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NATIONAL DISASTER MANAGEMENT GUIDELINES

PSYCHO-SOCIAL SUPPORT AND MENTAL HEALTH SERVICES IN DISASTERS



December 2009

NATIONAL DISASTER MANAGEMENT AUTHORITY
GOVERNMENT OF INDIA

National Disaster Management Guidelines

Psycho-Social Support and Mental Health Services in Disasters

National Disaster Management Guidelines: Psycho-Social Support and Mental Health Services in Disasters

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The National Guidelines are formulated under the Chairmanship of Lt. Gen. (Dr.) J.R. Bhardwaj, PVSM, AVSM, VSM, PHS (Retd.), Hon'ble Member, NDMA, in consultation with various stakeholders, regulators, service providers, and specialists in the concerned subject/field from all across the country.

National Disaster Management Guidelines

Psycho-Social Support and Mental Health Services in Disasters

National Disaster Management Authority
Government of India

Contents

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Vice Chairman
National Disaster Management Authority
Government of India

FOREWORD

Preparation of guidelines for various types of disasters constitutes an important part of the mandate of the National Disaster Management Authority. Formulation of guidelines on Psycho-Social Support and Mental Health Services is an important landmark in this direction.

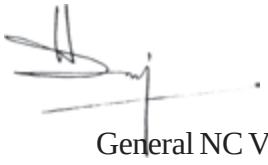
Disasters leave a trail of agony which significantly impact the survivor's mental health. Psycho-Social Support and Mental Health Services have an important role to play, to cope up with the challenges in the recovery and restoration of the victims to the pre-disaster status. Unfortunately, this facet also tends to be generally ignored while handling of any disasters. Consequently, the formulation of the national guidelines on the entire gamut of Psycho-Social Support and Mental Health Services has been one of our key thrust areas with a view to build our resilience to respond effectively in all types of disasters.

The intent of these guidelines is to develop an integrated, holistic, coordinated and proactive strategy for management of Psycho-Social Support and Mental Health Services in disasters through a culture of prevention, mitigation and preparedness to generate a prompt and effective response in the event of an emergency as part of comprehensive medical preparedness and response.

The document contains comprehensive guidelines for preparedness activities, strengthening of the existing legislative, institutional and operational framework and support during the preparedness, response and rehabilitation phase. It specifically lays down the approach for implementation of the guidelines by the central ministries/departments, states, districts and other stakeholders, in a time bound manner.

The national guidelines have been formulated by members of the Core Group and Steering Group constituted for this purpose, involving the active participation and consultation of over 100 experts from central ministries/departments, state governments, scientific, academic and technical institutions, government/private hospitals etc. I express my deep appreciations for their significant

contribution in framing these guidelines. I also wish to express my sincere appreciation for Lt Gen (Dr.) J.R. Bhardwaj, PVSM, AVSM, VSM, PHS (Retd) for his guidance and coordination of the entire exercise.



New Delhi
24 December 2009

General NC Vij
PVSM, UYSM, AVSM (Retd)

सत्यमेव जयते

Member
National Disaster Management Authority
Government of India

ACKNOWLEDGEMENTS

Disasters have a devastating effect on the survivor's physical as well as mental health resulting in social disability and affecting overall well being of the survivors. It was only during Tsunami PSSMHS as part of disaster response received greater importance and required further institutionalisation. The Government has initiated various programmes like National Mental Health Programme and District Mental Health Programme as part of national health plan to reach out to every citizen of the country. In order to strengthen PSSMHS in disasters it is imperative to integrate PSSMHS in to these programmes to provide both short and longer psycho-social support and mental health care. These guidelines would provide directions and impetus to proper planning for comprehensive psycho-social and mental health care to the surviving.

The National Disaster Management Guidelines on Management of Psycho-Social Support and Mental Health Services in disasters have been formulated by the untiring efforts of the core group members and experts in the field. I would like to express my special thanks to all the members who have proactively participated in this consultative process from time-to time. It is indeed the keen participation by the Ministry of Health and Family Welfare, Ministry of Home Affairs, Armed Forces Medical Services, Ministry of Defense, state and union territory health departments, academic and research institutions and non-governmental organisations, that has been so helpful in designing the format of this document and provided valuable technical inputs. I would like to place on record the significant contribution made by Dr. Nimesh Desai, Dr. Nagaraja. Dr. K. Sekar, Dr. P. Ravindran, Brigadier Saldana and other core group experts.

Teams from IHBAS and NIMHANS, Professor Nimesh and Professor Sekar have immensely contributed in preparation of the guidelines. I would like to place on record that Prof Nimesh Desai who has been coordinator of the core group has worked very hard in bringing number of experts together at various forums for discussions and deliberations which have proved very useful in this formulation of guidelines. Prof. K. Sekar brought in the interface between the field realities coupled

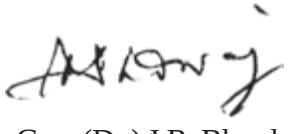
with the capacity building expertise and the critical dimensions in the formulation of the guidelines. Dr. Sujata Satpathy, Assistant Professor at National Institute of Disaster Management has untiringly worked days after days in framing up and editing of PSSMHS.

I would like to thank Dr. Surinder Jaswal of Tata Institute of Social Sciences and Dr. Mohan Agashe for their sustained help and support throughout the process of development of these guidelines.

I would also like to express my sincere thanks to the representatives of the other central ministries and departments agencies and institutes including National Institute of Mental Health and Neuro sciences, Armed Forces Medical College and Institute of Behavior and Allied Sciences, professionals from other scientific and technical institutes, eminent mental health professionals from leading national institutions like the Tata Institute of Social Sciences, National Institute of Disaster Management and various INGOs and NGOs sector for their valuable inputs that helped us in enhancing the contents and overall presentation of the Guidelines.

The efforts of Dr. Jayakumar C, Senior Specialist, PSSMHS in providing technical inputs, editing, shaping and coordinating release of the guidelines and Dr. Raman Chawla in coordinating the guidelines during the preparatory stages are highly appreciated. I would like to appreciate the support rendered by Dr. Pankaj Kumar Singh and Dr. T.S Sachdeva. I would like to acknowledge the active cooperation provided by Mr. A.B. Prasad, Secretary and the administrative staff of the NDMA. I express my appreciation for the dedicated work of my secretarial staff including Mr. Deepak Sharma, Mr. Munendra Kumar and Mr. Vinod during the convening of various workshops, meetings and preparation of the Guidelines.

Finally, I would like to express my gratitude to General N.C. Vij, PVSM, UYSM, AVSM (Retd), Hon'ble Vice Chairman, NDMA, and Hon'ble Members of the NDMA for their constructive criticism, guidance and suggestions in formulating these Guidelines.



New Delhi
24 December 2009

Lt. Gen. (Dr.) J.R. Bhardwaj
PVSM, AVSM, VSM, PHS (Retd)
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Abbreviations

AFMC	Armed Forces Medical College
AICTE	All India Council of Technical Education
ASSWI	Association of Schools of Social Work in India
ATI	Administrative Training Institute
CBDM	Community-Based Disaster Management
CBO	Community-Based Organization
CLW	Community Level Worker
CME	Continuous Medical Education
CMO	Chief Medical Officer
CSR	Corporate Social Responsibility
DDMA	District Disaster Management Authority
DDMP	District Disaster Management Plan
DFID	Department For International Development
DIET	District Institute of Education and Training
DM	Disaster Management
DMHP	District Mental Health Programme
DMT	Disaster Management Team
ECHO	European Commission's Humanitarian Aid Office
GGSIPU	Guru Gobind Singh Indraprastha University
GHPU	General Hospital Psychiatric Unit
GIS	Geographical Information System
GO	Government Organization
GoI	Government of India
IASC	Inter-Agency Standing Committee
ICDS	Integrated Child Development Scheme
ICMR	Indian Council of Medical Research
IGNOU	Indira Gandhi National Open University
IHBAS	Institute of Human Behaviour and Allied Sciences
IMA	Indian Medical Association
INGO	International Non-Governmental Organization

IPS	Indian Psychiatry Society
LGBMH	Lokopriya Gopinath Bordoloi Regional Institute of Mental Health
MCI	Medical Council of India
MIMH	Maharashtra Institute of Mental Health
MoD	Ministry of Defence
MoH&FW	Ministry of Health and Family Welfare
MoL(ESIC)	Ministry of Labour (Employees' State Insurance Corporation)
MoR	Ministry of Railways
MoSJ&E	Ministry of Social Justice and Empowerment
MoW&CD	Ministry of Women and Child Development
NAC	National Accreditation Council
NBE	National Board of Examinations
NCC	National Co-ordination Committee
NCERT	National Council for Educational Research and Training
NCMC	National Crisis Management Committee
NDMA	National Disaster Management Authority
NDRF	National Disaster Response Force
NEC	National Executive Committee
NGO	Non-Government Organization
NHP	National Health Policy
NIDM	National Institute of Disaster Management
NIMHANS	National Institute of Mental Health and Neuro-Sciences
NMHP	National Mental Health Programme
NIRD	National Institute of Rural Development
NRHM	National Rural Health Mission
NYK	Nehru Yuva Kendra
PSFA	Psycho-Social First Aid
PHC	Primary Health Centre
PPP	Public-Private Partnership
PRI	Panchayati Raj Institutions
PSS	Psycho-Social Support
PSSMHS	Psycho-Social Support and Mental Health Services
PTSD	Post-Traumatic Stress Disorder
QRT	Quick Reaction Team

SDMA	State Disaster Management Authority
SHIFW	State Institute of Health and Family Welfare
SMHA	State Mental Health Authority
SSW	School of Social Work
TISS	Tata Institute of Social Sciences
ToT	Training of Trainers
UGC	University Grants Commission
ULB	Urban Local Body
UMHP	Urban Mental Health Programme
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UT	Union Territory
WHO	World Health Organization

Executive Summary

Background

India is vulnerable to natural and man-made disasters, prolonged conflicts and other complex situations that impede the country's overall development. Disasters are quite devastating and usually leave a trail of human agony including loss of human life, livestock, property, livelihood and physical injuries that have a significant impact on the survivors' quality of life. Along with relief, rehabilitation and care of physical health and injuries, psycho-social and mental health issues are also important that need to be addressed on priority. Apart from logistic and material help, the survivors will require psycho-social and mental health interventions.

Psycho-social support in the context of disasters refers to comprehensive interventions aimed at addressing a wide range of psycho-social problems arising in the aftermath of a disaster. Psycho-Social Support and Mental Health Services (PSSMHS) should be considered as a continuum of the interventions in disaster situations. Psycho-social support will comprise of general interventions related to the larger issues of relief work needs, social relationships and harmony to promote or protect psycho-social well-being of the survivors. Mental health services will comprise of interventions aimed at prevention or treatment of psychological symptoms or disorders. These interventions help individuals, families and groups to restore social cohesion and infrastructure along with maintaining their independence and dignity.

There is considerable experience and evidence supporting the benefits of PSSMHS. The experiences from PSSMHS interventions in Orissa super cyclone, Gujarat earthquake, Tsunami and Kashmir earthquake, reveal that PSSMHS need to be planned ahead of disasters so as to be executed in a co-ordinated and integrated manner at the time of disasters. The psycho-social support to the disaster-affected communities needs to be provided on a long-term basis. Appropriate and timely interventions will determine the victims' adjustment to various changes in lifestyle, caused by the disaster. The interventions have to be community-based and culturally sensitive, taking into account the needs of vulnerable groups like women, children, the elderly, the disabled etc. Such support can relieve the psychological distress of the affected people to a significant extent.

The main aim of the PSSMHS Guidelines is to envisage that disaster-affected communities are able to rebuild their shattered life through combined community activity, provided that the diminished capacity and support systems are rebuilt at the earliest and their coping capacity is increased through the simple mechanism of minimal emotional support, combined with a spectrum of care.

The objective of the PSSMHS Guidelines is to prepare national guidelines as a part of 'all hazard' health plan which shall concentrate on response, relief and rehabilitation aspects of different kinds of disasters. It shall also focus on implementation of PSSMHS activities through capacity building, training, service delivery, research, documentation, monitoring and evaluation at the national, state, district and community levels. The provision of PSSMHS shall be based on the general health programmes and will be integrated with National Mental Health Programme (NMHP) as well as with District Mental Health Programme (DMHP) and it will be delivered through general health care programme and district health plan.

Structure of the Guidelines

The Guidelines are designed to acquaint the reader with the basics of managing Psycho-Social Support and Mental Health Services.

These Guidelines deal with the subject in a balanced and thorough manner and give the information required by organizations to formulate PSSMHS at various levels. It is also envisaged that these Guidelines will be used for the preparation of national, state and district Psycho-Social Support and Mental Health Services as a part of 'all hazard' Disaster Management (DM) Health Plan. Standard Operating Procedures (SOPs) shall be prepared for all the stakeholders.

Chapter 1 – Introduces the subject and provides the background to these Guidelines. The psycho-social trauma and its long-term consequences are presented. The emotional reactions and behavioural responses due to disasters are outlined in Annexure-A. It also deliberates on the need, aims and objectives of the Guidelines.

