal and even aggression, violence and conflict can occur.

- Phase 1 (during and up to 4 weeks)
 - Acute stress reaction/ Disaster syndrome
- Phase II (2-6 months)
- Phase III (>6 months)
 - Delayed manifestations
 - PTSD (symptoms of acute stress reaction lasting for more than one month)

Large majority of the affected population will need only minimal support in 'normalizing' their lives. This can best be provided by people who are knowledgeable about the community, understand the needs expressed and otherwise, and have the attitude and time for care and support of their neighbours.

- Most people do not see themselves as needing mental health services following a disaster and will not seek such services.
- Survivors may reject disaster assistance of all types.
- Disaster mental health assistance is often more practical than psychological in nature.
- Disaster mental health services must be uniquely tailored to the communities they serve.
- Mental Health workers need to set aside traditional methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully in disaster.
- Survivors respond to active, genuine interest, and concern.
- Interventions must be appropriate to the phase of disaster.

- Social support systems are crucial to recovery.

Psychosocial support systems are critical for recovery in disaster situations. The two major aspects of psychosocial interventions for victims of disaster are

- Rebuilding the community, and
- Individual intervention.

While the healing and rebuilding of the community is an essential underpinning for the healing of individuals and families, this in turn is necessary for the reconstruction of the community. Either way, the underlying principle is to encourage healing processes in individuals, families and communities.

Other principles of psychosocial support include empowering individuals affected by the disaster, creating support groups and building on the community strengths, traditions and resources.

Initial relief efforts after the tsunami focused on recovery and subsequently on rehabilitation. The need for psychosocial support (PSS) was felt strongly at this point and soon medical camps with psychiatrists and mental health professionals were set up.

The medical camps provided much needed medical and psychological aid to the affected community and acute symptoms were identified and treated. However, the care providers were often unfamiliar with the social and cultural background of the community and the local language. Besides, there was the added limitation of accessibility, affordability, availability and even continuity of these camps. This necessitated the development of a new paradigm for community based psychosocial support in disaster situations.

The WCO (WHO India Country office), along with the UN team for recovery support, proposed a community based approach in which trained community level workers would provide the primary level of care. This approach was successfully applied in the disaster-affected states of Tamil Nadu, Andhra Pradesh, Kerala and the Union Territory of Pondicherry. Lessons learnt from its application were used to build a generic model for providing psychosocial support in disaster situations.

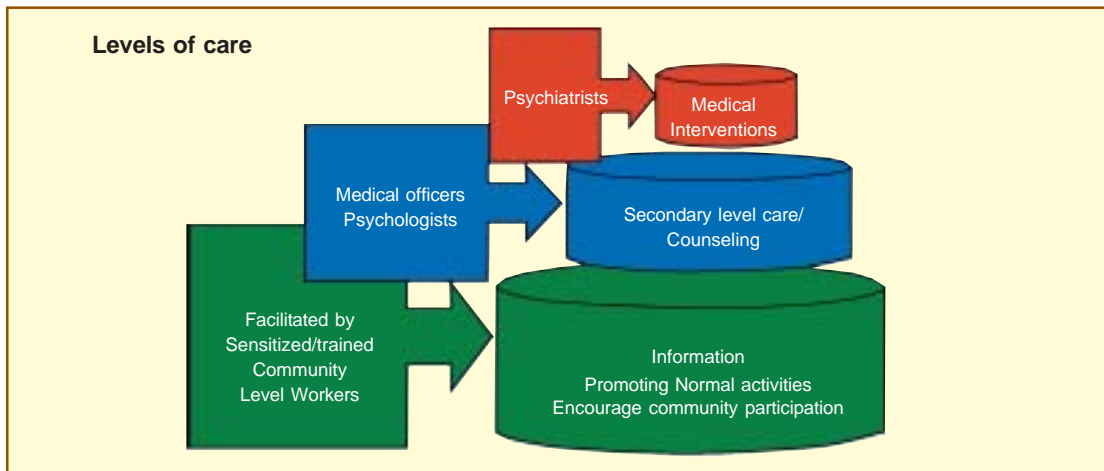


II. Framework for Psychosocial Support

Figure 2 provides the framework for PSS at different levels of care. The first level is through trained Community Level Workers (CLWs), whose responsibilities are listed in Box 1. CLWs are identified from those people and agencies that are available in the affected area for a longer duration. After a structured training, they are guided and their activities coordinated by a nodal agency. Each CLW is allotted a minimum of 20 families (approximately 100 individuals at an average of 5 persons per family), to help promote recovery by being active listeners of the community. They will also provide necessary social support to help individuals and families to normalize their lives as much as possible.

Medical Officers at the primary health care level and psychologists will form the next level of care and most of the common mental disorders can be handled at this level. Psychiatrists from the District Hospital or Medical College can provide technical support and referral care.

Fig. 2 Framework for PSS



Trained CLWs can remain as a community resource and their services can be utilized in various social support and development programmes.

For disaster preparedness, the vulnerable areas can identify a group of CLWs and train them in providing PSS. Such trained CLWs can be pressed into action in the unfortunate event of a disaster.

Box. 1. Responsibilities of Community Level Workers (CLWs)

- Integrate PSS fully with overall relief and rehabilitation activities
- Strengthen local resources
- Provide information
- Enable people to help themselves
- Establish / support information centres
- Involve other sectors and NGOs
- Help bereaved families
- Help the physically injured and their families
- Help severely mentally disturbed persons
- Help orphans/widows and others in special need
- Debrief rescue workers



III. Report of Psychosocial Support Activities

The proposed framework has been supported by the United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF), United Nations Office on Drugs and Crime (UNODC) and United Nations Population Fund (UNFPA).

The PSS activities were initiated in Tamil Nadu, Kerala, AP and Pondicherry. The framework for the training and delivery of services were the same and the report presents the work undertaken in these areas through various agencies.

The service provider in Tamil Nadu was the social welfare department whereas in Kerala, Andhra Pradesh and Pondicherry, it was the mental health institutions and medical colleges. Non-governmental organizations (NGOs) and other community based organizations provided technical resources and field support.

The PSS programme in Tamil Nadu was partnered by the UN Team for Recovery Support. In other states, the PSS initiatives were partnered by WCO.

a. Tamil Nadu

Tamil Nadu was the State worst affected by the tsunami disaster. An estimated population of 8,96,163 was affected across eleven districts resulting in massive loss of lives and damage to property. Nagapattinam district reported the maximum number of deaths and about 1,96,184 people were affected. Cuddalore district had a total affected population of 99,704 and Kanyakumari 1,87,650.

Following the disaster, a joint team comprising of the World Health Organization (WHO), United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF), United Nations Office on Drugs and Crime (UNODC) and the Department of Social Welfare began consultations on developing a comprehensive psychosocial support programme for the state at a workshop on 24 January, 2005. Seventy-nine members from non-governmental organizations, training and research organizations, medical colleges and United Nations agencies participated in it. The meeting worked out details of the training strategy, identification of trainers and development of training

schedules at the state and district level, and a plan for the implementation of psychosocial care was finalized.

Model of delivery

Service delivery was through trained community level workers who would provide the primary level of care. These workers were drawn from health, social welfare and education departments, anganwadi workers, NGOs, among others. They were sensitized to the psychological needs and symptoms of victims and worked purely on a voluntary basis.

The Department of Social Welfare, Government of Tamil Nadu, was identified as the state's nodal agency. It planned the training at the state, district and community levels and coordinated the implementation of PSS activities in the state. Activities were also initiated with National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore, Vidyasagar Institute of Mental Health and Neuro Sciences (VIMHANS), New Delhi, and Schizophrenia Research Foundation of India (SCARF), Chennai, under the WCO framework.

Training

Training was conducted at the state, district and community levels. The process was of a cascading nature, which filtered down from the master trainers' level to the community level workers. WHO training manuals for psychosocial care were translated into Tamil and used for training.

Orientation for master trainers

A master trainer's orientation was held on 3rd February 2005 at the Department of Social Welfare, Chennai. The purpose of this orientation was to thoroughly familiarize and guide selected master trainers on the strategies and plans of psychosocial support in the state, the training manuals, and the training methodology and schedules at the regional and district levels.

Ten resource persons conducting the orientation were drawn from the above mentioned organizations and from UN agencies, professors of social work and professional psychiatrists. The Department identified 48 professionals selected from the field of mental health and social work drawn from the government and NGOs as master trainers. These master trainers would in turn train trainers at the district level.

Training manuals were given out for study and review. It was decided that the 'training

of trainers' program would be divided into two streams: one for adults, and the other for children.

The training methodology was planned on adult learning principles with thorough utilization of participatory learning and action tools. It would be guided by creative responses, keeping in mind the level of sophistication, knowledge, skills and literacy of the community level workers.

Training of trainers (ToT)

The Department of Social Welfare clubbed the 11 tsunami-affected districts into 4 regions based on their geographical locations and proximity. Details of the ToT conducted at the regional level are given in Table 1 (page 20).

Table 1 Training of Trainers - Tamil Nadu

S. No.	Place of TOT	Districts Covered	Date	No. of Resource Persons	No. of Trainees
1	Chennai Kancheepuram, Tiruvallur	Chennai,	10,11,12 Feb 2005	16	109
2.	Cuddalore Viluppuram	Cuddalore,	23,24,25, Feb 2005	8	100
3.	Thanjavur Nagapattinam, Tiruvarur	Thanjavur,	23, 24, 25 Feb 2005	10	125
4.	Tirunelveli Thootukudi, Kanyakumari	Tirunelveli,	22, 23, 24 March 2005	8	96
	Total				430

The process for the arrangement and organization of the TOTs was similar in all the four regions.

District Social Welfare officers first obtained mandatory permission from the District Collector to implement the programme in the respective districts. Next, details of the psychosocial programme , its aims and objectives , training schedules and service delivery mechanisms were sent out to all heads of departments to recommend

prospective participants. Participants for the ToT were mostly drawn from government health departments, local NGOs, youth groups, local schools and colleges. Participants were trained in batches of 25-35 each for three days and parallel training methodology and techniques were deployed.

District level training of Community Level Workers

Following the TOTs in the four regions, district level trainings of community level workers (CLWs) were conducted by the trainers in each of the tsunami-affected districts of the state. A total of 120 training programmes were conducted in batches at the district level, organized by the District Social Welfare departments of the respective 11 districts. Table 2 presents the training schedules of CLWs at the district level in Tamil Nadu.

Table 2 Training of CLWs -Tamil Nadu

S. No.	District	Dates	Number of resource persons	Number of trainees
1	Chennai	21, 22 February 05	16	162
2	Tiruvallur	1, 2 March 2005	6	50
3	Kancheepuram	17, 18 February 2005	30	250
4	Cuddalore	28, 29 April 2005	40	500
5	Viluppuram	8, 9 June 2005	20	250
6	Thanjavur	29, 30 March 2005	3	25
7	Nagapattinam	19, 20, 23, 24, 25 May 2005	73	800
8	Tiruvarur	4, 5 Apr 2005	11	76
9	Thootukudi	4, 5 April 2005	6	50
10	Tirunelveli	30, 31 May 2005	3	25
11	Kanyakumari	2, 3 April 2005	50	625
	TOTAL			2,813

The training was conducted in batches with 25-30 trainees per group and 3-4 master trainers conducting the activities. Community level workers were selected from the existing network of government departments at the grassroots level, NGO's and field level workers who were familiar with and working in the affected area. They were representatives of the community who were approachable, had good communication skills and were well liked. Extension officers and field level functionaries of the District social welfare departments identified them from the following groups:

- Health, education and social work personnel working at the community level
- Anganwadi workers (ICDS)
- Nehru Yuva Kendra members
- Auxiliary nurse- midwives
- NGO s & CBO's
- Social work students
- Retired teachers
- Self help groups
- Volunteers from the community

Each training programme was for two days. On the first day the objectives and service cycle of psychosocial support and basic counselling skills were introduced by role-play and group discussion. Communication skills and identification of symptoms in adolescents and adults was taken up on the second day. Community level workers were sensitized to the psychological needs and symptoms of affected families. Simple facilitation techniques were taught for developing rapport, listening to and empathizing with survivors, and using culturally appropriate ways to manage grief.



Fig 3. Resource persons from the UN team conduct a review workshop with the Department of Social Welfare, Tamil Nadu.

The Department of Social Welfare conducted a review and follow up workshop on 12 and 13 April, 2005 at Natesan Institute of Cooperative Management, Chennai. District social welfare officers and Department officials participated in the meeting coordinated by resource persons from WHO.

To ensure successful continuation of psychosocial care and support in Tamil Nadu, a workshop for coordination, referral linkages and sustainability was organized by the Department on 2nd and 3rd August 2005 in Chennai. The workshop recommended the establishment of a strong coordination and referral mechanism between the health and social welfare departments, mapping of personnel and services available and sharing of this information; sensitization and capacity building of staff in the health department, training and retraining of workers, and monitoring the community level workers.

Field Work

Each CLW was allocated a minimum of 20 families in his/her area. A format with data containing details of family members and basic health problems was given for use during visits to families. The CLWs were instructed to visit their allocated families 3-4 times a week and counsel them as needed. This helped people to normalize their lives and get back to their daily routine. The CLWs served as links between various agencies and the community, and would liaise with the district administration and government departments on any concerns of the community such as delays and impediments in receiving relief packages.

Although there was no formal arrangement with the health department, CLWs referred severe trauma and mental health cases needing psychological/ psychiatric support to professionals at the district and block level. They also provided particular assistance to vulnerable groups of children, orphans, the destitute, the physically disabled and injured, and widows. The CLWs also helped identify a few social and economic problems and ensured that appropriate help was provided.

The work of CLWs was monitored through a reporting structure from the village, block, district and to the state level. CLWs filled the formats and submitted them to the field level coordinators at the village level. They in turn would forward it to the extension officers at the block level from where it would reach the district level social welfare officer. The reports were collated and summarized at the district level and findings presented to the state level. The district social welfare department held monthly review meetings of community level workers' groups (e.g. ICDS, NYK, SHG) preferably in their own locations to share information, provide consultations and advice, and discuss problems and situations in the field. One representative from each group in turn had weekly or biweekly meetings with the department in concerned areas.



Fig 4. Community level worker visiting an affected family in Nagapattinam

The district social welfare staff also monitored the CLWs by supervising their visits regularly. This was done to evaluate the level of rapport and relationship of the community level worker with the families.

Psychosocial cell

A dedicated cell with a full time psychologist and data manager was established in the Department of Social Welfare, Chennai. The psychosocial cell helped in the coordination and reporting of PSS activities in the State.

Status of the PSS programme at one year

Trained CLWs have counselled 32,852 families and 1,51,424 individuals in the affected communities. This counselling is an ongoing process. Using a simple format, details of the affected families are being collected and their mental health status is being assessed and analyzed.

In the initial days after the tsunami, the CLWs were mainly engaged in providing support to reduce the trauma and grief from the tsunami and helping families recover. Currently, their role has expanded beyond providing psychosocial support, to being a link between the communities and various government and non-governmental agencies. The CLWs have been able to develop a lasting rapport with the affected families, and have become a permanent resource for their communities. The details of the numbers of families and individuals supported are provided in table 3 (page 17).

Table 3: Numbers of families/ individuals counselled

S. No.	District	Number of CLWs trained	Number of families counselled	Number of individuals counselled
1	Chennai	162	744	2,180
2	Kancheepuram	250	3,571	14,284
3	Thanjavur	25	840	3,781
4	Kanyakumari	625	3,101	13,594
5	Thiruvallur	50	266	1,290
6	Cuddalore	500	4,317	14,080
7	Nagapattinam	800	15,600	72,400
8	Thoothukudi	50	145	578
9	Tirunelveli	25	326	1,522
10	Villupuram	250	3,914	27,644
11	Thiruvarur	76	28	71
	TOTAL	2, 813	32,852	1,51,424

b. Pondicherry

In the Union Territory of Pondicherry the tsunami disaster affected a total population of 43,432 across fifteen villages. The death toll stood at 591 while 75 persons were reported missing. District Karaikal was worst affected with 16,383 people affected across ten villages, 484 deaths and 66 missing.

Model of delivery

The Jawaharlal Nehru Institute of Postgraduate Medical Education and Research, Pondicherry (JIPMER) was selected as the nodal agency for psychosocial support in the Union Territory.

As in Tamil Nadu, here too the service delivery utilized community level workers and the nodal agency, JIPMER, directly conducted the training. The cascading nature of training from district to the community level was not adopted because of the relatively small size of the population and area.

Training

Community level training was conducted for four groups comprising of school teachers, NSS (National Service Scheme) volunteers, NCC (National Cadet Corps) cadets and two groups of medical and paramedical personnel attached to Government General Hospital at Pondicherry. The nine resource persons were drawn from the Department of Psychiatry, JIPMER, psychiatric social workers, paediatricians and faculty from other medical colleges. Training programmes were organized in association with the Directorate of Education, Directorate of Health and Family Welfare and NSS coordinators at Pondicherry and Karaikal.

WHO training manuals for psychosocial care, translated into Tamil, were used for training. The training programmes were conducted in a day's session and all the means of identifying individuals requiring psychosocial support were explained.

Table 4 : Training of CLWs - Pondicherry

S.No.	Date	Participants	Number	Venue
1	19-01-2005	School Teachers	100	Chevallier Sellan Govt. Hr. Sec. School, Pondicherry
2	30-01-2005	NSS Volunteers	100	Youth hostel, Solai Nagar, Pondicherry
3	2-02-2005	Medical and paramedical personnel	19	General hospital, Pondicherry
4	12-02-2005	NCC and NSS Volunteers	100	PAJANCOA & RI, Karaikal



Fig 5 - Training on psychosocial intervention by JIPMER, Pondicherry

Status of the PSS programme at one year

Two hundred and thirty two individuals (99 men, 107 women and 26 children) were identified for further care. Of these, 68(of 69) in Pondicherry and 138 (of 163) in Karaikal recovered completely. Tables 5 and 6 give the recovery profile of patients who received repeated counselling.

Table 5: Recovery profile of patients - Pondicherry

S. No.	Follow-up Date	Total Identified with illness	Improved	Referred to Hospitals	Still have problem
1.	2/2/2005	69		69	69
2.	5/3/2005		34	28	28
3.	4/4/2005		50	19	19
4.	6/5/2005		67	2	2
5.	3/6/2005				2
6.	7/7/2005		68		1
7.	8/8/2005				1

Table 6: Recovery profile of patients - Karaikal

S. No	Follow –up Date	Total Identified with illness	Improved	Referred to Hospitals	Still have problem
1.	8/2/2005	163		163	163
2.	10/3/2005		62	101	101
3.	13/4/2005		90	52	52
4.	11/5/2005		128	35	35
5.	14/6/2005		138	25	25
6.	17/8/2005				25

c. Kerala

The tsunami tidal wave affected a large number of villages in the districts of Thiruvananthapuram, Kollam, Alappuzha and Ernakulam in the state of Kerala. The total population affected was 13,00,000 with 171 deaths.

The Kerala State Government responded to the disaster by setting up medical camps for relief and rehabilitation activities. This included a team from the Department of Psychiatry, Trivandrum Medical College, which visited the affected areas. This team focused on providing psychological aid and treatment to the victims.

Model of delivery

The Kerala State Mental Health Authority, (SMHA) Thiruvananthapuram along with the Director of Medical Education and Director of Health Services, Kerala was the nodal agency for implementing the psychosocial support programme in the state. WCO entered into contracts with SMHA, and Medical College, Trivandrum and TD Medical College, Allepey for providing PSS.