Chapter 2 – Describes the present status of mental health resources available in India and the Indian experience of working in various disasters. The chapter also deals with the various government policies, programmes and initiatives on Disaster Management (DM) Health Plans. The chapter briefly describes the evolution of PSSMHS in India and capacity development in terms of both human resources and infrastructure in the country during disaster and non-disaster situations. The chapter also provides a clear picture about the role of different ministries, department of health and other stakeholders in the management of PSSMHS during disasters.

Chapter 3 – Reveals the salient gaps in delivering PSSMHS. The noticeable gaps in policies, strategies, planning, human resources and other preparedness-related aspects are presented. The gaps and limitations are clearly noticeable at various levels for adequate capacities, lack of skilled human resource, service delivery, co-ordination, research and development, proper documentation, adequate finance and proper implementation.

Chapter 4 – Deliberates on legislation for institutional and operational framework. It also describes proper planning and resource mapping at all levels. Capacity development and upgradation of infrastructure required for implementing PSSMHS are described along with hospital preparedness. The need for creating a network of institutions is been stressed, which shall prepare adequate knowledge material and modules for training of various human resources at different levels. The need for activation of psycho-social support, enhancing manpower for psychiatry and psychology, psychiatric social work, psychiatric nursing, community level workers and other volunteers is stressed. Proper documentation, international co-operation and the role of NGOs are delibrated. Appropriate attention to vulnerable groups and the necessity of creating proper referral systems for disaster-affected people once stressed.

Chapter 5 – Deals with the mechanism of response for the PSSMHS in the Response phase at national, state and district levels, by various ministries and departments and all the other stakeholders including International Non-Government Organizations (INGOs), Non-Government Organizations (NGOs) and communities. This chapter also describes the mechanism of including PSSMHS in the general relief work and health plans. It further deals with the integration of community practices in PSSMHS in case of a disaster. The important aspect of long-term PSSMHS services is to be included in the recovery, rehabilitation and reconstruction phases of disaster. The importance of providing special care to the vulnerable groups as well as to the care-givers to enhance the quality of service delivery is stressed.

Chapter 6 – Rounds off the Guidelines to provide a broad perspective on PSSMHS in disasters. Various components of a system necessary to prepare for, and respond to, disasters once set out. The time-lines proposed for the implementation of various activities in the Guidelines are both important and desirable. Precise schedules for structural measures will, however, be evolved in the PSSMHS in DM plans that will follow at the central ministries/state level, duly taking into account the availability of financial, technical and managerial resources. In case of

compelling circumstances warranting a change, consultation with the National Disaster Management Authority (NDMA) will be undertaken well in advance, for adjustment on a case-to-case basis.

These Guidelines provide a framework for action at all levels. The Ministry of Health and Family Welfare (MoH&FW) shall prepare an Action Plan to enable all sections of the government and administrative machinery at various levels to prepare and respond effectively.

Milestones for implementation of Guidelines are as follows :

A) Phase-1 (0-3 years)

i) Regulatory Framework

a. Dovetailing of existing Acts, Rules and Regulations with the DM Act, (2005).

b. Ensuring implementation of PSSMHS in National Mental Health Programme (NMHP) and District Mental Health Programme (DMHP)

c. Integration of the PSSMHS in DMHP and General Health Programme as part of hospital and district health plan.

d. Enactment/amendment of any Act, Rule and Regulation, if necessary, for better implementation of PSSMHS across the country.

ii) Mitigation

a. Formation of a National Sub-Committee on PSSMHS.

b. Developing/strengthening a mechanism for quick and effective referral system.

c. Training of National Disaster Response Force (NDRF), Quick Reaction Teams (QRTs) Disaster Management Teams (DMTs) in all basic psycho-social support skills.

d. Integrating with Disaster Management (DM) Plan and Health/Hospital DM Plans.

e. Inclusion of PSSMHS in the Minimum Standard of Medical Care in disasters.

f. Establishing linkages with all stakeholders identified to play an important role in PSSMHS.

g. Strengthening the government agencies and NGOs; devloping Public Private Partnership (PPP) and the partnership mechanism in capacity development, research and service provision on mutually agreed terms and conditions.

iii) Capacity Development

a. Sensitising and training (basic and advanced) on PSSMHS across identified departments, sectors and levels.

b. Strengthening of the national, regional and nodal capacity building institutions and resource centres at state and district levels.

c. Developing PSSMHS needs assessment indicators and templates.

d. Strengthening of District Counselling Centres under the Department of Social Welfare/ Women and Child Development.

e. Strengthening the resource base and data management/ documentation in PSSMHS.

iv) Education and Training

a. Inclusion of Disaster PSSMHS in Post-graduate Curriculum of Psychiatry, Psychology, Social Work, Disaster Management, Emergency Medicine and Health Education.

b. Inclusion of PSSMHS in Under-graduate medical studies.

c. Integrating with all training programmes in the area of

Psychology, Social Work, Mental Health, Emergency Medical Response, Hospital Administration, Nursing and Paramedics.

v) Community-Based Disaster Management (CBDM)

a. Inclusion in the CBDM Plan and training of Panchayati Raj Institution (PRI) members.

b. Developing awareness material for the community.

c. Evolving a mechanism for community outreach education programmes on PSSMHS.

B) Phase-II (0-5 years)

i) Capacity Building

a. Strengthening nodal institutions and hospitals.

b. Developing database management and evidence-based research.

c. Evolving a mechanism for follow-up response.

d. Establishing a National Accreditation System for quality assurance.

e. Continuation and updating of human resource development activities.

ii) Preparedness

a. Creation of a core group of master trainers at district level.

b. Strengthening Public-Private Partnership in research and development.

c. Formation of National PSSMHS Resource Inventory to be part of National Health Resource Inventory.

d. Initiation of distance learning courses for sensitisation across different categories of disaster management stakeholders.

e. Development and standardisation of uniform training packages for various designated target groups.

iii) The following Phase 1 activity will continue in this Phase as well: Integration of PSSMHS training in DMHP, district health and hospital plans.

C) Phase-III (0-8 years)

The long-term Action Plan will intensify the areas identified in Phase-I along with the important issues that have been raised in chapters 4 and 5. A detailed action plan, will be prepared by the National Sub-Committee and submitted to the NDMA and MoH&FW. The long-term planning will include the following important aspects:

i) Evolving a mechanism to include disaster-induced psychiatric disorders/ physical disability in the disaster insurance and medical/health insurance.

ii) Intensive Post-graduate Diploma/Post-graduate courses in PSSMHS.

iii) Networking of Institutions and their activities.

1 Introduction

India due to its unique geo-climatic conditions has been experiencing natural disasters like earthquakes, tsunamis, cyclones, floods, droughts and landslides. The country is equally vulnerable to man-made disasters like chemical, biological, radiological and nuclear emergencies. Disasters, whether natural or man-made, cause enormous devastation and human suffering to the community. These disasters usually leave a trail of human agony, including loss of human life and injuries, Emotional trauma, loss of livestock, property and livelihood, resulting in long-term psycho-social and mental health problems. Apart from logistic and material help, the affected community requires Psycho-Social Support and Mental Health Services(PSSMHS).

Psycho-social support in the context of disasters refers to comprehensive interventions aimed at addressing a wide range of psycho-social and mental health problems arising in the aftermath of disasters. These interventions help individuals, families and groups to build human capacities, restore social cohesion and infrastructure along with maintaining their independence, dignity and cultural integrity. Psycho-social support helps in reducing the level of actual and perceived stress and in preventing adverse psychological and social consequences amongst disaster-affected community.

Mental health services in disaster interventions are aimed at identification and management of stress related psychological signs and symptoms or mental disorders among disaster-affected persons and persons with pre-existing mental health problems. In addition, psycho-social support interventions are aimed at mental health and psychological well-being, promotion and prevention of psychological and psychiatric symptoms among disaster-affected community.

The Psycho-Social Support and Mental Health Services shall be considered as a continuum of the interventions as an important component of general health services in disaster situations. Psycho-social support will comprise of the general interventions related to the larger issues of promoting or protecting psycho-social well-being through relief work, meeting essential needs, restoring social relationships, enhancing coping capacities and promoting harmony among survivors. The mental health services will comprise of interventions aimed at prevention or treatment of psychological and psychiatric symptoms or disorders. The overall goal of the Psycho-Social Support and Mental Health Services is restoration of well-being of the disaster-affected community.

1.1 Significance of Psycho-Social Support and Mental Health Services (PSSMHS) in Disaster Management

There is adequate knowledge amongst the professionals both at the national and

international levels regarding the psycho-social and mental health consequences of disasters. It has been recognised that most of the disaster-affected persons experience stress and emotional reactions after a disaster as a 'normal response to an abnormal situation'. While some of the survivors would be able to cope by themselves, a significant proportion of them may not be able to do so effectively. In the absence of appropriate and adequate support, these survivors experience emotional distress and decline in social functioning there by require psycho-social support and mental health services. The individual psycho-social responses/reactions are directly related to the type of trauma and severity of the disaster.

The greater the trauma, the more severe is the psychological distress and social disability. The magnitude of psychological trauma and subsequent experiences due to disasters like earthquakes and tsunamis may be severe for a majority of the people. The magnitude of trauma in lesser gravity disasters may be less severe. In contrast man-made disasters such as communal riots, terrorism, chemical, biological, radiological and nuclear disasters cause more prolonged psychological distress than natural disasters. In both cases, large-scale human suffering and psycho-social consequences require co-ordinated response from both government and non-government organizations as will as from the community. The recovery process is directly related to the severity of the experience and is prolonged in the case of higher magnitude disasters.

Traditionally, psycho-social and mental health consequences of disasters as shown in Annexure A (Table 1.1) have been understood more in terms of mental illnesses/ disorders. The common mental health disorders reported after disasters are Normal and pathological grief (Bereavement), acute stress reaction, depression, generalised anxiety disorder, Post-Traumatic Stress Disorder (PTSD), alcohol and drug abuse rather than the issues related to psycho-social well-being. Besides clearly identifiable mental health and psycho-social problems, various emotional/ psychological reactions and behavioural responses to the disasters have been documented to highlight its spectrum Annexure A (1.2)

Emotional reactions such as guilt, fear, shock, grief, Hyper-vigilance, numbness, intrusive memories, and despair are universal responses in people experiencing unforeseen disastrous events beyond their coping capacity. Emotional reactions reported by the people are normal responses to an abnormal event. It is estimated that nearly 90% of survivors undergo these emotional reactions immediately after the disaster. However, it reduces to 30% over a period of time with psychological reactions to stress, leading to a change in behaviour, relationships and physical or psycho-social situations. Continuation of the situation leads to an abnormal pattern and long-term mental illness among the survivors, if not attended to. Indian experience in Orissa super cyclone, Gujarat earthquake, riots and tsunami has demonstrated that appropriate psycho-social intervention during the rescue, relief, rehabilitation and rebuilding period significantly decreases the distress and disability among survivors, leading to an overall improvement in the quality of life.

Experiences in recent major disasters in India indicate that there is an increasing in awareness about the role of PSSMHS. There is a need to create psycho-social support to develop protective barriers for the community

to reduce the long-term effects of disasters. These protective resources are themselves vulnerable to the impact of disasters and they decline or deteriorate in their capacities. In order to tap the community resources, three important dimensions are identified: Human Capacity, Social Ecology and Cultural Capacity. These dimensions are complementary in nature for the total well-being of people and the community.

i) The first dimension Human Capacity is primarily constituted by the health (physical and mental), knowledge and skills of an individual. In these terms, improving physical and mental health, or education and training in support of increased knowledge, enhances human capacity and psycho-social well-being.

ii) The second dimension is Social Ecology. It includes social relations within families, peer groups, religious and cultural institutions, links with civic and political authorities. It also includes changes in power relations between ethnic groups and shifts in gender relations etc. (all of these may be referred to as the 'social capital' of the community). It is a well established that disasters and the effects on social dimensions are widely accepted as contributing factors to psycho-social well-being. There is strong empirical evidence linking mental health outcomes to the presence of effective social engagement, including wider cultural and pragmatic concerns.

iii) The third dimension is Cultural Capital, which essentially comprises of values, beliefs and practices of the community. Disasters, irrespective of their nature, can threaten cultural traditions and erode the values and beliefs due to devastation and trauma.

Therefore, it is essential that the various interventions shall also focus on the three important dimensions–Human Capacity, Social Ecology and Cultural Capacity–as well as regional and cultural sensitivities of the area which may differ from region to region.

1.2 Need for PSSMHS

The importance of mental health and psycho-social interventions after disasters has been increasingly recognised. The World Health Organization (WHO) recommends that appropriate interventions are necessary to prevent and manage the psycho-social and mental health consequences of a disaster.

The PSSMHS interventions are intricately related to general relief work and general health services after disasters. A well-planned and co-ordinated general relief work adequately addressing the needs of the affected people will have a positive impact on their mental health and psycho-social needs. Timely and appropriate management of injuries and general medical conditions will decrease the level of stress and the need for mental health interventions. The quality and quantity of general relief work and health services provided during disasters have tremendous impact on the psycho-social well-being of the people. It is essential to effectively integrate PSSMHS with general relief work and health services. This will ensure maximum utilisation of the limited resources available during disasters.

The PSSMHS plan shall be prepared during the pre-disaster phase which will be integrated, co-ordinated and monitored by nodal agencies at national, state and district levels. This shall cater to immediate and long-term needs of the affected communities.