The first step was formation of state and district level committees. A meeting was held on 8th April 2005 in Thiruvananthapuram, to constitute these committees. It was decided that the state level committee would consist of the Secretaries of the Health and Education Department, Director of Medical Education and Health Services and the Secretary of the SMHA. The district level committee of Kollam comprised of the district collector as the patron and district medical officer as the secretary, with two technical nodal persons and district social welfare officer as members. In Alappuzha district, the principal of Allepey Medical College was chosen as the patron while the head of the psychiatry department, technical nodal persons, elected member of panchayat and local mental health professionals were made members of the committee.

The meeting also discussed the model of programme delivery with CLWs as the primary level of care, details of the selection of the CLWs, tasks to be assigned to them and coordination with other volunteer agencies involved in psychosocial support.

Support, in the form of two clinical psychologists and two social workers for the districts of Kollam and Allepey, was provided following the recommendations of this meeting.

Training

A cascading training was planned, filtering down from the state to the district level. Training manuals from WHO were adapted, translated into the local language, Malayalam, and distributed to the districts.

Training of trainers

The training of resource persons for district level training was conducted by the SMHA in Thiruvananthapuram at the Department of Psychiatry, Medical College. It was a one day programme with 38 participants. They comprised of eight members from the faculty of Psychiatry, Medical College, Trivandrum, four from the Psychiatry

Department, Medical College, Allepey, two social scientists, three district medical officers of Kollam, five psychiatric social workers, twelve students of clinical psychology and social work and four members from NGOs. The participants were provided with training materials in the form of hard copy and CD copy.

Training at District level

Community level training was conducted for all three affected districts in the state as given in Table 7.

Table 7 : Training of CLWs - Kerala.

District	Date	Venue
Thiruvananthapuram	18/05/05-19/05/05	De-addiction Centre, Trivandrum Medical College
Alappuzha	30/05/05- 31/05/05	Main Auditorium, Allepey Medical College
Kollam	23/05/05-25/05/05	IMA Hall, Karunagapally

Fourteen trainees from the five most affected panchayats in Thiruvananthapuram district attended the training. Resource persons were from among those trained at the training of trainers' programme. Community level workers were selected from the Literacy Mission. In Kollam, 51 community level volunteers attended the training from whom 35 were selected. In Alappuzha, hundred volunteers attended the training programme including members from health services and the Mahila Swasth Sangh. Nineteen members from the Nehru Yuva Kendra and 15 from the Literacy/ Saksharatha mission were chosen as community level workers. Two resource persons were chosen from the Department of Psychiatry, Allepey Medical College. One psychiatric social worker from Medical College, Kottayam and one from the Department of Community Medicine, Medical College in Allepey also participated.

The training agenda consisted of basic skills in counselling and relaxation techniques, ventilation and listening skills. The training sessions also included identifying psychological responses to disasters and psychosocial support to special groups like women, children and the elderly. CLWs were informed about their specific tasks in the community and their reporting structure via formats and proforma designed by SMHA.

Field Work

CLWs visited families and individuals at frequent intervals to help in the normalization process.

Kollam district

The Psychosocial Support team organized several group meetings in the affected communities following the programme launch. In June 2005, a women's meeting was organized where family issues, alcohol dependence, problems of children, trauma related problems and stress management were discussed. In the same month, a survivor's group meeting was held which discussed life after disaster, relaxation techniques and stress management.

In July 2005, adolescent group meetings were held to discuss alcohol and substance abuse, educational issues and to provide career counselling. In August 2005, children's group meetings were held involving play therapy, social activities, drawing and painting.



Fig 6- Nodal psychiatrist and social worker visiting an affected family

Thiruvananthapuram district

During the period June 2005 to October 2005, the psychosocial support team held awareness and counselling sessions in schools, local associations, clubs, orphanages, and charitable trusts. Counselling services were rendered to five schools and six local associations in the affected panchayats of the district. The team made visits to churches, arts and sports clubs to create awareness about the specific psychosocial interventions and mental health issues. Self-help associations were visited by the social worker for the same purpose.

Alappuzha district

A strong network was established with local national and international agencies like Oxfam, World Vision, Non resident Indian Foundation, Quilon, several schools and other institutions. One of the outcomes of these relationships was that World Vision agreed to provide medicines free of cost to the patients identified by the CLWs.

CLWs were monitored directly by the social worker and psychologist in the field. The inspection of a field diary, containing details of all the families and individuals visited and identification of cases for referral, was done on a monthly basis. Individual and family health details were also recorded in this diary. The social worker and psychologist made supervisory visits in the field and assessed the work done. The social worker also reported the CLW's regular activities to the nodal psychiatrist and district health officer.

The social worker and psychologist held bi-weekly review meetings with the CLWs. Nodal persons held monthly meetings with the CLWs to discuss any problems and to get feedback from the field.

Status of the PSS programme at one year

In Thiruvananthapuram district, the social worker along with the CLWs visited 6563 houses, screened 11,831 persons and identified 484 problem cases. The mental health team saw 176 cases of which 12 were diagnosed as post- traumatic stress disorder (PTSD), 6 as panic disorder, 3 as generalized anxiety disorder and 22 cases as adjustment disorder. Twenty-five cases of alcohol dependence were also identified.

In Kollam district, the CLWs visited 3520 houses, screened 6526 persons and identified 213 subjects for referral care. The diagnoses in these subjects included

depression, anxiety disorder, PTSD, complicated grief and alcohol dependence. Treatment was provided appropriately.

In Alappuzha District, CLWs visited 7500 persons, and identified 600 subjects for referral care by the psychiatrist.

d. Andhra Pradesh

In Andhra Pradesh the tsunami caused extensive damage to 166 villages in the districts of Nellore, Krishna, Guntur, Prakasham, East and West Godavari. Sixteen thousand five hundred and seventy eight people were affected across thirty villages in Nellore, 30,700 in twelve villages of Guntur, 92,547 people in seventy two villages of Prakasham district and 13,061 in thirty five villages of Krishna district. Following the disaster, psychosocial support programmes was initiated in these four districts in the state.

Model of delivery

In the first week of April, WCO held meetings with the departments of Health services, Medical Services and Education and the State Mental Health authority (SMHA) at Hyderabad. The SMHA was identified as the nodal agency for providing psychosocial support in the state. Programme implementation in Krishna and Nellore districts was directly under the SMHA while the Psychiatry Department of Guntur Medical College was given charge of Prakasham and Guntur districts.

The model of programme delivery was based on the framework proposed by the WCO. As in the models for Tamil Nadu and Kerala, community level workers provided the first level of care. Training was conducted at the state, district and community levels. CLWs were trained by trainers, who in turn were trained by resource persons at the district headquarters.

Training

Training at State Level

On 18 April 2005, a state level training was held at the Institute of Health and Family Welfare, Hyderabad. The 25 participants consisted of district medical and health officers, and faculty of psychiatry from the different districts of Andhra Pradesh. The resource persons were from the faculty of the Institute of Mental Health, Hyderabad. The topics covered were psychosocial reactions seen among victims, general social measures to enhance emotional well-being of disaster affected people, psychosocial

intervention for special groups, and counselling techniques to be used by CLWs. WHO training manuals were translated into the regional language Telugu and distributed.

During the state level training strategies were worked out for training at different levels, service delivery and monitoring of the programme. The details for identification of potential CLWs, training venues, duration and materials to be used were also mapped. Training duration for the district level was fixed for a day and at the village level for two days. A nodal psychiatrist and a district health officer were chosen for providing technical support and a social worker was chosen for identification of CLWs and reporting for each district. All fieldwork activities were to be coordinated by the social worker and supervised by nodal psychiatrists.

Training at district Level

Nellore district

The training for CLWs in Nellore district was conducted on 6 May 2005 at the District Headquarters Hospital. Thirty-three participants from the seven affected mandals of Nellore district attended the programme. The CLWs were identified from among anganwadi workers, self help groups and volunteers from the community. The sessions were conducted by two psychiatrists from the hospital, the district coordinator, medical and health officers.

A follow up district level training for health assistants, medical officers and district welfare officers was conducted on 18 August 2005 at the District Hospital.

Krishna district

The district level training followed the same pattern here as in Nellore district. The community level training was conducted on 19 May 2005 at the District Headquarters Hospital in Machilipatnam, Krishna. Twenty trainees, identified from the four affected mandals of the district attended. The resource persons were two psychiatrists from the district headquarters hospital, the district coordinator of health services, district immunization officer, psychiatric social worker, district health and medical officer and the superintendent of the district hospital. The trainees were from self-help groups, anganwadi workers and volunteers from the community.

A district level training of health assistants and medical officers was conducted on 20 August 2005, at the District Headquarters Hospital in Machilipatnam, Krishna.

Field Work

Each CLW was allotted 20 families on an average. The CLWs made regular visits to the affected families allocated to them by the nodal social worker in their respective districts. In addition, CLWs conducted group-counselling sessions at the village panchayat halls, and identified people with problems at these sessions. Whenever they identified severe trauma and related cases, the CLWs made frequent visits to the concerned family and counselled them. If needed, referrals were made to the health department at the district level.

The work of CLWs was coordinated by the social workers at the village level. The CLWs filled the formats and submitted it on a monthly basis to the social workers. The social workers made consolidated reports of cases identified by the CLWs for referral. These reports were submitted to the nodal psychiatrist and nodal district level health officer every fortnight. They in turn decided the course of action for these referrals and supervised follow up of those referred.

Status of the PSS programme at one year

In Nellore district a total of 43 cases have been identified as suffering from phobia, anxiety and depression. The community volunteers, social workers and MPHAs have counselled all of them. Twenty-three patients have recovered after follow up counselling and 20 referred to the medical officers. Out of these 14 were referred to the psychiatrist. All patients have recovered fully.

In Krishna district a total of 48 cases have been identified as suffering from phobia, anxiety, depression, acute stress and alcohol abuse. Out of them, 38 have been counselled by CLWs and ten cases by the nodal social worker. Thirty cases have completed a second follow up session and twenty-four cases, a third follow up session. Eight cases have been referred to primary health care doctors in the district and seven referred to psychiatrists.

e. SCARF, Chennai

The Schizophrenia Research Foundation of India, SCARF, in collaboration with WCO provided psychosocial support to the tsunami victims in Chennai, Cuddalore and Pondicherry. SCARF's main focus was to train mental health professionals and community health workers in psychosocial management, provide psychosocial and psychiatric intervention to the victims of the disaster and provide care for the mentally ill in the community.

After making a rapid assessment of the tsunami affected populations, SCARF identified the need for psychological support in terms of counselling and medication as an important need expressed by the people surveyed. About 53% of the individuals surveyed indicated the need for some kind of psychosocial support.

Model of delivery

The first step was to train social workers both lay and professional. These social workers then identified people needing psychosocial support and counselled them as appropriate. Severely depressed and traumatized cases were referred back to the SCARF team for psychiatric medical management. The final step dealt with follow-up of cases, which was done through the social workers from the community.

Training

During disasters such as these, a lot of makeshift counselling is done by people who are keen to do their bit for the victims, but are not trained to do so. SCARF, therefore, developed training modules for different sections of the population to lend a scientific basis for counselling. The three modules were:

1. For mental health professionals (psychiatrists, psychiatric social workers, psychologists and those who had some basic training in counselling)
This module included descriptions of sequelae of disasters such as Acute Stress Disorder and PTSD, detection of early signs and symptoms, and their medical and psychosocial management.



Fig.7 Medical officers receiving certificates for PSS training in Nellore

2. For lay counsellors, staff of NGOs working in the field, women's groups, etc. This focused on identification of signs of stress and simple measures of support and counselling that can be given.
3. For teachers, parents, etc. to help them deal with problems of children. It described children's reactions to stress and their management.

SCARF also made posters in Tamil and English that were put up in the tsunami affected areas. These contained simple, practical advice on handling psychological trauma and dealing with the process of normalization.

Details of various training programmes in different places are given below.

Chennai

The first training programme was held on 3rd January 2005, at Stella Maris College and was attended by more than a hundred students and volunteers. The content of the programme comprised of an introduction about crisis intervention and its need, common traumatic stress reactions experienced by survivors, signs and symptoms of stress disorders, general principles of emergency care, types of treatments available/ possible, psychosocial interventions, special needs of vulnerable groups such as children, aged persons and the disabled.

Subsequently, more than a dozen training programmes have been held in Chennai for other NGOs, Women's self help groups, individuals and professionals. Around 850 individuals have been trained in Chennai alone.

Table.8 : Training programmes by SCARF.

S. No.	People Trained	No of people trained	Venue	Date of the Training
1	Students of Stella Maris College, Professionals & Volunteers	120	Stella Maris College	3 Jan 2005
2	Psychology students of SIET College	44	SIET College	4 Jan 2005
3	Students, professionals, volunteers	25	SCARF	5 Jan 2005
4	Students, professionals, volunteers	14	Jeevan Blood Bank	6 Jan 2005
5	Psychology students of WCC	153	Women's Christian College	12 Jan 2005
6	Relief workers of ACDS	30	ACDS office	5 Feb 2005
7	Relief workers of UDAVI	50	Hotel Pentagon	6 Feb 2005
8	Relief workers of MCDS	15	Lufthansa Centre	19 Feb 2005
9	NSS volunteers	50	ACDS Office	19 Feb 2005
10	Relief workers of UDAVI	56	UDAVI office	20 Feb 2005
11	Women's SHG (MCDS)	66	MCDS Office	10 Mar 2005
12	Elders' SHG (MCDS)	60	MCDS Office	15 Mar 2005
13	Relief workers of MCDS	30	MCDS Office	18 Mar 2005
14	Relief workers of UDAVI	25	UDAVI office	21-23 Mar 2005
15	Field staff of MCDS	40	MCDS, Thiruvamiyur	5 Apr 2005
16	Field staff of MCDS	25	MCDS, Pattinapkkam	15 Apr 2005
17	Field staff of MCDS	40	MCDS, Besant Nagar	20 Apr 2005
18	Field staff of AID	44	SCARF Auditorium	14-16 Nov 2005
	Total	887		

Cuddalore

Training programmes have been conducted in Cuddalore for teacher trainers, women's self help groups and other NGOs such as CREED, MNTN and BLESS. SCARF also worked with the local administration and District Collector, JD Health services, DRDA, Women's SHG, Nehru Yuva Kendra, Dalit Munetra Kazhakam, local psychiatrists, local panchayat and community volunteers.

SCARF has trained around 350 individuals (both professional and lay workers) who were involved in relief activities. Table 9 presents details of types of people trained by SCARF in psychosocial relief activities.

Table 9 : Training by SCARF - Cuddalore.

S.no.	Type of People Trained	No. of people trained	Venue	Date of Training
1	Teacher trainers	50	Women's Development Corporation, Cuddalore	5 Jan 2005
2	Village volunteers	54	Collectors office, Cuddalore	6 Jan 2005
3	Women's SHG	53	Sonakuppam, Cuddalore	7 Jan 2005
4	Members of NYK	48	Hotel Durai Plaza, Cuddalore	5 Feb 2005
5	Relief workers of Dalit Munetra Kazagam (DMK)	35	DMK office, Cuddalore	24 to 26 Feb 2005
6	MNTN Cuddalore	12	Cuddalore	10-11 Mar 2005
7	CREED	20	Chidambaram	25-26 Mar 2005
8	MNTN - SHG	35	Cuddalore	21-22 Jun 2005
9	CREED	20	Chidambaram	23-24 Jun 2005
10	Help Age India	33	HAI office, Cuddalore	5- 6 July 2005
	Total	360		

Pondicherry

In Pondicherry, SCARF held training programmes for volunteers including survivors, relief workers, residents of the Auroville Ashram, local NGOs and women's self help groups among others. In all, five training programmes have been held in which over 200 individuals received training. Table 10 provides details of training conducted by SCARF in Pondicherry.

Table 10: Training by SCARF in Pondicherry.

S.No.	People Trained	No. of people trained	Venue	Date of Training
1	Women's SHG	57	Auroville community centre	25 Jan 2005
2	Women's SHG	65	Auroville community centre	1 Feb 2005
3	Women's SHGs & Volunteers	70	Auroville community centre	8 Feb 2005
4	Relief workers from Auroville	15	Auroville community centre	8 Feb 2005
5	Women's SHGs & Volunteers	22	Auroville community centre	21 May 2005
	Total	239		

Other Regions

Training programmes were held in Nagercoil for relief workers from TRUE (Tirunelveli), ATWT (Tuticorin), SEED (Kanyakumari) and PRAXIS (Kanyakumari). In all, over 200 individuals received training on how to identify cases and the techniques of providing psychosocial intervention for the affected individuals. Training programmes were also held for the NGOs from Nagapattinam such as ISED, Bharathi Trust, Help Age India and Avvai Trust. Table 11 presents details of training programmes held in other tsunami affected regions.

Table 11: Training programmes held in other tsunami affected regions.

S.no.	People Trained	No. of people trained	Venue	Date of Training
1	Relief Workers of Leprosy Mission Trust	13	Villipuram	2 Feb 2005
2	Relief workers of ISED	10	Nagapattinam	9 Feb 2005
3	Relief workers of TRUE, ATWT, SED & PRAXIS	48	Nagercoil	1 to 3 Mar 2005
4	Relief workers of TRUE, ATWT, SED & PRAXIS	65	Nagercoil	4 to 6 Mar 2005
5	Relief workers of ISED	38	Nagapattinam	16 June 2005
6	Bharathi Trust staff	12	Nagapattinam	22 June 2005
7	Avvai Trust staff	18	Nagapattinam	24 June 2005
8	Help Age India staff	12	Quilon	11-12 July 2005
9	Village heads, Panchayat leaders, SHG members	36	Nagapattinam	22 Nov 2005
10	Field staff and SHG members of Help Age India	14	Quilon	24-25 Nov 2005
	Total	266		

Field work

SCARF held its first psychiatric camp for tsunami survivors in Pattinapakkam area in Chennai on 29th Dec 2004, three days after the tsunami. It has since been conducting regular psychiatric clinics here every two weeks. At present 102 individuals have been identified as being in need of psychosocial/ psychiatric intervention and have been treated at these clinics.

At Cuddalore, from mid February till date, the SCARF team visited all the 58 affected villages of Cuddalore. Of these, 30 villages were provided consultation and counselling. Currently, 285 individuals have been found requiring psychosocial intervention of whom 208 received treatment.

In Pondicherry psychiatric camps were conducted in collaboration with the Auroville Health Center.

By November 2005, the tsunami camps were functioning as community mental health camps and providing psychiatric support in terms of medication and even admission to the chronically mentally ill in areas which had limited access to mental health care.

Major mental illnesses such as schizophrenia, bipolar disorder, psychotic depression, etc., made up 8.5% of all the cases seen. Minor mental illnesses such as anxiety, depression, etc., and Post Traumatic Stress Disorder (PTSD) made up the bulk (82.1%) of the patients seen.

Status of the PSS programme at one year

A total of 1,742 individuals were trained in psychosocial intervention comprising mental health professionals, students, NGO staff, Nehru Yuvak Kendra members, members of SHGs, teachers, village leaders, NSS volunteers, panchayat heads, relief workers and volunteers in Chennai, Cuddalore, Pondichery, Nagapattinam, Nagercoil, Villipuram and Quilon.

About 450 individuals were treated at SCARF's tsunami camps. Most have recovered well. In November 2005 only about 96 individuals required sustained treatment. Of these 71 were chronically ill persons suffering from major mental illness.