Appropriate and timely interventions will facilitate survivors' adjustment to various changes in lifestyle, caused by the disasters. These interventions will be community-based, culturally sensitive and will take into account the needs of vulnerable groups like women, children, the elderly and the disabled etc.

1.3 Aims and Objectives of the Guidelines

Under Section 6 of the Disaster Management Act, (2005), the National Disaster Management Authority (NDMA) is, inter alia, mandated to issue Guidelines for preparing action plans for holistic and co-ordinated management of all disasters. The Guidelines will focus on all aspects of Psycho-Social Support and Mental Health Services (PSSMHS) with a emphasis on prevention, mitigation, preparedness, response, relief and rehabilitation in disaster senario.

The Guidelines will form the basis for preparation of plans for the concerned central ministries and departments, state authorities and districts to evolve programmes and measures to be included in their Action Plans. It is basically meant for all the functionaries who are involved in general health-care related interventions in all types of disasters. The PSSMHS Guidelines envisage that disaster-affected communities will be able to rebuild their shattered lives through combined community activity, provided that the diminished capacity and support systems are rebuilt at the earliest and their coping capacity is enhanced through the simple mechanism of emotional support, combined with a spectrum of care-based activities.

The major objectives of the Guidline are:

i. To provide guidelines to various stakeholders on the preparedness, response, relief and rehabilitation aspects of PSSMH services, in different kinds of disasters.

ii. To provide guidelines for the implementation of PSSMHS activities such as resource mobilisation, capacity building, training, service delivery, research, documentation, monitoring and evaluation at the national, state, district and community levels.

iii. To facilitate development of the institutional framework and response mechanism for providing PSSMHS during disaster situations.

iv. To facilitate the standardisation of preparedness, response, relief and rehabilitation measures in PSSMHS during disaster situations.

2 Present Status and Context

Psycho-social support and mental health aspects of disasters in India in terms of service delivery, training and research activities carried out during the last two decades reveal a progressive shift in the nature and scope of services. This shift is well reflected in the developments that have taken place during major disasters like the Bhopal gas tragedy (1984), Latur earthquake (1993), Orissa super cyclone (1999), Gujarat earthquake (2001), Tsunami (2004) and Kashmir earthquake (2005). The developments in the area of service, training and research have been taking place in a parallel and complementary manner. The present status of these developments is described in this chapter.

2.1 Institutional and Policy Framework

2.1.1 National Health Policy

The National Health Policy (NHP) was formulated in 1983, and since then, there have been marked changes in the determinant factors relating to the health sector. The changed circumstances made it imperative to review the old policy and to formulate a new policy framework as the National health Policy (2002), according to which an adequately robust disaster management plan has to be in place to effectively cope with situations arising from natural and man-made calamities'.

2.1.2 The National Mental Health Programme (NMHP)

The NMHP programme was initiated in 1982. The re-strategised NMHP's District Mental Health Programme was developed as an approach to deliver mental health-care through the Primary Health Care system for all districts. DMHP has been implemented in nearly 94 districts. Based on the mid-term review and two national consultative meetings, the existing DMHP programme is being strengthened by adding the adolescent mental health programme that includes health promotion for high school students, intervention for students with emotional problems, counselling for out of school children and college-based counselling services for college students. Apart from continuing the existing programmes, it is envisaged that 500 more districts will be brought under the DMHP activities in the 11th Five-Year Plan. Urban Mental Health Programme is a new addition to the NMHP. It has been envisaged to start UMHP in 50 centres by the end of five years. Specific budget allocation has been made for 500 rural and 50 urban districts in the country. As such, since the target/goal of the NMHP during the 11th Five-Year Plan period is extensive, it is proposed to achieve nearly complete coverage of all the districts in the country. The availability of mental health teams in every district for a disaster situation shall be ensured. This can form one of the major starting points for the PSSMHS in disaster situations.

2.1.3 National Rural Health Mission (2005)

The mandate of the National Rural Health Mission (2005) is to provide total health solutions to the grassroot level population, reaching different states, districts, taluks and villages. One of the main goals of the programme is to buildup the capacity of the grassroot level workers and forge partnerships among various actors to provide effective health-care. The district health plan will be set up through National Rural Health Mission (NRHM) so that health-care reaches every part of the country. The resources and infrastructure created through the programme shall be used for PSSMHS preparedness and response to fill the existing gaps, especially in the area of skilled human resources.

All the initiatives delivered through various national policies and programmes shall converge into a comprehensive district disaster management plan in which the various initiatives get translated into deliverables for the disaster-affected people throughout the country.

2.1.4 Panchayati Raj Act (1992)

The Constitutional Amendments of 1992 (73 and 74) mandate the States to enact laws for devolution of powers and responsibilities to the Panchayati Raj Institutions and Urban Local Bodies respectively for preparation of plans for economic development and social justice. This relates to implementation of the twenty-nine subjects listed in the eleventh schedule of the Constitution.

Panchyati Raj Institutions (PRIs) constitute the foundation for the implementation of most of the Rural Development Programmes. They empower the local communities, ensuring their participation and contribution in reconstruction of the village. PRIs play a catalytic role by empowering the community to function as a well-knit family in case of any disaster. From the recent experiences, the capacity building of the community at panchayat level demonstrated the usefulness of local capacities. It is envisaged to include PRIs to build capacities at grassroot level for PSSMHS interventions in every community.

2.1.5 Other Government Initiatives

2.1.5.1 The Disaster Management Act (2005)

The Government of India initiatives, subsequent to the Orissa super cyclone, in terms of the High Power Committee recommendations and the National Disaster Management Plan (2000) had provided impetus to disaster related activities. These policies became structuralised after the Tsunami when the National Disaster Management Authority (NDMA) was established in (2005) to enact the institutional mechanism at national, state and district levels. Through this mechanism the State Disaster Management Authorities (SDMA) will strengthen the capacity building for both natural and man-made disasters so that relief, rehabilitation and reconstruction are quick and efficient. In terms of the implementation mechanism, the District Collector/District Magistrate who is also the chairperson of the District Disaster Management Authority (DDMA) assumes the leadership in terms of both administrative control as well as regulatory mechanism for rescue, relief, and rehabilitation. He/she is responsible for the overall co-ordination, supervision and monitoring of various activities performed by the government and non-government agencies. The long-term rebuilding process largely rests upon the collective efforts of government and non-

government agencies, including the affected community itself.

2.1.5.2 National Disaster Management Authority

The Disaster Management Act, (2005) was enacted to provide effective management of disasters. The Act seeks to institutionalise mechanisms at the national, state and district levels to plan, prepare and ensure a quick and efficient response to natural calamities and man-made disasters/accidents. The Act mandates the following: (a) formation of a national apex body, the NDMA, with the Prime Minister of India as its Chairperson, (b) creation of SDMAs, and (c) co-ordination and monitoring of Disaster Management (DM) activities at district and local levels through the creation of district and local level DM authorities.

The NDMA is responsible to (a) lay down policies on DM; (b) approve the National Plan; (c) approve plans prepared by the ministries or departments of the Government of India (GoI) in accordance with the National Plan; (d) lay down guidelines to be followed by state authorities in drawing up the state plan; (e) lay down guidelines to be followed by the different ministries or departments of GoI for the purpose of integrating mitigation effects of disasters in their development plans and projects; (f) coordinate the enforcement and implementation of the policy and plans for DM; (g) recommend provision of funds for the purpose of mitigation; (h) provide such support to other countries affected by major disasters as may be determined by the central government; (i) take such other measures for the prevention of disasters, or the mitigation or preparedness and capacity building for dealing with the threatening disaster situation or disaster as it may consider necessary; and (j) lay down broad policies and guidelines for the functioning of NIDM. NDMA is assisted by the National Executive Committee (NEC), consisting of Secretaries of 14 Ministries and Chief of the Integrated Defence Staff of Chiefs of the Staff committee, ex-officio as provided under the DM Act, (2005).

NDMA is, *inter alia,* responsible for coordination/mandating the government's policies for disaster reduction/mitigation and ensuring adequate preparedness at all levels. Co-ordination of response to a disaster when it strikes and post-disaster relief and rehabilitation will be carried out by National Executive Committee (NEC) on behalf of NDMA.

NDMA has been supporting various initiatives of the central and state governments to strengthen DM capacities. NDMA proposes to accelerate capacity building in disaster reduction and recovery activities at the national level in some of the most vulnerable regions of the country. The thematic focus is on awareness generation and education, training and capacity development for mitigation, and better preparedness in terms of disaster risk management and recovery at community, district and state levels.

Ministry of Health and Family Welfare (MoH&FW), the nodal ministry for medical preparedness, is mandated to formulate and implement national health policies and programmes in the country including mental health. All the other line ministries including Ministry of Railways (MoR), Ministry of Defence (MoD), Ministry of Women and Child Development (MoWCD), Ministry of Labour - Employees State Insurance Corporation (MoL-ESIC) who have their own medical set-up will

also follow the policies and plans laid down by the nodal ministry.

2.1.5.3 National Crisis Management Committee (NCMC)

The NCMC, under the Cabinet Secretary, is mandated to co-ordinate and monitor response to crisis situations, which includes all disasters. The NCMC consists of 14 union secretaries of the concerned ministries including the Chairman, Railway Board. NCMC provides effective co-ordination and implementation of response and relief measures in the wake of disasters.

2.1.5.4 State and District Disaster Management Authorities

State and District Disaster Management Authorities, (SDMA & DDMA) shall also ensure incorporation of NMHPs at the state and district levels and integrate them into state and district disaster management plans and part of general relief and general health response.

2.2 Resources for PSSMHS

The available resources for psycho-social support and mental health services are currently limited in the country. There are 43 state-run mental hospitals in the country. All recognized medical colleges are required to have a psychiatric unit which qualifies as general hospital psychiatric unit (GHPU). In addition, ESIC, Railways, Armed Forces and many other public sector undertakings have general hospital psychiatric units. The District Mental Health Programmes are there in 123 Districts under the National Mental Health Programme of India, but the manpower availability is limited. The last survey of mental health resources was done in (2002) by ICMR. As per the survey, there were 2219 Psychiatrists, 343 Clinical Psychologists and 290 Psychiatric Social Workers in the country. A current estimate of these mental health professionals would be 3500 Psychiatrists, 500 Clinical Psychologists, 400 PSWs and 1000 Psychiatric Nurses in the country. Further, out of many institutions providing training in mental health, only a few have been consistently working in the area of PSSMHS in disaster situations.

Human resources are the most valuable asset of a mental health service provision. In resource-rich countries like USA, UK and Australia the proportion of available manpower in mental health is far higher than in comparison to a country like India as shown in the table below. The paucity of manpower in making provision of mental health care in the whole country makes it much more difficult to provide psycho-social support and mental health services in disaster situations. Hence, there is a need to deprofessionalise the skills and create multi-agency, multi-disciplinary, inter-sectoral, private and NGO sectors to participate in developing non-professionals in mental health care at different levels with defined roles and

Table No. 1 – Status of Global Mental Health Manpower

Professionals per 100,000 Population	WORLD	USA	UK	AUSTRALIA	INDIA
Number of Psychiatrists	1.20	13.7	11	14	0.2
Number of Psychologists	0.60	31.1	9	5	0.03
Number of Social Workers	0.40	35.3	58	5	0.03
Number of Psychiatric Nurses	2.0	6.5	104	53	0.05

Ref. Mental Health Atlas, 2005

tasks, according to their educational background. These non-mental health professionals could be involved in provision of PSSMHS to promote mental health, prevent disorders and provide care for people with mental disorders.

2.2.1 PSSMHS for Disaster Management

Earlier, PTSD was considered as a prime effect of the disasters and most of the interventions were focused on these symptoms. Subsequent identification of long-term psycho-social effects on the survivors in Bhopal disaster, Orissa super cyclone, Gujarat earthquake and Tsunami has revealed negative impact on the persons' mental health, behaviour and ability to function normally. This has reaffirmed that psycho-social factors will have short and long-term effects on the community. Thus, there is a need to expand and bring out guidelines to provide holistic PSSMHS care to communities. Epidemiological surveys conducted in populations not affected by disasters revealed that the proportion of people requiring mental health services is around 8-10% of the population. After disasters, people requiring psycho-social support and mental health services are likely to increase by two to three times.

PSSMHS in the post-disaster phase were given by mental health professionals, institutions and the MoH&FW, albeit to a limited extent, from the Bhopal gas tragedy onwards. These were quite visible at the time of the Gujarat earthquake. However, clearer and greater recognition of the significance of PSSMHS by the Government came at the time of the Tsunami. Ministry of Health and Family Welfare, National Institute for Mental Health and Neuro-Sciences (NIMHANS) and a large number of NGOs, INGOs and community-based social workers came forward to address the short- and long-term psycho-social effects of Tsunami for the affected community.

The area of disaster mental health has evolved during the last two decades. From a mental disorder based approach after the Bhopal gas disaster, the approach has been modified to mental health integrated with public health after the Latur earthquake and further broadened to psycho-social and mental health care in the Orissa super cyclone, Gujarat earthquake, Tsunami and Kashmir earthquake. The purely clinic/hospital-based planning and delivery of services has given way to community-based services with active utilisation of community resources. The nature of manpower involved in service delivery has also undergone a significant change. Earlier, only psychiatrists were visible but now all mental health professionals, including clinical psychologists, psychiatric social workers, etc., to professionals, para-professionals and trained community level workers (CLWs) and volunteers can be seen, as service providers.

It is important to note that available resources like medical service providers in private sector, NGOs working with the community, Schools of Social Work, Departments of Clinical Psychology, Nursing Colleges, Family Counselling Centres, Indian Medical Association, Indian Psychiatric Society, Nursing Council of India and other professional bodies are not being used adequately though they have the potential to make up the deficiency in PSSMHS.

2.2.2 Provision of Service

2.2.2.1 Service Providers

i) Mental Health Professionals from the mental health institutions and

psychiatric departments in medical colleges are engaged in providing specialised mental health services in the country. An evolving trend has been seen wherein besides psychiatrists, other mental health professionals like clinical psychologists and psychologists and psychiatric social workers and social workers from other disciplines have also been involved in providing services.

ii) The centre and state governments have been deploying a few mental health professionals immediately after the disasters. These professionals have taken the initiative to provide mental health services and psycho-social care in different disasters ranging from emergencies like bomb blasts and train accidents to major disasters like earthquakes and cyclones.

iii) Medical officers were trained to provide services for people with identifiable mental disorders after the Bhopal gas disaster. After the Gujarat earthquake and Tsunami, some health workers were also imparted brief training in PSSMHS, who supported the community for psycho-social support and health-care services.

iv) The list of formalised service providers was further enlarged where Community Level Workers (CLWs), Social Welfare department workers, Anganwadi workers, and community-based religious and spiritual organizations significantly contributed in providing PSSMHS to the affected community. During Orissa super cyclone and Gujarat earthquake, CLWs, including volunteers from non-affected areas and some survivors of the disaster-affected community, were trained to provide PSSMHS.

v) Some Government Institutions like NIMHANS, Institute of Human behaviour and Allied Sciences (IHBAS) and Maharashtra Institute of Mental Health (MIMH) etc., have been actively involved in providing PSSMHS.

vi) The involvement of the government sector in the delivery of PSSMHS has been largely through MoH&FW. Though it has been possible to integrate mental health services with general health service delivery after disasters, up to some extent, the overall PSSMHS activities have not been well co-ordinated with other components of disaster response.

vii) A significant development during the last decade has been the extensive involvement of International agencies, especially UN agencies like Office for Coordination of Humanitarian Action (OCHA), World Health Organization (WHO), United Nations Childern's Fund (UNICEF), United Nations High Commissioner for Refugees (UNHCR) and United Nations Population Fund (UNFPA) in PSSMHS activities during disasters in Gujarat earthquake, Tsunami and Kashmir earthquake.

viii) A number of national and international level NGOs have also participated in providing disaster PSSMHS. The notable NGOs in the field are Action

Aid, Aga Khan Foundation, Save the Children, CARE, Catholic Relief Services (CRS), CARITAS, Medicines Sans Frontiers (MSF), Oxfam, World Vision, American Red Cross, International Federation of Red Cross & Red Creseant, Indian Red Cross Society and many other community based NGOs in providing PSSMHS after disasters. These organizations have frequently worked in collaboration and partnership with institutuions like NIMHANS and Tata Institute of Social Sciences (TISS) for technical support in providing PSSMHS.

2.2.2.2 Nature of Services

After the Bhopal gas tragedy, the focus was on identification as well as treatment of those who suffered from clinically diagnosable mental disorders and who visited the health clinics, started after the disaster. Identification and treatment of psychiatric disorders by mental health professionals in the field, or identification and referral of persons with psychiatric disorders continued as a major mental health service activity. Since then, the nature of PSSHMS provided after disasters have also undergone a significant change during the last two decades.

i) A number of non-disorder oriented interventions were undertaken to restore the psycho-social and mental health well-being in subsequent disasters specially after Orissa super cyclone and Gujarat earthquake.This interventions were crisis intervention, emotional first aid, counselling for grief reaction, group therapy, play therapy for children, facilitating community self-help groups by trained workers as well as mental health professionals. However, only a small fraction of the needy people could receive it in the absence of an institutionalised approach and appropriate co-ordination mechanism. After Tsunami, these interventions were provided in a more widespread manner but there is a need for a more systematic and structured delivery of services.

ii) Spiritual and faith based group activities like prayers, singing bhajans, discourses by religious leaders contribute to psycho-social well-being and might play a significant role in preventive mental health care and promote well-being. Other indigenous practices and alternative medicinal systems have also been utilized and they have gained a wide acceptance.

2.2.2.3 Delivery and Impact of the Services

A paradigm shift came after the Orissa super cyclone, Gujarat earthquake and the Tsunami and volunteers were trained at the community level to impart PSSMHS with referral support from mental health professionals.

i) PSSMHS interventions in the country have been a stand-alone activity and were integrated only partially with the general health services. Varieties of community-based mental health interventions have been developed and these were found useful after the tsunami. These community-based models were developed, incorporating contextual realities and cultural practices of the community.

ii) A systematic evaluation of the impact of mental health delivery models provided in disaster situations in India

has been carried out only in a few instances, after the tsunami.

iii) PSSMHS services have not been able to reach all the affected people. This has been mainly due to lack of skilled human resources and co-ordination.

iv) There has been no systematic plan for PSSMHS disaster preparedness and all the PSSMHS that have been carried out so far, happened in an adhoc manner after the disaster. These interventions usually lasted for only 3 to 6 months, except in case of the tsunami where these activities were planned for 2-3 years.

2.3 Capacity Development

Capacity building encompasses human, scientific, technological, organisational, and institutional resource capabilities. The primary goal of capacity building is to enhance the ability of persons and institutions based on the needs perceived. Capacity building is a long-term, continuing process, in which all stakeholders participate to enhance their skills and knowledge to achieve the desired objectives.

2.3.1 Human Resource Development

Human resource development is the process of equipping individuals with the understanding, skills and access to information, knowledge and training that enables them to perform effectively.

i) Human resource development in the area of PSSMHS has undergone a dynamic shift from the Bhopal disaster to the recent tsunami. But the growing inadequacy of the available human resources is evident and resources in PSSMHS are grossly inadequate to cater to the needs of our country.

ii) After the Bhopal Gas Disaster, it was evident that there was a dire need for training of non-mental health professionals to deliver mental health services to the disaster-affected community. It was also established that non-mental health professionals could provide effective intervention if trained properly which was demonstrated in various disasters like the Bhopal Gas Disaster, Latur earthquake, Orissa super cyclone, Gujarat earthquake, and the Tsunami.

iii) A dynamic shift was witnessed after the Orissa super cyclone where the volunteers and survivors were trained to provide basic psycho-social support and mental health support with the help of mental health professionals. For rehabilitation of tsunami victims, it was widely adopted and practised by many organizations, both government and non-government.

2.3.2 Target Groups for Training

The list of target groups for training has grown tremendously from professionals to non-professionals like medical officers, NGO workers, social work students, health workers, community level workers, teachers, Civil Defence personnel, Nehru Yuva Kendra (NYK) volunteers, Anganwadi workers, community leaders and various other relief providers.

2.3.3 Nature and Impact of Training

Post-disaster capacity building training was provided mainly by the mental health professionals, usually from outside the disaster-

affected areas with or without collaboration of local mental health professionals. These initiatives were technically and financially supported by various international organizations like WHO, UNICEF, Action Aid and Care India. The training was imparted, based on the needs of the disaster-affected community and the trainees/participants. The most widely followed approach was the top-down approach for master trainers, trainers and volunteers. The training included non-pharmacological interventions as well as pharmacological interventions and referral. Standardization of training methods by using indicators for evaluation has been done and the same has been imparted in large-scale training programmes, subsequent to the tsunami disaster.

2.3.4 Training Material

Training manuals for different categories of care-providers like medical officers, community level workers and the community were developed both for general and disaster specific situations by organizations like NIMHANS and WHO. These manuals were developed, keeping in mind prevailing local culture and customs and are available in regional languages to benefit the community.

The material on the care of care- providers is available to help care-providers and their organizations to take care of their emotional needs. Information, education and communication material was also developed to disseminate information and create awareness among the disaster-affected communities and the general population.

2.3.5 Recent Progress in Training and Capacity Development

Steady progress has been noticed in the last two decades in training and capacity development activities, which is evident during disasters in the country. These advances indicate a major shift in the approach to PSSMHS by emphasising the need to carry out these activities in the preparedness phase rather than initiating them in the post-disaster phase. There have been significant developments such as the inclusion of disaster management in the curriculum at the school level. Some universities (e.g., GGSIPU, IGNOU etc.) have included the subject in their curriculum both at under graduate and post-graduate levels. A few Schools of Social Work like TISS and Indian Red Cross have started full-fledged courses.

2.4 Research

i) Indian Mental Health and Social Science researchers have been keenly involved in carrying out research on the mental health aspects of disasters for more than two decades. The nature of issues addressed in various research studies have undergone a significant change. These range from a pure epidemiological head-counting of mentally ill, through normative approach to know about the overall human experiences and behaviour in disaster situations to intervention-based research.

ii) Institutions like WHO and ICMR have a credible record of supporting research studies for disasters like the Bhopal gas tragedy, Latur and Gujarat earthquakes, and Tsunami. Institutions like NIMHANS, IHBAS, MIMH and many medical college psychiatry departments have been involved in these research projects as well as other research studies.

iii) Research studies have focused on various aspects of response and rehabilitative measures. Some studies have established the gross inadequacy of trained manpower and availability of services for the disaster- affected community. A few long-term research studies have also established mental health morbidity and outcome.

iv) Conclusions can be drawn from the few short and long-term research studies conducted by various institutions which reveal the following: 1) Definite need of providing PSSMHS to the disaster-affected community as emergency psycho-social first aid and long-term recovery and rehabilitation support. 2) Common mental health disorders reported in the post-disaster studies are depression, anxiety, somatoform disorder, and alcohol and substance abuse. 3) Post-Traumatic Stress Disorder has not been found to be the most common disorder as reported by many western countries. 4) There is a significant gap between need and service provision.

2.5 Convergence and Integration

i) Integration of PSSMHS with relief and rehabilitation support involving different departments of Government and NGO sector, combined with various training and research activities, is essential for optimum utilisation of the limited resources. Yet very limited work has been done for this crucial aspect. In this direction, professionals, administrators and other key players involved in the PSSMHS of disasters, conducted workshops and conferences to share their experiences, which advocated the need for PSSMHS in a disaster situation. The experience from previous disasters shows that often the mental health professionals and agencies, carrying out research for psycho-social and mental health aspects of disasters, also delivered services either as a part of ethical obligation or independent of that. These research works have shown no uniform pattern and are generally sporadic in nature. There is a wide gap in co-ordination among different agencies and a lot of duplication of services is seen.

ii) Inter-convergence of mental health services with general relief work and general health services did occur to some extent, as a result of training of medical officers, health workers and CLWs in providing PSSMHS. Significantly, inter-sectoral convergence between government, NGOs and international agencies occurred to a limited extent. However, no inter-sectoral convergence with non-health sectors in planning or actual delivery of services has occurred.

2.5.1 International, Public and Private Sector Initiatives

Functionally, the PSSMHS has broadened from a counselling and medical approach to a more comprehensive and integrated approach, incorporating social and economic dimensions. These developments have enlisted more organizations to take up PSSMHS to empower the community and to deliver these

interventions. A number of international, public and private institutions have played a significant role in the area of community preparedness.

The UN agencies (such as WHO, UNFPA, UNICEF, UNESCO and the UNDP) contributed to the standardization of approaches and processes, supporting the Government agencies in training, material development, stocktaking and policy formulation. It is important to mention here the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psycho-Social Support in Emergency Settings, (2007), was developed to provide a range of essential guidelines in this area. The objectives of these guidelines are to enable the humanitarian actors to plan, establish and co-ordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psycho-social well-being in the midst of an emergency.

Various International and National NGOs have contributed significantly to the evolution of the PSSMHS to its current level. The NGOs have carefully analysed and understood the vulnerability caused by emotional trauma after disasters and discovered the socio-economic dimensions of the emotional trauma. These organizations have provided psycho-social first aid, developed educational and informational materials and done capacity building at the community level and provided psycho-social support to the affected people. Further, they contributed by identifying specific needs of the affected community, documenting their experiences and creating a dedicated work force to work in disasters.

The government being the main responder, played a pivotal role in all the disasters. The Ministries of Health, Education, and Social Welfare of various state governments are responsible for providing psycho-social care to the affected communities in conjunction with the nodal agency NIMHANS. Further, the efforts of the international NGOs also helped to converge the efforts of the government and the non-government organizations in the area of PSSMHS.

Donor agencies such as WHO, UNICEF, USAID, ECHO, DFID and other bilateral donor agencies play an important role by supporting these efforts, thus helping the overall evolution of PSSMHS in India.