The following are the suggestions made by SCARF as a result of its experience in working for the mentally ill in the tsunami affected areas:

- Most of the trainees were individuals and organizations that were not native to the region. They had visited the area in their eagerness to help and participate in relief efforts. Their activities and expertise were primarily focused on providing material relief. And following the fulfillment of this agenda, they left. Therefore SCARF recommends that training in psychosocial management is provided to the staff of NGO's native to the region. Those working in the area of health care should be preferred as they have strong pre-existing ties with the community, knowledge local customs, language and culture and will continue to function in the area after the "visiting" NGOs have left.
- A significant number of trainees were found to have undergone similar training conducted by other agencies. A centralized coordinating agency should be in place to coordinate activities of all agencies involved in providing relief measures.

- Most individuals who were traumatized psychologically by the tsunami recovered in about three to four months after the disaster and on an average required about two sessions. Normalization of their routines following provision of houses, livelihood, restarting of schools, etc. paved the way to recovery. The need for psychosocial intervention is in the period immediately following the disaster.
- Sufficient attention should be paid in controlling rumours to stop creating panic among the affected population. Concise and easily understandable information in the local language must be made available to be disseminated among the public with regards to its nature and mechanism, frequency and safety measures that can be taken.
- The mentally disabled form an especially vulnerable population following any disaster. Their access to mental health care remains virtually nonexistent particularly if they belong to a remote pocket where other needs receive priority. The mentally ill population must not be marginalized or ignored when disaster management strategies are planned. When service providers exit from the area alternative arrangements need to be made for the individuals who require prolonged care.

f. NIMHANS, Bangalore

The National Institute of Mental Health and Neuro Sciences, (NIMHANS) Bangalore, is a WHO Collaborating Centre that has been providing psychosocial care in the tsunami affected regions in partnership with the WHO. NIMHANS undertook psychosocial work for tsunami victims in four affected districts of Tamil Nadu. These were Nagapattinam, Cuddalore, Kanyakumari and Chennai.

The Institute's primary focus has been to train personnel from NGOs and other agencies working in the field. The aim was also to impart counselling skills tailored to post disaster scenarios and to assist the counselling programmes already in progress.

Training

The training was to be achieved through a three-step agenda:

- 1) By imparting essential counselling skills to voluntary agency personnel in order to facilitate them to provide psychosocial care.

- 2) Monitoring the care process through simple recording systems.
- 3) Implementing the psychosocial care programme and assessing its scope periodically.

Personnel from 30 voluntary agencies, each from Chennai, Cuddalore, Nagapattinam and Kanyakumari, were given a three day comprehensive training in counselling. The focus of the training was on:

- Ventilation
- Empathy
- Active Listening
- Social Support
- Externalisation of interest
- Value of relaxation
- Spirituality, and
- Referral techniques

To facilitate collaboration between NIMHANS and other Mental Health Professionals of Tamil Nadu, a Voluntary agencies' workshop was organized at Madurai on 21st January 2005 for about 80 participants. A Training of Trainers programme was also conducted at NIMHANS, Bangalore from 24 – 29 January 2005. About 30 participants attended the training. Table 12 provides details of training programmes conducted by NIMHANS in Tamil Nadu.

Table 12: Training programmes by NIMHANS in Tamil Nadu

S. No.	Agency personnel	Training duration in days	Date of training	Venue	No. of Participants
1.	Representatives from 11 NGOs	1	11 January 2005	Thiruvarur	57
2.	Volunteers from Art Of Living Foundation	2	3, 4 February 2005	Bangalore	17

contd on..page 37

Table 12: contd from ...page 36

S. No.	Agency personnel	Training duration in days	Date of training	Venue	No. of Participants
3.	Resource Centre teachers of Sarva Siksha Abhiyan	1	5 February 2005	Nagapattinam	37
4.	Resource Centre teachers of Sarva Siksha Abhiyan	1	7 February 2005	Mayiladathurai	33
5.	Community volunteers of DHAN Foundation	3	9,10,11 February 2005	Velankanni, Nagapattinam Dst	25
6.	Community volunteers of DHAN Foundation	3	12,13,14 February 2005	Cuddalore	27
7.	Teachers	1	12 February 2005	Chattanathapuram, Cuddalore	57
8.	Members of Nagapattinam Psycho Trust	1	12 February 2005	Nagapattinam	14
9.	Volunteers from Art of Living Foundation	3	15,16,17 February 2005	Ezhaipillaiyar Koil, Nagapattinam	42
10.	MSW students, NIMHANS	2	4, 5 April 2005	Bangalore	60
11.	Teachers & parents of Kendriya Vidyalaya Sangathan School	2	7, 9 April 2005	Kalapakkam	35
12.	Volunteers of OfERR	2	11, 13 April 2005	Trichy	50
13.	Local volunteers	3	18,19,20 May 2005	Tiruchi	52
14.	Teachers	2	22, 23 May 2005	Melmanakudi	20
15.	Volunteers for follow up activities	3	29, 30, 31 July 2005	Tarangambadi	50
16.	Staff of NGOs	3	28, 29, 30 September 2005	Nagapattinam	25
17.	Staff of EFFICOR	3	11, 12, 13 January 2006	Nagapattinam	15

NIMHANS is collaborating with all the NGOs working in the state of Tamil Nadu for follow-up training activities of the trained members. On the first anniversary of the tsunami, a follow-up training programme for NGO staff members was organized at Nagapattinam and at Cuddalore from 26th to 28th December 2006.

Working in tandem with the district and local administration, NIMHANS is making an attempt to evolve a comprehensive long-term plan of action. Other plans include networking with NGOs and CBOs, and initiating long-term training programmes for the staff of the department of Health, Education and Social welfare. Plans are also afoot to bring Nagapattinam, Cuddalore and Kanyakumari under the District Mental Health Programme. Besides, there is an effort to enhance the availability of trained personnel for providing psychosocial care. The target is to have one person for every 100 to 200 people.

Status of the PSS programme at one year

The following have been some of the achievements as a result of yearlong PSS activities in the state.

- Many TOT programmes have been conducted across the state. Three day training programmes have been organized in as many affected areas as possible utilizing the already trained personnel, particularly nurses, paramedical workers and personnel from educational institutions and anganwadis. The programme has yielded positive results as shown by the figures below:

No of Training Programmes:	25
No of participants:	912
No of Districts Covered:	12

Participants' Background

NGO Staff:	425
School Teachers:	182
Mental Health Professionals	175
Government officials	70
MSW Students	60

- With the help of mental health professionals in the state, a network of training has been established which caters to volunteers from different NGOs and CBOs.

Throughout the affected districts of the State, a mechanism has been set up to delineate the network of mental health professionals who are involved in providing psychosocial care. The zonal coordinators were identified, and through them the ongoing work monitored within the respective zones.

Trained volunteers have been providing psychosocial care effectively for women, children, men, disabled and the aged. The widely used techniques are ventilation, active listening, spirituality and social support.

A survey revealed that the training helped 69% of the community level workers to gain confidence in providing psychosocial care interventions. Nearly 12% of them are now able to train local volunteers on psychosocial care.

Thirty percent of the trained CLWs have been visiting families regularly. Twenty two percent of them have also been visiting the local schools/ Anganwadi centers sometimes. When compared to their other regular work, 53% of them have been satisfied in providing psychosocial care.

Community level workers have reported that more than half of the tsunami survivors have successfully gone back to their normal routines.

WHO-NIMHANS Workshop on “Psycho Social Support in Disasters”

The WCO sponsored a two day national workshop on “Psycho Social Support in Disasters” on 3rd and 4th February 2006, at the National Institute of Mental Health and Neuro Sciences, NIMHANS, Bangalore. The aim was to provide a platform to all those involved in providing psycho social care to the survivors of the tsunami victims for sharing their experiences. Participants at the workshop came from all the tsunami affected Indian states of Tamil Nadu, Andhra Pradesh, Kerala and the Union Territories of Pondicherry and Andaman and Nicobar Islands.

It was a great opportunity for mental health professionals, paraprofessionals, administrators, representatives of voluntary agencies personnel, survivors of the tsunami and others involved in psychosocial services from various parts of the country to review the quality and quantity of services provided and the impact on the disaster survivors in the country as a whole at the national level. The workshop also provided a platform to collate strategies adopted by professionals in reaching the victims of the

tsunami and to understand the activities undertaken at the field level by paraprofessionals and non-professionals from voluntary agencies.

The workshop was inaugurated by Dr. R. Parthasarathy, Professor and Head of the Department of Psychiatric Social Work (PSW) at NIMHANS. Several leading professionals spoke on the occasion. Among them were Dr. Cherian Varghese, Coordinator Non-Communicable Diseases and Mental Health, Office of the World Health Organization (WHO) Representative to India, Dr. Dinesh Bhugra, Dean, Royal College of Psychiatrists, London, Dr. Vijay Chandra, Regional Advisor-Mental Health, WHO Regional Office for South-East Asia, New Delhi, Dr. D. Nagaraja, Director and Vice Chancellor of NIMHANS and Prof. Vinod Chandra Menon.

Delegates discussed different aspects of disaster management such as capacity building and training, collaboration and coordination, relief and rehabilitation and monitoring and evaluation. The sessions also involved sharing of personal experiences by several tsunami survivors.

Workshop Recommendations

The workshop made the following recommendations:

1. Capacity building should incorporate both government and non-governmental sectors in the setting of psychosocial care services for disaster survivors.
2. NIMHANS, with its large qualified manpower, should be appointed as the principal training centre for training master trainers as part of disaster management. It was recommended that NIMHANS should take up the responsibility of development and compilation of psychosocial care and support manuals, with periodic suitable and appropriate modifications and such materials should be readily available for future training.
3. The training manuals for the TOT programmes should incorporate additional information on communication and interpersonal skills, harmful use of alcohol, drugs and high-risk behaviour.
4. The role of NGOs in the disbursement of psychosocial care services should be properly defined.
5. Planning for psychosocial care services should be on a long-term basis. This

would require the involvement and participation of the health and education sectors.