2.6 Genesis of National Disaster Management Guidelines : Psycho-Social Support and Mental Health Services in Disasters

One of the important roles of NDMA is to issue guidelines to ministries/departments and states to evolve their DM Plan for holistic and co-ordinated management of disasters as identified in the DM Act, (2005). In the year (2006), a core group was formed to draft National Guidelines on Medical Preparedness and Mass Casuality Management and on the recommendations of the mental health experts from the core group to expand the importance of PSSMHS to a larger framework to formulate guidelines on PSSMHS. In this direction, a National meeting of experts in Psycho-Social Support and Mental Health Services was convened by NDMA at its headquarters in New Delhi in January (2007) as part of a nine -step participatory and consultative process to deliberate the present status of PSSMHS and evolve the National Disaster Management Guidelines : Psycho-Social Support and Mental

Health Services in disasters. Stakeholders from various ministries/departments of GoI (Health, Home Affairs, Defence) R&D organizations/ Institutes [NIMHANS, TISS, AFMC and IHBAS]. Professional institutions and professionals, NGOs and experts, in the field of Psycho-Social Support and Mental Health in disasters participated in the deliberations. The present status of the management of PSSMHS during the disasters in the country was discussed and important gaps were identified. The meeting also identified priority areas for prevention, mitigation and preparedness for Psycho-Social Support and Mental Health Services in disasters and provided an outline of comprehensive guidelines to be formulated as a guide for the preparation of action plans by ministries/ departments/states. A future course of action was set.

A Core Group of Experts comprising major stakeholders as well as state representatives was constituted under the chairmanship of Lt. Gen. (Dr.) J. R. Bhardwaj, PVSM, AVSM, VSM, PHS (Retd.), Member, NDMA to assist in preparing the Guidelines. Several meetings of the Core Group were held to review the draft versions of the Guidelines in consultation with concerned ministries, nodal and technical institutions and other stakeholders to evolve a consensus on the various issues regarding the Guidelines. Then the draft document was sent to experts who are actively working in the field of PSSMHS across the country for feedback and comments. The comments obtained were discussed by the Core Group and necessary amendments were made.

3 Salient Gaps

The chapter provides a description of the situational analysis in the areas of service delivery, capacity development and research in relation to PSSMHS in disaster situations in the country. The past experience of PSSMHS, notably after the Bhopal gas Disaster in (1984), the (1993) Latur earthquake, the Orissa super cyclone of (1999), Gujarat earthquake of (2001), Tsunami in (2004), and the Kashmir earthquake of (2005) has repeatedly brought out the psycho-social needs of the survivors, notwithstanding the progress made in various aspects of disaster PSSMHS. A closer look into these activities reveals that there have been certain noticeable gaps both in terms of macro issues of policy, strategies and planning as well as micro issues of preparedness, field logistics, co-ordination and implementation. This section identifies the important gaps and scope for improvement in the legal, institutional and operational framework to institute preparedness and put forth a robust response.

The experience shows that the overall approach in PSSMHS has been medical rather than bio-psycho-social. The activities have mostly been short-term and natural disaster oriented. These perceivable gaps, if addressed, will further strengthen the preparedness and response for PSSMHS.

3.1 Operational Framework

3.1.1 Planning and Co-ordination

Planning and co-ordination has been a vital aspect of PSSMHS intervention. It is necessary to address the following points in planning and co-ordination.

i) There has been limited planning with regard to immediate response in the area of physical and material response for the survivors of disasters. There has been complete lack of planning for preparedness and capacity development for PSSMHS.

ii) PSSMHS has been planned as a stand-alone vertical programme in most of the disasters. There is a need to plan and adopt an integrated and inter-sectoral approach to address immediate and long-term needs in the field of PSSMHS.

iii) Mental health professionals have usually been issued instructions to accompany the medical teams dispatched to the disaster-affected areas. It would be better if they were actively and appropriately involved in the planning process of PSSMHS.

iv) PSSMHS is largely considered as a "time-bound" activity, whereas the real need of reconciliation goes along with long-term rehabilitation itself. PSSMHS needs to be planned not as a "time-bound" activity but rather as a "time-line" activity for a period of 3-5 years and sometimes even more than that.

v) Inter-agency co-ordination has been found lacking between those who are

involved in providing PSSMHS and the general relief providing agencies. There is inadequate co-ordination even among PSSMHS providers thus resulting in duplication of services or uneven distribution of services.

3.1.2 Service Requirements and Delivery

3.1.2.1 Assessment

Based on the Geographical Information System (GIS) mapping of the area it is essential to carry out a comprehensive risk and vulnerability assessment as a part of preparedness activity. This will ensure proper implementation of PSSMHS programme at the time of disaster.

Overwhelming response during the initial period of disaster, i.e., by providing too much relief followed by its quick weaning, needs to be replaced by appropriately designed phase-wise response. There is a necessity to streamline the proportionate services based on need assessment.

3.1.2.2 Manpower

There is an acute shortage of skilled service providers both in psycho-social support and mental health care services. Even professionals lack adequate training for PSSMHS during disasters.

3.1.2.3 Service Delivery

The mental health services in the country have been mainly concentrated in the psychiatric units of tertiary hospitals and the psychiatric hospitals of different states, or in large cities. The District Mental Health Programme (DMHP) has so far been implemented in only one-sixth of the districts in the country. At present, the mental health services in the country are inadequate to meet the enhanced requirements for PSSMHS during disaster situations.

There is lack of standardized tools in the form of manuals and indicators for a systematic approach which are required by care-providers for PSSMHS.

Most of the PSSMHS activity models that were extended earlier were focused on immediate interventions. They did not have sustainability to ensure availability of such programmes for long-term relief and rehabilitation programmes.

Existing PSSMHS programmes are based on the concepts developed by donor agencies without the participation of, and deliberations with, the community as well as NGOs working in the area. These programmes also get the priorities and time lines as per the priorities laid down by the donor agencies, quite often disregarding priorities and needs of the community.

3.1.2.4 Integration

The PSSMHS services have been mainly provided by organizations from out of disaster-affected area. They have inadequate knowledge of the cultural beliefs and practices and the community priorities of the affected population, resulting in half-hearted acceptance and impact of such services. These organizations often do not collaborate with local authorities, thus affecting adversely the long-term sustainability of the interventions.

There is an urgent need for integration of government and non-government and other private care-providers engaged in activities related to PSSMHS. A workable permanent Public-Private Partnership (PPP) model is presently lacking.

There is a strong need to integrate and co-ordinate the various kinds of PSSMHS provided by different agencies. It will avoid duplication of services and ensure appropriate delivery of services.

3.1.2.5 Planning

The service provision in PSSMHS is not 'all hazard' focused. It should include all types of disasters, including populations affected by conflict situations and internally migrated/ displaced communities and disasters of low intensity.

The services provided have primarily followed a medical model whereas there is a strong need to devise a bio-psycho-social-model of care. The shift from medical model to psycho-socio-medical model, begun with Orissa super cyclone, Gujarat earthquake, Tsunami and Kashmir earthquake, is required to be strengthened.

Specific intervention models for vulnerable groups, alcohol and substance dependents have been devised but have not been applied to a desirable extent during disasters.

The mental health services have seldom utilized the local best practices and indigenous systems of care, resulting in vertical system of care with limited resources. It is essential to adopt and integrate well tested and recognised methods of intervention for PSSMHS.

3.1.2.6 Ethical Considerations

During disasters, it has been observed that the ethical norms necessary to maintain the dignity of the individual and the community are usually compromised. It is because of inadequate resources, pressure to respond within short periods and lack of training of the care-providers. Necessary ethical guidelines are also not available for PSSMHS.

3.1.2.7 Monitoring and Evaluation

There is no institutional mechanism for monitoring and evaluating the progress and impact of services at different levels and phases of disaster management.

Necessary mechanism and protocols are required to assess the quality of the programmes, which should ultimately lead to accreditation of programmes by nodal Institutions.

It is essential to develop measures and outcome inputs for different programmes run by various stakeholders. Standardized indicators are required to be developed for such programmes to make these prgrammes effective. Sample indicators are given in Annexure B.

3.2 Capacity Development

Capacity building means creating compatible infrastructure and enhancing knowledge, skills and abilities of people to empower them. It would enable them to respond promptly and efficiently in pre, during and post-disaster phases. The following are some of the significant limitations identified in the aspect of capacity building in PSSMHS.

3.2.1 Human Resource Development

Trained manpower to provide PSSMHS is inadequate in our country and the issue has not been addressed in a proper and systematic manner for disaster situations. For the management of PSSMHS, there has been inadequate capacity for major disasters like the Orissa super cyclone, Gujarat earthquake, Tsunami and Kashmir earthquake, both in the

government and NGO sectors. It has been observed that there is:

i) Lack of database of trained manpower and infrastructure, limits the service providers in mobilising existing resources in the affected areas. There is underutilisation or non-utilisation of available trained manpower in disaster situations.

ii) Most of human resource development at community level has been focusing only on short-term interventions. Such an approach is not ideal for proper PSSMHS.

iii) Earlier, human resource development was mainly focused on training of health workers and medical doctors. Recently, the focus has been broadened to other departments of education, welfare, community level workers and local volunteers. It was done only during the response phase of Orissa super cyclone, Gujarat earthquake, Tsunami and Kashmir earthquake–and not extended to preparedness.

iv) There is a lack of inventory on the availability of skilled and trained personnel at district or state levels.

v) There is inadequate networking and institutional framework for training and capacity development for PSSMHS in the country.

vi) There has been no mention of PSSMHS for disaster management in the District Mental Health Programme. This will need a revisit to DMHP by the nodal ministry (MoH&FW).

vii) Some basic components of PSSMHS for disaster, need to be included in the education curriculum of the health sector at undergraduate level and psychology and social work at master's level.

viii) There is an urgent need for more mental health specialists for providing PSSMHS. Newer strategies are required to be adopted to train more mental health specialists like clinical psychologists, psychiatric social workers, and psychiatrists who shall train community level workers.

ix) Documented literature is available for awareness and training for various types of disasters. But most of the documents do not mention anything about psycho-social needs and mental health care during disasters.

3.3 Implementation and Co-ordination

The following are the key lacunae, identified in co-ordination and implementation of PSSMHS. There is complete absence of co-ordination amongst various stakeholders who are responsible for PSSMHS during disasters. A predetermined co-ordination mechanism is essential for proper implementation of PSSMHS.

i) PSSMHS has always been provided in isolation by various agencies with little inter-agency co-ordination. There is also lack of local and regional level co-ordination for PSSMHS. The present approaches for intervention are either medical or psychological, or sociological in nature which lack in an integrated bio-psycho-social approach.

ii) The PSSMHS services are poorly co-ordinated and integrated with general relief work and only partially integrated with general health work.

iii) Mostly, there were no well-defined/ designated agencies for implementation of PSSMHS activities, except in the Tsunami and Kashmir earthquake. Thus, the accountability could not be decided for PSSMHS in most of the disasters. There has been complete lack of established institutional mechanism for planning and implementation of PSSMHS activities.

iv) The potential of the District Mental Health Programme for providing PSSMHS, needs to be reviewed carefully. This is attributable to lack of proper evaluation of effectiveness and impact of the programme in delivery of basic mental health services. In view of the integration of district mental health programmes with primary health centre, it is essential to review and strengthen the functioning of PHC. It is because of its additional responsibilities of providing PSSMHS, so that PSSMHS programmes can be properly implemented.

3.4 Research and Development

Research and development are the most important tools of PSSMHS intervention. The systematic tracking of every level of intervention and scientific analysis of effectiveness of service delivery and outcomes will provide avenues to identify the shortcomings and improve service delivery. The areas of basic and applied research and development that need to be considered are:

i) There is no identified body which screens and passes proposals based on local or scientific 'need', nor which acts as a `gate-keeper' for the vulnerable communities facing the disaster. The institutional research boards/ethics committees may not be able to capture all the aspects of research proposals in relation to the ethical implications to the local situation after a disaster.

ii) Ethical guidelines for conducting research are non existent or in adequate. It is because of donor driven research are publication driven research. Hence the need of the survivours are not properly taken care of. This deprives the professinals or the host communities of the relevant knowledge to plan the rehabilition.

iii) Documentation to disseminate either scientific findings to the research community and professionals or the host communities to plan their own rehabilitation is at times delayed by years together, losing much of its relevance and application.

iv) Trans-cultural issues related to disaster mental health such as occurrence and manifestation of PTSD, community responses to disasters, individual and group resilience to the psychological consequences of the disasters have not been researched.

v) There is no research on non-exposed cohort studies. Research using controlled experimental design is also lacking.

vi) Studies on the possible correlation between severity of disaster and its psychological consequences are inadequate.

vii) Though the resilience of people in developing countries is emphasised, very little research has been initiated to try to understand the factors underlying the concept.

viii) Research on protective and risk factors for diverse groups and regions is lacking.

ix) Culturally relevant concepts such as 'Collective trauma', or the particular meanings of cultural groups to various responses are not understood as they are not studied in depth.

x) There are comparatively few scholars researching the subject at the doctoral or post-doctoral level. It highlights the need for conceptual exploration in this field with sound and rigorous methods and from the public health perspective.

xi) There are no studies available that indicate the differences between the psycho-social and mental health impacts caused by natural and man-made disasters.

xii) There is no gender and vulnerable population specific tools or studies about the psycho-social impacts.

3.5 Documentation

It is very important to document each and every event during a disaster, integrating details about the number and the quality of services provided during disasters.