6. All psychosocial care services that are planned should be culturally appropriate to the local community at which the disaster has occurred. This would mean a bigger role for the local non-governmental agencies that would have a better understanding of the affected community.
7. District Mental Health Programmes should also be enlisted for the execution of the psychosocial care programmes for disaster management.
8. The district administrative services should formulate a database of available governmental/ nongovernmental agencies and independent persons, which can be periodically reviewed.
9. Minimum standards of care for the survivors of disaster as well as for the process of disaster management have to be well defined.
10. There have to be national and state level committees to monitor and evaluate actual programmes in times of disaster and to focus on disaster preparedness in normal times.
11. NIMHANS faculty and other state level psychosocial personnel could help in this process of monitoring and evaluation on a predetermined basis.



IV. Impact Assessment of Mental and Psychosocial relief efforts after the Tsunami

WHO South East Asia Regional Office has undertaken an impact assessment of the mental health and psychosocial relief efforts after the tsunami disaster in India, which was carried out by Dr Dinesh Bhugra, Professor of Mental Health and Cultural Diversity, Institute of Psychiatry, London & Dean, Royal College of Psychiatrists, London. The following sections are the report of his assessment.

The impact of the tsunami on individual lives and health care systems in general has been devastating. The mental health and psychosocial needs of the affected population emerged as a major concern. The response was a result of a multitude of factors which worked at three levels. At societal and national levels, it shaped the way the central and state governments accessed help readily and appropriately. Other factors were at local levels, such as informing and supporting the affected persons, setting up camps and providing food, shelter and clothing. The third were the micro level factors- at individual or family and kinship levels, which allowed individuals to look after their immediate family members and friends. In addition to these three levels, there were three phases of the response – immediate, short to medium and long term response.

General overview

As mentioned earlier in the beginning of this report, the UN team for recovery support nominated the WCO to lead the psychosocial relief efforts in collaboration with the Department of Social Welfare of the Government of Tamil Nadu. They worked together with other UN agencies, government and non government mental health institutions and departments of psychiatry of medical colleges of the affected states to mobilize the mental health and psychosocial (MHPS) relief efforts in the tsunami affected areas.

The programmes launched in the affected states reflect the issue of centre-state relationships and responsibilities regarding health care delivery in the country. Health

being a state subject, all affected states launched their own MHPS relief efforts using their resources. At the same time the central government nominated NIMHANS as the central nodal agency for MHPS services based on which they conducted independent programmes in all affected states.

Overall, the provision of MHPS relief services was excellent. However, there appeared to be a considerable degree of overlap between training and delivery with some problems in the coordination of activities in some areas. Reproduced here are the questionnaires used to assess the overall response to psychosocial relief efforts after the tsunami. These include information gathered from a variety of sources such as government departments, official documents, community leaders, etc.

SECTION 1: ASSESSMENT BASED ON INFORMATION OBTAINED FROM GOVERNMENT DEPARTMENTS

Impact on policy makers as assessed by increased awareness with corresponding action on mental health and psychosocial (MHPS) issues

Assess WHO's role for each question if appropriate.

Activity to be assessed	Pre-tsunami	Post-tsunami
What was the relative priority assigned to MHPS issues compared to other major programme areas?	MHPS issues were assigned relatively low priority in the affected areas with more emphasis at tertiary care psychiatric services where available, and at best at the district hospital level.	MHPS issues received increased priority both at the policy level and at service delivery level. This was partly due to the involvement of Departments of Social Welfare and Health in Tamil Nadu, establishment of mental health authorities in Andhra Pradesh and Kerala and designation of NIMHANS as the nodal agency for MHPS issues on behalf of the central government of India.
Does the country have a national mental health policy? If yes, how was it developed?	No	No

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Activity to be assessed	Pre-tsunami	Post-tsunami
<p>Does the country have a national mental health programme? If yes, how was it developed?</p>	<p>Yes. The National Mental Health Programme (NMHP) launched in 1982, was re-structured in 2002 for implementation during the 10th Five Year Plan (2002-2007) with a quantum increase in fiscal allocation. It forms the basis for public health initiatives in the field of mental health.</p>	<p>Three affected districts in Tamil Nadu have been added to the District Mental Health Programme. There is a proposal to add another two districts soon.</p>
	<p>Mental health is part of the primary health care system and is available in 22 out of about 600 districts. It will be extended to over 100 districts by 2007. There are regular training courses for primary care workers in the field of mental health. In the last two years about 600 personnel have been trained. Many workshops have been undertaken for the sensitization/ training of programme officers, voluntary agencies, health directorate personnel and mental health professionals. A range of training materials have been developed and field-tested. Mental health facilities in community care are available in some designated districts. In addition, various nongovernmental organizations provide different types of services ranging from telephone hotlines to residential rehabilitation services for a number of psychiatric conditions.</p>	

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Activity to be assessed	Pre-tsunami	Post-tsunami
What MHPS services are available at the PHC level and what is the basis of development of these services?	Limited clinical mental health services were available at selected PHC's which come under the District Mental Health Programme. No structured psychosocial activity was routinely available.	Clinical mental health services were made available at the community level. This is a relatively recent development. There has also been intensive recruitment and training of community level workers who have been able to provide help with, psychological, social, medical and legal needs of affected people.
Is there a regular budget allocated for providing MHPS services? Define the allocation.	Health is a state subject and the states provide a substantial budget for providing mental health services through Medical College Hospitals and District Hospitals.	Substantial amount of extra budgetary resources have been used. State level resources (mental health professionals in state medical colleges) were mobilized by states to lead their programmes. Additional central government funds have been received in those districts where the DMHP is being implemented. The next budgetary cycle will reveal if there has been an actual increase in the regular mental health budget.
Are there established training programmes on MHPS issues for different cadres of health care providers?	Numerous manuals for mental health care for different cadres (GPs, health workers, nurses) are available but how extensively they are utilized is unclear.	Yes. Programmes are provided by Department of Social Welfare, Tamil Nadu, by local medical colleges in Kerala, Andhra Pradesh and Pondicherry and by NIMHANS in Andaman and Nicobar islands and Tamil Nadu. In addition, several NGOs in different geographical areas also provided such training.

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Activity to be assessed	Pre-tsunami	Post-tsunami
Are common psychotropic medications(anti-psychotics, anxiolytics, anti-epileptics) regularly available at all levels of health care facilities? If yes, are they free?	Yes. Limited supplies are free. But most private pharmacies will have all medications.	Same as pre-tsunami.
Is there a clear chain of command for decision making and coordination of MHPS services?	Yes. The District Mental Health programme has a nodal officer at the district, who is responsible to the state nodal officer in the State Directorate for Mental health services. At the Centre, the Directorate General of Health Services is the responsible agency. In addition, there are State Mental Health Authorities in each state, and a Central Mental Health Authority at the centre.	There are State vs National coordination issues as evidenced by NIMHANS working independently of the state organizations for training and delivery of MHPS. Health and social welfare have parallel chains of commands in Tamil Nadu, but the interaction between the two is not entirely clear.
Does the government have a long-term plan for MHPS services?	Yes in some districts.	There has been strengthening of district mental health programmes in 3 affected district of Tamil Nadu. Long terms plans to integrate mental health care and psychosocial services in primary health settings is being prepared.
Is there any mental health legislation in the country?	Yes. The Mental Health Act 1987.	Not Applicable

- WHO MHPS support in India was coordinated by WCO. Technical material developed by SEARO was made available widely. WCO provided substantial funding and support where required but there has not been uniform data collection to ascertain resources required and the utilization of such resources.
- Issues regarding compensation to the families of those whose bodies have not been found need to be addressed urgently.
- Children who have lost both their parents have been adopted by the extended families in Andaman and Nicobar but are being placed in orphanages in Tamil Nadu. This needs to be studied carefully to avoid long-term sequelae parental loss. The existing research data from other parts of the world indicate potential psychological problems in such individuals in adulthood.

Conclusion

There has been an impressive improvement in building of psychosocial intervention strategies and related training at the basic community level which has been appreciated and acknowledged by the community itself.

SECTION 2 : ASSESSMENT BASED ON INFORMATION OBTAINED FROM GOVERNMENT DEPARTMENTS

Government's plan of action for mental health and psychosocial (MHPS) aspects of disasters

Assess WHO's role for each question if appropriate.

Item to be assessed	Response	Comments
Was there a pre existing disaster preparedness plan of action for the health sector?	Health sector has contingency plans for disaster management.	A National Disaster Management Authority has been set up.
If yes, what was its MHPS component?	The health sector has identified resources in various centres of excellence in mental health in India and teams of mental health professionals from these centres are deputed if needed.	The Community Level Worker mediated psychosocial support programme has introduced an innovative care model.
If yes, was the plan implemented as designed? Please specify the experience with its implementation	As per the plan, mental health professionals were deployed in the disaster affected populations and were present in medical camps organized in the affected areas.	Ensuring sustained presence of mental health professionals is a challenging task.
If no, was a new plan of action for the health sector prepared after the tsunami?	NA	NA
Does the new plan have an MHPS component?		The importance of PSS has been recognized and appropriate strategies will be incorporated.
Was the new plan implemented as designed? Please specify the experience with its implementation.	NA	NA

Conclusion

Disaster management has always incorporated mental health services and professionals from leading mental health centres have been deployed to provide services in the affected areas. Studies of PTSD had been carried out by the Indian Council of Medical Research. The national Disaster Management Authority will be considering the recommendations and suggestions from the model developed for the tsunami.

SECTION 3: ASSESSMENT BASED ON INFORMATION OBTAINED FROM MULTIPLE SOURCES AND REVIEW OF DOCUMENTS

Evaluation of efforts for building MHPS systems and assessment of quantum of services provided

Assess WHO's role for each question if appropriate.