The following are the major deficiencies in the area :

i) Absence of proper format for documentation.

ii) Lack of adequate knowledge among first responders in documentation.

iii) Complete lack of knowledge about the management of information.

iv) Absence of reassuring entry of skilled manpower.

v) Documentation has at best been need driven, such as conducting `needs assessment' or case studies to negotiate with the state bureaucracy or national and international donors. Reports and other forms of documentation are mainly for accessing resources.

vi) During disasters, there are no uniform, structured guidlines for documentations. There are no clear-cut ethical guidelines laid down for providing PSSMHS.

vii) There are no generic manuals on natural and man-made disasters that could be adapted to specific disasters.

viii) There is no accepted and documented framework within which PSSMHS can be planned and implemented. There is also not enough documentation on indicators of the outcome of PSSMHS. Disaster situations need to be looked at in a continuum, as actions taken during various phases have an impact on each other. Therefore, there is a need for a common framework within which different actors can plan their

PSSMHS so that programmes and outcomes are comparable. A framework also makes it possible to generate measurable and comparable indicators of outcome.

ix) The increasing influence/impact of the media in reporting and recording disasters has not been researched to study its growing impact on resource mobilisation and giving visibility to issues of PSSMHS.

x) Much of the documentation in disasters and mental health is in the form of reports to meet the requirements of contributors or state institutions. There is inadequate scientific documentation of the local experiences at the national or global level. Though professionals from fields such as psychiatry, social work, psychology, sociology etc., have been published in reviewed publications this has been sporadic and based on individual or institutional needs. There has been no mandatory reflective publication of the Indian experiences which highlights the progress as well as gaps in planning and implementation of the programmes.

3.6 Finance

Disaster management has earmarked funds for emergency response which the state can operate, namely the Calamity Relief Fund (CRF) and National Calamity Contingency Fund (NCCF). However, the disasters for which CRF and NCCF can be utilized are defined. PSSMHS must be brought under purview of CRF/NCCF. Also under the provision of DM Act, (2005), adequate funds need to be earmarked for provision of PSSMHS in disaster situations.

The National Disaster Response Fund will be created and adequate funds earmarked for the management of PSSMHS in disasters from this fund.

Adequate financing for disaster prevention, preparedness, rehabilitation and management in PSSMHS at national, state and district levels has not been addressed properly. The authorities concerned need adequate earmarked funds to strengthen PSSMHS. These issues are required to be addressed on priority basis so that the funds are made available for long-term planning and preparedness.

4 Guidelines for Disaster Preparedness in PSSMHS

Disaster management involves a planned and systematic approach towards understanding and solving problems in the wake of a disaster. Natural or man-made disasters can be prevented or mitigated by proper planning and preparedness. The guidelines address all aspects of PSSMHS, including prevention, mitigation, preparedness, response, relief, rehabilitation and recovery. All important stakeholders including MoH&FW, other line ministries and departments along with the mental health professionals and community shall prepare themselves to achieve this objective. All concerned central ministries and departments of health in the states will prepare for the management of PSSMHS intervention based on the guidelines and will constitute the national resource for the management of PSSMHS. The nodal ministry shall also lay down clear policies and plans including appropriate institutional and operational framework that addresses all aspects of PSSMHS. The preparedness and response plan is to be prepared at the centre, state and district levels with the role and responsibilities of various stakeholders clearly defined. Disaster plans will be prepared by the nodal central ministry, state and district authorities on the basis of the guidelines issued by the national and state authorities.

4.1 Legislative Framework

The policies, programmes and action plans need to be supported by appropriate legal instruments, wherever necessary, for effective management of PSSMHS in disasters. It is important to develop a robust, though flexible, legal framework for achieving the above objectives. The existing Acts, Rules and Regulations at various levels will be reviewed and amended by the nodal ministry/state governments/local authorities. The proposed draft legislation should also enable the government to access equipment/ training available in the private sector. New Acts or Regulations, if needed, will be enacted and Rules laid down to strengthen the management of PSSMHS in disasters at the centre, state and district levels.

4.1.1 Policy, Plans and Programmes

The Ministry of Health and Family Welfare (MoH&FW) is the nodal ministry which will evolve plans and programmes for prevention, preparedness and mitigation and response to PSSMHS in disasters. The plans and policies will be a part of the National Mental Health Programme.

i) The primary responsibility of managing PSSMHS in disasters vests with the state governments as health is a state subject. The central government will

support the states in terms of guidance, technical expertise, and with human and material logistics. All the states will develop their own plans and guidelines for managing PSSMHS in disasters, in accordance with the national guidelines.

ii) PSSMHS interventions will be planned and integrated in NMHP and DMHP.

4.1.2 Institutional and Operational Framework

PSSMHS is a part of the general health programme but it is a specialised component of health during disasters and it needs to integrate with plans prepared by nodal ministries, state health departments and district authorities. The plans for PSSMHS will be prepared, based on the national guidelines, national policies and NMHP. This will be integrated with health plans at all levels. MoH&FW will be the nodal ministry at the centre. Other line ministries shall have health plans based on national guidelines and will be networked with plans prepared by MoH&FW.

The existing nodal institute like NIMHANS need to be declared as centres of excellence and create regional institutes to cater to the different regions of the country.

i) The existing medical college hospitals and universities and schools of social work will be made centres of PSSMHS in disasters. This would require upgradation in terms of infrastructure and human resource development.

ii) The institutions which are providing technical expertise for PSSMHS during disasters require capacity development in the areas of teaching, training and research.

iii) In the districts, DDMAs will provide the requisite management structure for district DM, factoring in the requirements for managing PSSMHS in disasters. At the district level, requisite PSSMHS management structure will be integrated into medical preparedness as part of district health plan. Ministries, departments and district authorities will encourage participation of private institutions, NGOs and community level social workers in providing PSSMHS.

iv) The strategic approach for management of PSSMHS in disasters would include responsible participation of the government, private sector, NGOs and civil society.

v) Implementation of PSSMHS services delivery can be ensured only through well prepared plans based on the guidelines. The plan will provide adequate infrastructure and human resources, training, public awareness and public participation which are important components of preparedness.

4.2 Planning and Preparedness

Planning is the first step in disaster preparedness and it includes planning for different phases of disaster. Psycho-social support and mental health services for disaster prone and vulnerable areas shall be planned much ahead of any disaster. Planning shall not be done in isolation to create a stand-alone vertical programme for psycho-social support and mental health. It shall be a component of overall planning for disaster management with an aim of providing psycho-social support and

mental health services integrated with health-care and general relief work. Planning should emphasise appropriate inter-sectoral as well as intra-sectoral collaboration and horizontal as well as vertical co-ordination among various agencies involved in disaster management.

i) The district shall be the primary unit for planning. The planning at state, regional and national level is closely related to district plans. The national and state level planning at macro level should include all the requirements of district level planning.

ii) The aim of planning and preparedness on disaster PSSMHS shall be targeted at short and long-term quality support and services to the affected communities in the post-disaster phase.

iii) Functionaries of DMHP and its infrastructure shall be incorporated in the institutional framework for disaster management for planning and delivering mental health services component. Proposed expansion of NMHP to cover most of the districts during 11th plan may provide adequate opportunity for such linkages. Planning of NMHP including its programme components, training materials, programmes and research shall be appropriately modified. Consequently, mental health aspect of disaster management to make such linkages successful shall be included in it.

4.2.1 Review and Regular Updating

The planned preparedness programme needs systematic monitoring. The execution of planning for preparedness has to be monitored and the preparedness status regarding PSSMHS should be reviewed periodically. The review meetings of the working group shall take place at district and state levels. It will also be reviewed by the National Co-ordination Committee on PSSMHS at the national level. A checklist on disaster preparedness should be developed and used for review of preparedness status.

4.2.2 Planning at the National and State levels

Planning of PSSMHS services shall include national, state and district levels so as to complement and facilitate each other. The broad areas of actions for preparedness for PSSMHS at the national and state levels shall include the following:

i) MoH&FW shall constitute the National Co-ordination Committee on PSSMHS to co-ordinate, implement, monitor and evaluate programmes based on national, mental health programme and plans prepared by the nodal ministry. This plan will integrate with general health plans for disasters up to district level.

ii) At present NIMHANS is the only nodal institute which offers expertise in capacity development, training human resources and research. Hence, it needs to be nominated as a centre for excellence. A number of other regional institutions shall also be nominated as nodal centeres to meet the enhanced requirement of training and capacity development.

iii) The MoH&FW shall coordinate with other line ministries and departments who have similar roles in PSSMHS so

that the programmes are implemented uniformly.

iv) Efforts of MoH&FW shall be strengthened by other ministries who will play a vital role in co-ordination, training and implementation of PSSMHS. This would include ministries of Labour, Women and Child Welfare, Human Resource Development and Social Welfare.

v) State authorities shall ensure inclusion of PSSMHS as an integral part of disaster planning for preparedness and response, relief and rehabilitation. The district plans shall include PSSMHS as part of general health care and relief work in the disasters.

vi) To ensure disaster preparedness for PSSMHS at the district level, a nodal officer from DMHP will be appointed He/She shall work closely with the Chief Medical Officer as well as to co-ordinate and monitor PSSMHS. A standard intervention model shall be duly prepared incorporating national and international best practices. This shall achieve uniformity in PSSMHS across the country. The districts shall plan adequate funds for implementation of PSSMHS.

vii) The present scenario depicts a complete lack of uniform intervention modules of PSSMHS in disasters. The modules of PSSMHS in complex emergencies/situations need to study both national and international experiences and collaborate/tie up with national and international bodies/ agencies. The module shall incorporate best practices to develop a culturally oriented uniform model for implementation across the country.

viii) Structured and standardized capacity building programme for different training modules of PSSMHS shall be developed.

ix) To ensure quality of service in the area of PSSMHS, an accreditation system for agencies working in this field shall be developed.

x) To ensure quality control and issues related to ethics and human rights during disaster management, appropriate qualitative indicators, monitoring and evaluation procedures shall be developed.

xi) All the response plans shall adequately adhere to the concerns, related to PSSMHS so that all vulnerable groups are adequately attended, on priority basis.

4.2.3 Resource Mapping

All the stakeholders involved in the PSSMHS will require adequate trained personnel for proper implementation of the programme. The inventory of such persons shall be maintained by MoH&FW at centre, state health departments and district health department and will focus on the following:

i) Resource mapping needs to be carried out both at macro and micro level to ascertain the existing infrastructure, material and manpower resources in terms of their availability and adequacy to provide PSSMHS.

ii) The potential stakeholders in PSSMHS at the national, state and district and community resources will be

systematically mapped to facilitate the total care and long-term care to the disaster-affected.

iii) Data of PSSMHS resources including government, non-government and civil society organizations will be continuously updated to create a national pool of resources to help the ministries and departments at the centre and states respectively.

iv) Potential care-providers within the community shall be identified, trained and included in the network of potential resources for PSSMHS in disaster management.

v) The mental health service infrastructure such as hospitals, health centres, social welfare centres where psycho-social or mental health services are provided in the district shall be mapped and networked to provide PSSMHS.

4.2.4 Preparedness for PSSMHS

There is an urgent need for preparedness in the field of psycho-social and mental health care in the management of effects of disasters. The need for institutionalising PSSMHS is integral to preparedness, nested within the DM. The PSSMHS preparedness seeks to anticipate emergencies/disasters and respond to them in an effective manner to provide holistic service delivery both on short- and long-term basis.

In order to respond effectively in disasters, a well-planned, integrated and co-ordinated effort shall be made for PSSMHS preparedness. It shall be based on the existing best practices—national as well as international–and incorporating lessons learnt from past experiences.

The preparedness activities for PSSMHS can be formally linked with various health programmes (like NMHP/DMHP, NRHM) as well as non-health development programmes like Rural Employees Scheme, Community Development Programme, NSS/NYK programmes.

Functionaries of DMHP its infrastructure should be incorporated in the institutional framework for disaster management for planning and delivering mental health services component. The proposed expansion of NMHP to cover most of the districts during 11th plan may provide adequate opportunity for such linkages. The planning of NMHP including its programme components, training materials, programmes and research should be appropriately modified to include mental health aspect of disaster management to make such linkages successful

The proper linkages between PSSMHS and developmental programmes will reduce the expenditure on PSSMHS preparedness. It will also improve the quality and impact of developmental programme. The linkage is also likely to add a humane aspect to the developmental programmes

4.3 Institutional Framework for PSSMHS

4.3.1 Institutional Framework at the National Level

The MoH&FW would continue to be the nodal ministry for managing PSSMHS in disasters. The institutional framework for PSSMHS will be part of the overall health intervention in disaster preparedness. An institutional framework operating at the state and district levels needs to be established by the state governments.