Item to be assessed	Response	Comments
Role of community-based health care providers for MHPS services		
<p>1. How many training programmes were conducted and for which category of health worker?</p>	<p>The structure and number of training programmes and trainees varied across states. The category of health worker varied from anganwadi workers, health workers, mid-wives, NCC and NSS cadets to general physicians.</p> <p>For some training programmes WHO India Country Office provided funds.</p> <p>Tamil Nadu One training programme was held for master trainers, where 48 master trainers were trained. 430 trainers were trained through 4 regional training programmes, and they in turn trained 2813 CLWs through 120 training programmes.</p> <p>Pondicherry 319 CLWs were trained through 4 training programmes</p> <p>Kerala 38 trainers were trained through 1 training programme at SMHA. They in turn trained 149 CLWs in 3 training programmes.</p> <p>Andhra Pradesh 25 trainers were trained at a state level training programme. 53 CLWs were trained in 2 training programmes.</p>	<p>WCO has been instrumental in conceiving, planning, implementing and in evaluating the training programme. Specific modules and manuals were developed for training which have become a good resource.</p> <p>The best organized effort was by the Government of Tamil Nadu where they had targeted one CLW per 20 affected families.</p>

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Item to be assessed	Response	Comments
2. How many health care providers were trained and how were they identified?	Several hundred care providers were trained and recruited using a number of strategies e.g. in Kerala they were recruited from 2 NGOs, in Tamil Nadu they were recruited from the community. In Andhra Pradesh they were recruited from social welfare departments. A total of 5139 Community level workers were trained. They were identified from organized groups like anganwadi workers, school teachers, NSS volunteers, Nehru Yuva Kendra members, and social work students. Individual volunteers were also trained.	A multi-disciplinary recruitment happened across all states which was quite helpful to the affected community as a range of social, psychological, medical and legal issues were addressed.
3. Was there a structured training format?	Yes. The training format and the training strategy for each state was decided at the state level workshop held in each affected state for planning psychosocial support in that state.	Structure varied in different states but it was aimed at appropriate level of training in close collaboration with mental health professionals.
4. Who provided the training material?	The WHO training manual was translated into local language and used for training initially. Separate manuals for community level workers, handling children and for alcohol and substance abuse were developed by WCO. Mental health professional did the training of master trainers. Other organizations like Red Cross, NIMHANS, CARE India, VIMHANS also conducted trainings, some of which used modified WHO material.	There appeared to be a degree of overlap in the content of the training and of trainers eg. in parts of Tamil Nadu training was provided by Department of Social Welfare, NIMHANS and SCARF independently.
5. Who did the training?	Training was of a cascading nature in TN, AP and Kerala, and direct in Pondicherry. Resource persons were psychiatry professionals, medical counsellors, and others who had a background in social work, psychology and counselling.	This meant that psychosocial issues were right at the forefront of intervention, however monitoring and supervision of master trainers needs to be put in place where it is missing.

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Item to be assessed	Response	Comments
6. Was there a programme for stress management for CLWs?	Yes. The training also provided skills on how to handle their own stress and pamphlets were provided.	Monitoring and supervision were made available to CLWs in Tamil Nadu.
7. Number of persons given psychosocial interventions	<ul style="list-style-type: none"> • 50,622 in 3 districts of Tamil Nadu up to December 2005 by CLWs trained by NIMHANS • 46,148 in 11 districts of Tamil Nadu by CLWs of Department of Social Welfare • 3,261 patients up to 23 March 2005 in Andaman and Nicobar islands 	In view of the extent of the damage, multiplicity of trauma and the multiplicity of agencies providing psychosocial intervention these figures should be taken as estimates.
8. Type of intervention provided	<ul style="list-style-type: none"> • Psychosocial first aid • Recognition of symptoms related to adjustment reaction, anxiety, depression and exaggeration of pre-existing psychiatric illness and referral to mental health professionals for treatment • Supportive psychotherapy 	<ul style="list-style-type: none"> • Structured assessments were used in some situations e.g. in Tamil Nadu and the case positive individuals were referred appropriately through secondary and tertiary care services.

Conclusion

WCO has led the UN Team for recovery support in the field of PSS and has introduced the concept of a structured sustainable support system. The highest ranking officials of the department of health and social welfare were sensitized. In the State of Tamil Nadu, the services were organized through the Department of Social Welfare, whereas in Pondicherry, Kerala and Andhra Pradesh, the mental health professionals from Medical College departments and state mental health authorities were the leading agencies. WHO India has developed manuals and modules and provided support for training through WHO Collaborating Centre, SCARF and centres of excellence such as VIMHANS and NIMHANS. Along with UNICEF a specific module for children has been developed.

SECTION 4: ASSESSMENT BASED ON INFORMATION OBTAINED FROM TECHNICAL FOCAL POINT

Assessment of psychosocial distress in the community using a structured format e.g. GHQ/Other instruments

Assess WHO's role for each question if appropriate.

Item to be assessed	Response	Comments
Initial assessment Qualitative/ Quantitative	<ul style="list-style-type: none"> In Kerala GHQ and trauma stress questionnaires were used to screen and provide initial counselling services within the first month following the disaster. NIMHANS report states that a qualitative and quantitative needs assessment was conducted in 3 districts of Tamil Nadu, Pondicherry and Andhra Pradesh and Andaman & Nicobar Islands. In Tamil Nadu seven questions on the impact of psychological trauma were added to the socio-demographic needs assessment form. 	<ul style="list-style-type: none"> Preliminary analysis of GHQ data has been carried out and was used for immediate psychosocial interventions. Further analysis according to gender, social class and severity of trauma would be helpful in planning and preparing for future disasters. NIMHANS report does not make clear as to what quantitative measures were used for assessment of need and whether these had been validated for the populations. The questions on psychological trauma are limited in their usefulness for screening for psychosocial needs assessment.
GHQ Scores/Other instruments used		
Was it validated?	<p>Data not available yet.</p> <p>Based on the report from Kerala it is difficult to say whether the</p>	<p>A cut-off score of 3 for identification of cases was used in GHQ-12. This is a low cut-off point for screening patients in disaster settings.</p>
Experience with its use	<p>instruments were validated.</p> <p>The GHQ has been used in two large samples in Kerala.</p>	<p>Issues remain in terms of validation of GHQ (in terms of linguistic and conceptual equivalence) in this population, establishing appropriate cut-off points. Data to establish cut-off point for screening persons for further intervention need to be established.</p>

Observations

Not having quantitative community-based data on the magnitude of psychosocial distress and mental health needs limits assessment of the impact of psychosocial relief efforts.

Conclusion

Reliable data on the magnitude of psychosocial distress in the community are an essential part of an evidence-based response to any disaster. These data have three main functions:

- i. Providing evidence-based culturally appropriate response based on their needs and magnitude of the distress
- ii. Providing evidence for the impact of psychosocial relief efforts
- iii. Providing quantitative basis for appropriate allocation of resources at the correct level

Appropriate valid instruments in appropriate languages should be available as a part of disaster preparedness plans.

- A clear plan should be in place to determine which instruments for assessment of psychosocial distress will be used, when and by whom
- Validated questionnaires (quantitative) for needs assessment and mental health status of the affected population should be readily available to all stakeholders and be clear as to who the depository for such information is and who will distribute and collect these.
- Technical support needed for data analysis and interpretation should be identified.

SECTION 5: ASSESSMENT BASED ON INFORMATION OBTAINED FROM COMMUNITY LEADERS

Impact of mental health and psychosocial (MHPS) relief efforts on the community

Assess WHO's role for each question if appropriate.

Item to be assessed	Response	Comments
Are displaced families now back home? How soon after the disaster did they return?	In Cuddalore, Tamil Nadu not all families are back home. A majority are still in relief camps.	In Cuddalore, construction of permanent dwellings is underway but some members of the community are reluctant to consider this because these homes are seen as too far away from the ocean.
Have families returned back to normal way of life? How soon did this happen?	Yes. In Cuddalore, by and large families were back to their normal way of life within 6 months. It was observed that children were in schools, housewives were doing their household chores and men were largely absent, presumably at work.	Some families reported increased alcoholism and domestic violence in men. CLWs have been providing help in dealing with these issues with appropriate referral for further investigation and treatment.
Have people returned to their occupation? How soon did this happen?	In Cuddalore, 40 boats have been donated and a significant proportion of men had returned to fishing within 6 months after the disaster.	Some men have expressed to CLWs their wish to seek alternative employment and not go back to fishing.
Have children returned to school? How soon did this happen?	Yes. In Cuddalore, children went back to school within 3 months of the disaster although the visit occurred in low season.	Children who were spoken to appeared confident, and well adjusted a year after the disaster.
Did the community get psychosocial support? Yes		
When?	Within a week after the disaster	In Cuddalore, the community found CLWs as the preferred point of contact because they were visible, easily approachable, accessible and understood the cultural needs of the community.
What type?	Psychological first aid, social support, help in filling forms, symptom identification and appropriate referral for further care	

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Item to be assessed	Response	Comments
By whom?	CLWs trained by Department of Social Welfare, Tamil Nadu and other NGOs	In Kerala, the visits of CLWs were daily for the first two weeks, then once every three days and then once a week.
How often?	At least twice a week in Cuddalore	
Was the community satisfied with the psychosocial support provided?	Yes	
Did the community get mental health support? Yes		
When?	Within a month after the disaster	There was a problem in upscaling links between CLWs and mental health teams in other parts of the affected areas. The psychiatrist interviewed recognized that the most important part of her involvement was being visible and establishing rapport with the community. Organizations like SCARF were involved in psychoeducation and elimination of fears about recurrence of tsunami.
What type/	Medication, psychotherapy and counselling	
By whom?	Mental health team from District Hospital, Cuddalore	
How often?	As required based on need identified by CLW	
Is the community satisfied with the mental health support provided?	Yes	
Were adequate amount of psychotropic medication available in the clinic?	Yes	
Did the community get adequate and appropriate information from the media?	Yes	Some NGOs like SCARF and SNEHA were particularly good at dealing with the media and disseminating right level of information using multiplicity of approaches. The District Collector in Cuddalore had regular meetings with the media for exchanging information.