The following are inportant aspects;

i) This institutional framework shall be a part of the larger overall institutional framework for disaster management horizontally at district level and vertically at state and national level as per the Disaster Management Act, (2005).

ii) The PSSMHS shall be an integral part of the state and District Disaster Management Plan (DDMP). The preparedness is done as per the action plans. It shall be the joint responsibility of the nodal officer for PSSMHS as well as chairpersons of SDMA and DDMA to ensure the integration with the overall state disaster management plan and DDMP.

iii) The mechanism for co-ordination among agencies with varied backgrounds, goals, visions, objectives, expertise and resources should be evolved through mutual consultations and discussions. This shall facilitate successful implementation of PSSMHS activities in a disaster situation.

iv) A small working group comprising the nodal officer and other designated focal points from other line departments, NGOs and selected community leaders shall be formed at state and district levels. This will help in effective planning, execution, monitoring and evaluation of the PSSMHS activities.

v) The roles and responsibilities of various functionaries and service providers during disaster situations shall be broadly delineated during preparedness phase as part of institutional framework. It will result in a with clearly defined chain of command and accountability at administrative and technical levels.

vi) The preparedness for PSSMHS shall simultaneously occur from district to state to national level. The institutional framework for implementation at the micro level, needs to be identified and formalised in accordance with the local administrative and government agencies like the Block Development Office and the local Panchayati Raj institutions that keep an account of available resources and services.

vii) The strengths and the potential of the local communities shall be channelised appropriately by the local administrative agencies. Therefore, service-providers and functionaries at three levels, a) village/local communities, b) block/ taluka c) district level will be identified in health sector, non-health government sectors like welfare, education, women and child development etc., NGO sector, corporate sector and local community organizations to include them as a part of institutional framework. They will be given appropriate basic training. Many of them will receive advanced training in providing PSSMHS during disaster situations by the nodal institutions as arranged by district authorities.

viii) The health institutions are the key modem of mental health service delivery specifically in linkage and collaboration with the local unit/team of the NMHP of the Government of India.

The broad ranging component of psycho-social support requiries involvement of health agencies. It goes well beyond the health or the welfare sectors and needs multi-sector participation/co-ordination for smooth PSSMHS delivery.

4.3.2 Institutional Framework at the State and District levels

The framework for PSSMHS at the state level may be most beneficially evolved and operationalised keeping in mind the linkages with (a) the larger relief, recovery and rehabilitation activities being carried out by district administration and (b) the state level general medical services and mental health programmes. Essentially, the PSSMHS activities while being operationally linked with the state level activities of the National Mental Health Programme must also be planned and carried out in the context of specific activities being carried out by the SDMA to be meaningful.

i) All some important fectors States and Union Territories already have a state level nodal officer and NMHP unit located at State Mental Health Institute. The activities of NMHP unit are specified and facilitated by department of health through the Principal Secretary Health who also chairs the state mental health authority.

ii) PSSMHS activities shall be integrated with the NMHP. In addition for the PSSMHS component, it will be necessary to co-ordinate with the State Department of Social Welfare as well as schools of social work/departments of social work in the state level universities and the state level NGOs working in the welfare sector.

iii) SDMAs shall co-ordinate and ensure the participation of the department of social welfare, along with the departments of social work in the state universities and other state level NGOs for PSSMHS.

4.4 Capacity Development

Capacity development in the psycho-social support and mental health is a priority area. There is an acute shortage of skilled human resources both in government and non-government organizations for management of PSSMHS. It requires all-round development of human resource infrastructure, at all levels of the organizations related to PSSMHS in the community. Special attention be given to the development of trained manpower, their availability during disasters, knowledge networking and scientific upgradation at all levels. The capacity building also will provide a platform to link the psycho-social needs of the beneficiaries to effective programming. The training shall include CLWs from the community.

4.4.1 Human Resource

Human resource development is one of the most challenging areas of PSSMHS due to paucity of professionals and trained manpower. The requirements of survivors are so wide that it requires immediate and dynamic attention to take PSSMHS to every one. The need for development of human resource is one of the paramount areas of planning the PSSMHS intervention in disasters. Compared to normal situations, disasters need a rapid deployment of trained manpower to cater to the needs of survivors.

A few vital factors are;

i) In disasters, the need for human resources is a continuous phenomenon where it requires different skills at different points of time due to changing psycho-social needs. The human resources in the country are inadequate for such an enormous population. Hence, the need for creating both professional and non-professional resources, keeping in mind the long-term implication of the psycho-social issues arising out of disasters, is imperative.

ii) The planning for human resource development on PSSMHS shall be carried out in accordance with the available human resources vis-à-vis human resource needs in the country. This planing is for implementation of PSSMHS based on hazard, vulnerability and risk assessment of the districts in the country. However, awareness and sensitisation programmes for PSSMHS shall form an integral part of the 'all hazard' district management plans.

4.4.2 Education

The need for imparting formal education to the students has become inevitable considering the increasing incidents of disasters. PSSMHS is a crucial component of education for professionals. Basic education on psycho-social support is essential and must be included in the syllabi of courses run by various regulatory bodies. Mainstreaming the disaster management knowledge in the education system will facilitate prevention and mitigation of adverse psycho-social effects of disaster.

Education on PSSMHS may be included at the graduate and post-graduate levels in various courses in humanities and other professional courses. The syllabi at various levels will focus on the following areas:

i) At the school level, the curriculum shall include 'do's' and 'don'ts', and basic knowledge of PSSMHS without overloading the students.

ii) At the degree level the curriculum shall cover adverse psycho-social effects of various types of disasters and basic knowledge of various interventions and support services.

iii) All professional degrees at under-graduate and post-graduate levels shall include adequate knowledge on PSSMHS, both for preparedness and response, during various types of disasters.

iv) Regulatory authorities like National Council of Educational Research and Training (NCERT), School Boards, University Grant Commission (UGC) and professional bodies like All India Council of Technical Education (AICTE) and Medical Council of India (MCI) shall ensure that the following are included in the syllabi as follows:

   a. Education programmes for non-professionals, Continued Medical Education (CME) for existing stakeholders.

   b. Adding or modifying a special paper on PSSMHS, in the post-graduate or other higher courses.

c. Part-time courses, distance education online courses for higher level managers.

d. Any other similar plan/activity.

4.4.3 Training

The need for capacity building at various levels is an essential part of PSSMHS, since the country needs a large number of community based resources to deal with disaster situations. Adequately trained manpower shall be prepared through education, training, academic/ professional forums, and community practices. The nodal ministry MoH&FW at the centre, state and district disaster management authorities, centre for excellence, as well as other nodal institutions will implement PSSMHS. The following system of training can be imparted to prepare the community-based resources on PSSMHS:

i) Standardized training will be imparted to the mental health professionals like psychiatrists, psychologists, psychiatric social workers. Training will also be given to paramedics, community level workers and NGOs on PSSMHS from time to time.

ii) In view of the acute shortage of psychiatrists, it is necessary to train medical officers who can identify the psychological signs and symptoms and mental health problems of the affected people going to primary health centres to enable prevention and treatment measures at an early stage. The Continuous Medical Education (CME) programme for these professionals will help them to deal with persons with psychological effects. These medical officers shall be trained on short duration standardized courses designed for the management of PSSMHS during disasters.

iii) A graded training system for Training of Trainers (TOT) for a standard module on PSSMHS shall be adopted during the preparedness phase. The training of state level master trainers will be conducted at designated national and regional institutes. Training of district level trainers shall be held at Administrative Training Institutes (ATIs), District Institutes of Education and Technology (DIETs), State Institutes of Health and Family Welfare (SIHFW), universities and other places.

iv) Similarly, the length of the training programme shall vary from 3 to 15 days, depending on whether it is the basic or the advanced course. Duration of training will largely depend on the type of the target group and the type of training i.e., basic/ advanced course, TOT, sensitisation and orientation.

v) Refresher courses shall be conducted from time to time for those who are already trained and are required to participate in PSSMHS. These refresher courses shall focus on latest trends and the prevailing best practices in the field of PSSMHS.

vi) The designated institutes for PSSMHS will develop uniform training modules and standard intervention practices to be implemented all over the country. These PSSMHS training modules shall be practiced and tested during various mock drills and simulation exercise to test their efficacy.

vii) A district wise resources list of all skilled and trained manpower, all government and non-government organizations working in the field of PSSMHS shall be prepared. It shall be shared with all the organizations and government functionaries.

viii) Regular training programmes in the form of CMEs, workshops and symposiums shall be held for regular updating and knowledge enhancement. The do's and dont's of psycho-social aspects for natural and man-made disasters need to be formulated at the state and district level and incorporated in the education programmes of schools, colleges and professional educational curriculum.

ix) Higher training of mental health professionals could adopt various models developed by different scientific organizations to manage the psycho-social trauma caused due to ripple effects produced by the disasters as secondary disasters, including mob hysteria.

x) The content of training must be designed to suit the particular culture and ethnic needs of the community. This will be organised in a systematic manner. The training will consist of brief orientation followed by ongoing support and supervision.

xi) The training of CLWs will play an important role in rehabilitation by involving them in identification and referral of the probable mentally ill persons from the disaster-affected community and follow–up of people with higher mental health needs. They will also liaison with other agencies for different types of interventions and provide holistic PSSMHS care.

xii) Civil defence is a vital resource in our country which can contribute immensely in preparing the CLWs for psycho-social first aid during the disasters.

xiii) The capacity development for First Responders shall be ensured to provide Psycho-social Support to the community during the disasters.

xiv) Personnel of NDRF are engaged in capacity development during various preparedness activities. The training to NDRF first responders will be imparted for providing both for sensitizing the community about the psycho-social effects of the disasters and also provide Psycho-social First Aid.

4.4.4 Research and Development

The scientific and systematic study of disaster population and intervention needs to be an integrated part of PSSMHS. The disaster work is very strenuous and involves numerous tasks to be performed at various levels. It is very important to record the implementation, how the intervention progresses and the process involved, in a scientific manner so as to identify the best practices and gaps for fine-tuning of the service delivery.

Investment in research and the wider dissemination of findings are important for extending knowledge about the magnitude and causes of psycho-social and mental health problems. They are also important for exploring possibilities of prevention and improved

service delivery. It is vital to use effective research methods and techniques to enhance the quality of the PSSMHS. New research initiatives using evidence-based research studies needs to be planned and conducted in the disaster areas. The research also needs to identify the risks and protective factors among the population during and after disasters. Case control studies will be helpful to determine the extent of psychological effects.

The important aspects of Research are as follows :

i) Basic research must focus on specific needs of a community based on prevailing culture and religion to determine specific reactions, response patterns and coping mechanism of the community.

ii) The research shall also focus on existing interventional methodologies to assess their effectiveness after determining proper indicators and standards. Proper research always includes the study of the control group.

iii) There is a need to carry out research on existing cultural best practices and those derived from alternative medicine and spiritual beliefs. Novel intervention modules and strategies must be developed where older intervention methods are found to be ineffective.

iv) Research shall also be carried out for determining best services intervention modules for people who are regularly affected by recurring disasters like floods, cyclone and drought. Attention shall also be paid to the people who are living in conflict situations like insurgency and militancy.

v) Research shall focus on the specific needs of vulnerable groups.

vi) Research must also be instituted to explore, identify and define the psychological assessment of persons who indulge in unlawful and terrorist activities.

vii) Epidemiological studies on the incidence and prevalence of mental disorders and psycho-social effects can be conducted on the affected community as well as general population to ascertain the differences.

viii) The research must be conducted on both short-and long-term basis keeping in mind the cultural and ethical guidelines of the research. There is an urgent need to develop newer comprehensive interventional methods that should be able to address the short and long-term effects of disasters.

ix) Studies shall also be carried out on existing international best practices in PSSMHS so that relevant best practices are incorporated in the plans.

x) Specific research studies must be undertaken to understand the vulnerability factors which are specific to different groups. This needs to be studied scientifically to facilitate effective intervention and holistic recovery of the vulnerable.

xi) Research findings related to PSSMHS should be widely disseminated in appropriate forums for various user

groups ranging from mental health professionals to policy-makers and to the general public.

xii) Research needs to be carried out on baseline mental health of prospective care-providers and on the psycho-social and mental health needs of the care-providers during disaster situations.

xiii) Adaptation and validation of research and survey instruments commonly used in disaster research, based on the potential research topics in the field of PSSMHS shall be carried out by the national and regional nodal agencies. This shall be in collaboration with the ICMR, academic institutions and experts in research on PSSMHS related issues.

4.4.5 Documentation

One of the crucial aspects of PSSMHS is documentation, where it captures the process of intervention from beginning to end. Proper and scientific documentation provides a comprehensive picture about the process of PSSMHS intervention. The following are few important aspects of documentation:

i) The centre of excellence and nodal agency as well as /DDMAs/SDMAs shall put a systematic methodology to elaborate the details of disasters, preparedness, response, mitigation, quality and quantity of response provided to the community. This would help in learning lessons for future programmes. DDMAs and SDMAs may take the help from nodal institutions to make the standardized protocol for documentation in disasters.

ii) Only authentic data provided by the district authorities shall be incorporated in case reports.

iii) The data collected shall be shared with all stakeholders at all levels. Such data will be made available to the public.

iv) PSSMHS must also capture salient points, lessons learnt and best practices of intervention.

v) Proper documentation shall provide a monitoring and evaluation tool to determine the quality of work in PSSMHS.

vi) Detailed documentation needs to be shared periodically at the district, state and national level for cross-learning, feedback and future planning.

vii) All research and documentation on PSSMHS will be part of the resource centres at all levels for easy access and effective use.