Conclusion

Mental health professionals were rapidly deployed in all the affected areas and they had adequate medical supplies. Those who needed immediate mental health services were provided the same. Psychiatrists were present in the regular medical camps in the initial months. Later on the CLWs were in the community to provide PSS.

Recommendations

The lessons from the tsunami disaster include preparedness for disasters, provision of psychosocial support and identification and management of psychological distress.

i) Building Community Mental Health Services

It is inevitable that when mental health services are inadequate, the response to additional demands made by any disaster will be poor. The long term planning of any disaster management must include strengthening of existing mental health services, which should be based in the community rather than in psychiatric hospitals. Although affected states have plans for community mental health care, these have been implemented at various speeds and levels. The key components of community mental health care, apart from offering support and treatment, must include public education and reduction of stigma towards psychiatric disorder. Therefore, public education and stigma reduction must involve teachers and community leaders, e.g. religious leaders, who can then respond rapidly in the time of disasters. Teaching psychological distress in schools and colleges provides a long term investment which will be worthwhile in the long run.

The community level workers form the core of the identification and screening of psychological distress and can be used to provide psychological first aid and culturally appropriate and acceptable interventions. In addition, their knowledge of the local set up, families and kinships is likely to be invaluable in planning medium to long term interventions. The details of mental health care systems across different countries can be obtained from the World Health Organization, Mental Health Atlas, 2005. Within this system, vulnerable groups such as children, adolescents, widows and the elderly must be watched out for.

ii) Coordination

Perhaps the most important component of managing disasters is by a clear chain of command, where it is clearly defined as to who has what responsibility, and what sources

can be accessed at that level. There will be good will from around the globe and donations which must be spent in a coordinated manner. Although various NGOs will have a considerable amount of experience in dealing with distress and disaster, their knowledge of the local culture, language and customs may not be sufficient to deliver services as required. There was a general feeling in the WHO-NIMHANS workshop that no single NGO should be put in charge of coordination, and close watch must be kept on all NGOs. One way of coordinating, especially in a state, is by getting one ministry, be it Health Ministry or Social Welfare, to take the lead. In large geographical areas, the command structure can be divided into districts where district coordinators can take the lead and deal with resources – as was done in Tamil Nadu.

Coordination does not end with the initial phase. In the intermediate and long term, this coordination becomes more important to allocate the resources which meet with the needs of the individuals and families affected by the disaster.

Within this role, training becomes of crucial importance to build capacity so that preparedness for future disasters is in place. Joint responsibilities need to be discussed and put in place. Training needs to be organised according to previous experience. Especially vulnerable groups must be identified and a process of tracking may be required.

iii) Long Term Mental Health Plan

The initiatives launched in different states need to be consolidated with adequate resources and funding. These plans must include teaching and training for reducing stigma towards psychological distress. As the community itself is the front line staff for providing services within the first 12 hours, it is crucial that these resources and their resilience are built upon. Long term mental health plans must be a priority at both central and local levels. Long term rehabilitation must be encouraged.

iv) Strategic Alliances

From within the community to outside, from social and psychological components through national and international stakeholders, alliances must be formed with clear lines of communication, coordination and chain of command. Donor agencies must form a key part of the alliances.

v) Evaluation

It is only appropriate that evaluation of any intervention is conducted thoroughly and

adequately. The response at every level and in every phase must be evaluated. The strengths and weaknesses of each intervention must be transparent so that lessons can be learnt across nations for preparedness and delivery of services for future disasters. It is crucial to have structures for assessments and evaluation so that not only lessons are learnt for future events but also for resource allocation and training purposes.



V. Generic Model for PSS in disaster

On the basis of feedback and lessons learned from the different models developed in different states, WCO has suggested a generic model for providing psychosocial support to disaster affected populations. The model of programme delivery proposes an integrated combination of mental health professionals, implementing agencies and departments, and community level workers.

Phase I (First 6 weeks after the disaster)

During this phase mental health professionals can be part of medical teams and provide care for acute events. Manuals and modules will have to be adapted for the particular community, translated by an academic agency into the local language and kept ready for use.

The State Departments of Health, Social Welfare and Education will identify nodal officers for psychosocial support in the State. This apex coordinating group of nodal officers will conduct a meeting of all the stakeholders (NGOs, academic institutions, UN agencies, multilateral agencies and development partners) along with responsible persons in the affected districts. The meeting can then develop an action plan for training, identification of service delivery and monitoring mechanisms.

Phase II (6 weeks to 6 months)

Selection of community level workers

The selection of community level workers is one of the critical areas in psychosocial support. From the experience in tsunami-affected areas in India it is felt that the best-suited personnel are those under an existing department or agency.

The suggested groups are teachers, anganwadi workers, health workers, literacy mission staff and members of reputed NGOs who are active in the field. The selection of unemployed youth may lead to issues of remuneration and sustainability.

When community level workers are given additional areas of work prolonging their

'formal engagement', it can lead to unreasonable expectations on the part of such workers about their continuation as a separate cadre, which is not feasible. It has to be kept in mind, that CLWs are only required for a short period of maximum one year by which time, the community would have rallied back to normalcy. The trained CLWs however, can remain as a community resource and continue to provide help outside a formal arrangement.

Training of CLWs and coordination of fieldwork

The training should be of a cascading nature, filtering down from the state to the district to the block level. Training has to be practical, need based and should be conducted as close to the affected community as possible. Resource persons can be identified from health departments, academic institutions, social work schools, NGOs and social organizations. Role plays and real life scenarios have to be enacted and the training should be sensitive to the local needs and cultural background. The training must also include the allocation of work to the CLWs and the tasks to be undertaken by them explained adequately.

The CLWs should have a pamphlet, which they can carry with them to the field. Posters for psychosocial support must be put up in the community. CLWs should also carry a questionnaire for collecting data pertaining to the families allocated to them. The referral of patients to the health department should be recorded.

The nodal department can monitor CLWs in the field. This can be done by analysis of the data from the questionnaire, such as details of individuals and families counselled, the number of referral cases, the number of vulnerable groups identified and the number of persons given interventions.

Review meetings and ongoing training of functionaries of the Departments of Social Welfare, Health and Education are suggested for strengthening the coordination of fieldwork. Periodic coordination at various levels is required and an indicative scheme based on the consultations in Tamil Nadu is provided (Fig 8). A representative of the education sector should also participate at all levels.

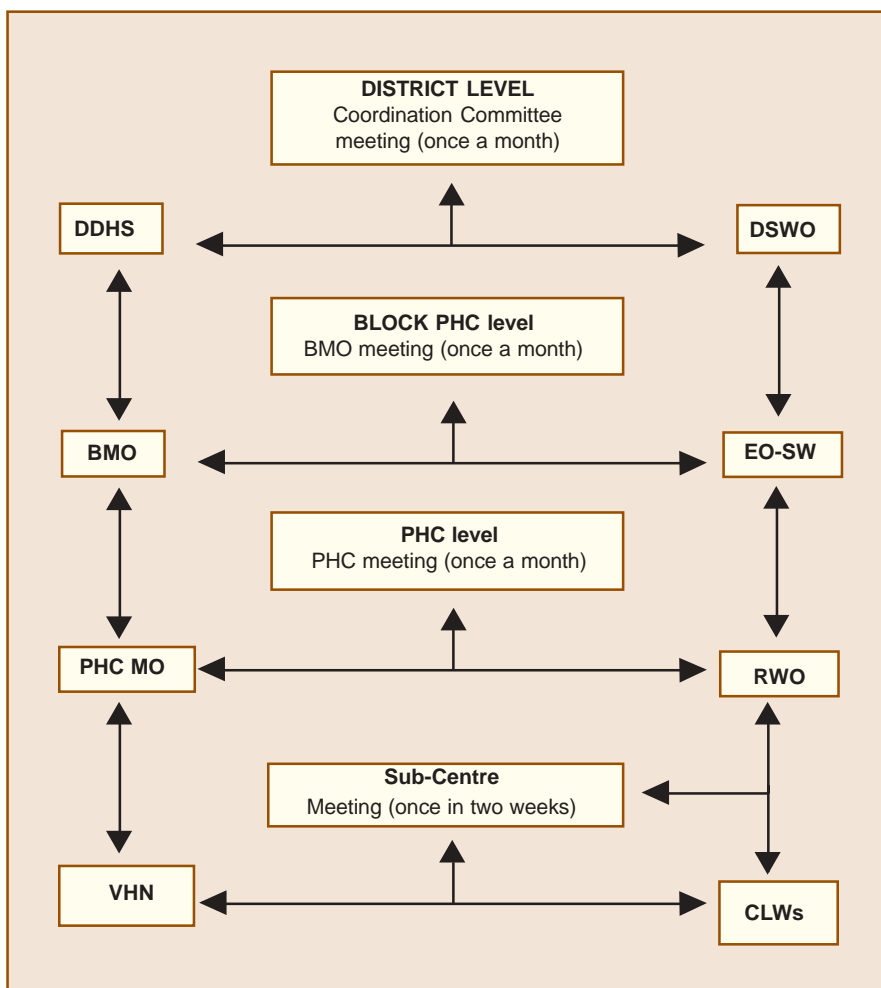
Comprehensive and detailed print and video documentation of the programme is also necessary for posterity and research purposes. Therefore, adequate resources must be mobilized towards this element.

Phase III (6 months to 1 year)

The first six months would require close supervision and strong referral linkages. From six months to one year, the intensity can be scaled down and by the end of two years the formal arrangements should be over.

To ensure sustainability, psychosocial programmes must be incorporated into existing health and social programmes. Also, it should be an integral and crucial part of disaster preparedness programmes and be included in the overall rehabilitation aspect of such programmes.

Fig. 8: The proposed coordination mechanism between Health and Social Welfare Departments.



DDHS – Deputy Director Health Services; BMO – Block Medical Officer; PHC – Primary Health Centre; DSWO – District Social Welfare Officer; EO-SW – Extension Officer – Social Welfare; RWO – Rural Welfare Officer; CLW – Community-level worker; VHN – Village Health Nurse



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