4.4.6 Community Participation

Community is the first responder in the event of any disaster and plays an important role in response and rehabilitation and provision of PSSMHS to the survivors of disaster. A large number of community level workers (CLWs) participate as important team members for providing psycho-social support to the community. To standardize and streamline community participation in PSSMHS the following things are important.

i) Training the community, especially CLWs, will enhance the reach of PSSMHS to the community and there is a need to sustain them in all the phases of disaster and for all hazards. These community level workers must

be utilized in all phases of disasters especially in preparedness phases to create awareness and information dissemination among the community. The integration of PSSMHS intervention with other modes of intervention will help holistic well-being and improvement of the quality of life.

ii) Other members of community like Civil Defence personnel, Panchayati Raj functionaries, local non-government and community-based organizations and civil society will be involved in preparedness, mitigation, response and rehabilitation.

iii) Community members understand the local culture and customs better than the outsiders. Therefore, it is essential to associate them in strengthening awareness, and resilience of the society. They can be involved in activities like street plays, dramas, posters, distribution of reading material, school exhibitions and interaction with media and publicity.

iv) Standardized training and intervention modules shall be prepared by the nodal institutions for training community level workers so that services provided by them are uniform throughout the country.

v) For promoting group work in the community, there is a need to inculcate the belief that a majority of the problems in the community are common, needing collective response. This will result in better community relationship and harmony for collective response to non-disaster related community problems, likely to become an appropriate context for community response in a disaster situation.

4.4.7 Role of Community Level Workers

The community plays an important role during disaster preparedness and response.

Community level workers help the community in the following ways:

i) Helping survivors understand the changes that they experience in their body and mind.

ii) Helping the survivors to understand the changes one undergoes due to traumatic experiences and losses.

iii) Decreasing physical and emotional reactions by using basic principles of emotional support by establishing a good rapport.

iv) To strengthen and improve the quality of response by the response teams.

v) To define the immediate impact of the disasters and provide immediate psycho-social support to the affected community, especially when there may be lot of panic, fear and apprehension.

vi) To understand and identify local hazards, vulnerability and risks of different communities.

vii) To rehabilitate and help in recovery by training them for follow-up and referral programmes, designed for psycho-social support interventions for various types of disasters.

4.4.8 Infrastructure for PSSMHS

The presently available infrastructure for management of PSSMHS like mental hospitals,

clinics and professional institutions is not adequate and therefore there is a need to expand this infrastructure to all the regions of the country. The PSSMHS capacity building shall start with the upgradation of existing physical infrastructure and creation of additional infrastructure at the centre, state and district levels. The responsibility of activities will be with the nodal ministry at the centre and the states.

Some significant points regarding the infrastructure are:

i) A well-equipped infrastructure will provide a good environment for management of PSSMHS both in preparedness and response. These facilities need to be designed and built with state-of-the-art infrastructure, keeping in mind the enhanced requirements of PSSMHS.

ii) Existing infrastructure will be upgraded to suit the various needs of capacity building for pre and post-disaster situations. This infrastructure will be developed in every district based on hazard, vulnerability and risk. The capacity development will not be limited to government sectors alone but also be encouraged in the private and corporate sector.

iii) A few more zonal centres shall be created or upgraded to meet the enhanced need during the disaster within medical colleges. Wherever such institutions are not available, the departments of psychiatry in the medical colleges can be upgraded.

The existing infrastructure under the District Mental Health Programme (DMHP), District Institute for Education and Training (DIET) and NGOs at the district level shall be utilized for preparedness.

4.4.8.1 Hospital Preparedness

Hospital preparedness is an important part of disaster management where PSSMHS forms an integral part of it. It enhances the hospitals' capacity to respond in the event of disasters, both in the government and private sector.

The following are the major factors of PSSMHS in hospital preparedness:

i) The hospital disaster management plan shall include PSSMHS as one of the specific components.

ii) Networking with other institutions for preparedness and sharing knowledge.

iii) Psychiatric ward of the hospital shall be upgraded to meet enhanced requirements during disaster, based on vulnerability and risk assessment.

iv) Adequate relevant medical equipment and other investigative tools shall be made available in upgraded wards.

v) In addition, these wards shall also be equipped with required equipment to handle acute emergencies to take care of vital functions of the patients.

vi) Adequate and specialised medical stores required for management of patients with psychological and mental disorders.

vii) Adequate networking/telemedicine facilities with other hospitals, medical colleges, zonal and national institutes to share and pool resources to meet the challenges of larger disasters.

4.4.8.2 Network of Institutions

The existing number of nodal institutions engaged in capacity development in the field for the management of PSSMHS are few in number. A network of such institutions at zonal teaching hospital level will be established to cover the entire country for the capacity development of the human resources.

A few things to be kept in view:

i) Existing institutions shall be upgraded and will be given responsibility to standardize training modules for both professional and non-professional responders. The existing structures and health programmers under national health policy need to be utilized and the programmes such as National Rural Health Mission (NRHM) will be used for this purpose.

ii) Institutes like NIMHANS which is a nodal institute of MoH&FW shall be developed as a centre of excellence and other regional nodal centres like IHBAS, MIMH, LGBMH, TISS etc. for formulating and designing standardized intervention modules for all professionals engaged in the area of PSSMHS, they will also be authorised to monitor and evaluate the PSSMHS.

iii) The center of excellence NIMHANS and other regional mental health institutes like IHBAS, MIMH, LGBMH etc. shall develop appropriate tools and materials and standard intervention models to tie up with the regional and local centres.

iv) The existing general hospital psychiatric departments and medical college units will be strengthened and networked with the DMHP programme. Special focus will be given to the already existing units.

v) SDMAs and departments of health will identify medical colleges in various states that would be designated and assigned the responsibility of formulating short courses of 3-6 months duration to train medical officers and other professionals. This would help in combating the existing deficiency of psychiatrists, psychologists and psychiatric social workers as part of the NMHP.

vi) Identified local universities and national bodies with the responsibility of imparting education/skill training on PSSMHS shall be co-ordinated to support infrastructural inadequacies of the training providing organization institutions in the district/state.

vii) The NIDM and ATI's, NIRD will train and build capacitates for administrative officials and community representatives. The training will be focusing on providing psycho-social first aid and psycho-social support.

viii) The district hospitals and medical college psychiatric departments will be nominated as referral centres.

A new network of institutions and organizations needs to be developed for cross learning, developing new ideas and exchange of ideas.

4.4.8.3 Public-Private Partnership

The private sector has substantial capacity and infrastructure and plays a vital role in the management of disasters. Many community-based programmes were collaborated on public-private partnership and they have successfully demonstrated the effectiveness of reaching the needy population.

The following recommendations may bring effective results in the field of PSSMHS through public-private participation.

i) Collaborations between the government and the private organizations based on mutually agreeable goals and objective of the PSSMHS intervention.

ii) Private sector facilities are required to be included in district-level plans. DM plans with collaborative strategies shall be evolved at the district level for the utilisation of manpower and infrastructure.

iii) Private medical health facilities, paramedical staff, NGOs and community-based organizations must be made part of the resources. Community-based social workers can assist in psycho-social need assessment, psycho-social first aid and psycho-social support to the affected population under the supervision of PSSMHS professionals.

iv) NGOs are valuable resources since many of them have skilled manpower and training centres that can be utilized for imparting education/skill training at community level, thereby maximising the capacities and minimising capital expenditure.

v) Health plan of the district may enrol all private institutes and their professional capacities and infrastructure during the preparedness, response and mitigation phases of disasters.

vi) A well-coordinated preparedness involving the government, panchayati raj institutions, private and corporate sector shall be adopted for planning, co-ordinating and implementing programmes. This will enable community participation and enhance their ownership in PSSMHS preparedness.

4.4.8.4 Technical and Scientific Institutions

Centre and state authorities will identify and designate technical institutions that have resources and expertise in disaster mental health. For example, NIMHANS will be designated as a centre of excellence because of its long-time association with the various disaster mental health interventions and its expertise in the field of PSSMHS. In addition, IHBAS, MIMH, LGBMH, TISS and other regional level nodal institutions will be identified and designated.

Some relevant points about these institutions are :

i) These institutions will function as key responders in the PSSMHS, conducting need assessment based on the hazard, risk and vulnerability of the affected community, developing standardized and structured need assessment tools to capture the psycho-social effects after disaster.

ii) These institutions with their manpower and scientific resources would conduct

research to ascertain the impact of disasters, coping, resilience, particular behaviour patterns, quality of life and well being of the survivors.

iii) These institutions will develop appropriate intervention modules to suit general as well as region-wise requirements.

iv) The mitigation strategies will be based on the mission of reaching out to all communities. The mitigation strategies include testing, evaluation, and upgradation of services. Based on the mitigation, the short and long-term goals of intervention and creating infrastructure will be undertaken.

v) There is a need to adequately train the required manpower according to population and local needs. The intervention needs developed shall be based on the other intervention to integrate PSSMHS with other methods of intervention to provide a holistic intervention.

vi) These institutions will develop models based on preventive strategy essentially focused to prevent the vulnerability of the population and mitigate the post-disaster effects. The strategy will include public health preparedness, long-term plans based on the coping and resilience factors of the population and community resources.

4.4.8.5 Communication and Networking

Communication is a vital component of PSSMHS intervention. Disaster poses severe disruption in the community because of loss of both human and physical infrastructure. The ill-effects of the disaster abruptly bring cessation in communication and results in confusion and chaos among the population. It is vital to develop good communication and networking among the various stakeholders in order to provide PSSMHS.

Various aspects of this vital component are :

i) Disaster PSSMHS communication needs to be established at the centre, state and district levels. There will be control centres at respective places to control and co-ordinate the communication between various responders and stakeholders.

ii) At the district level, all the hospitals and PHCs will be connected with a network. There is need to have intra-hospital horizontal type network linkages to facilitate swift communication.

iii) Communication about the affected community's PSSMHS needs to be disseminated through the print and electronic media. Creating awareness about PSSMHS through the media will enhance the information and knowledge level among the communities to alleviate their trauma arising out of any disaster.

iv) The media also helps to destigmatise the psycho-social effects. This helps in educating the community about the psycho-social effects and prepares the community to face rumours, panic and impending disasters.

v) The NGOs with their local knowledge of people and terrain make them

appropriate to disseminate information about psycho-social effects of the disasters. These organizations play an important role in sensitising and educating the community, on PSSMHS preparedness. Such agencies shall also be networked to provide PSSMHS.

vi) International organizations such as WHO provide information, communication and alerts on health related issues, and technical experts in disasters. Their expertise needs to be fully utilized.

vii) India Disaster Resources Network functioning under the Ministry of Home Affairs will be upgraded with PSSMHS related issues.

4.5 International Co-operation

There are many international agencies currently working in the country, including the UN agencies, that carry out a number of interventions like training and capacity building, participating in response for disaster management including PSSMHS.

International co-operation is a necessary element in the management of PSSMHS. Various activities that will be undertaken to enhance harmony in the functioning of PSSMHS service are as follows:

i) Establishment of an adequate mechanism to enhance the level of interaction between the various state and non-state actors who are required to work in tandem during such events.

ii) PSSMHS has been one of the main interventions in disasters in developed countries where it has demonstrated its effectiveness in facilitating recovery of the affected population. Incorporation of international best practices into PSSMHS will enhance the understanding of the intervention.

iii) The group of organizations working in PSSMHS will conduct workshops, seminars and conferences for direct interaction, exchange of ideas and policy enhancement, periodically.

iv) The forum will also promote the official interaction of state actors to evolve new policies and programmes in the changing dynamics of psycho-social needs in the wake of present situation.

v) The management of psycho-social support requires the pooling of health resources, logistics, trained human resources and other essentials at the international level. The management of psycho-social support requires a collaborative and integrated approach wherein the affected countries will make a combined effort to mitigate the impact.

vi) International mental health institutions, organizations that are involved in PSSMHS intervention, will collaborate in the field of PSSMHS research and material development to bring in more cross-learning. Adaptation of international best practices in PSSMHS intervention can bring more quality services at the local level.

Effective management of PSSMHS in disasters depends upon the level of co-ordination between various stakeholders and their preparedness. Such a process is highly complex at the international level and requires

the initiation and co-ordination of pre-determined plans in immediate response after disaster.

4.6 Special Care of Vulnerable Groups

Disasters do not affect uniformly and their effect differs from person to person and region to region. Even under normal circumstances, vulnerable groups due to their physical, emotional and social limitations do not get adequate help and support and are prone to both physical and psychological difficulties. Vulnerability is the degree to which a population, individual or organization is unable to anticipate, cope with, resist and recover from the impacts of disasters. These groups of survivors are more prone to adverse psycho-social and mental health consequences of disasters due to a number of reasons like age, gender, ethnicity, disability, poor health and mental illness. Due to these factors they are at the higher risk which varies from region to region.

The vulnerable group consists of children, women, refugees, internally displaced population, the aged, mentally ill, the disabled, people with special needs. They are at increased risk of developing mental health difficulties. These groups need special attention and extra care during disasters. Therefore, it is essential to prepare specific intervention manuals for vulnerable groups.

It is essential to identify these vulnerable groups on the basis of pre-defined parameters and update them at regular intervals. The following factors shall be kept in mind while preparing PSSMHS for vulnerable groups in different phases of disasters.

i) Based on the GIS mapping, it is essential to define the vulnerable groups and categories so that these group can be provided with immediate relief and be attended to first.

ii) Basic needs and minimum requirement of food, water and sanitation, medical cover shall be provided to vulnerable groups on priority basis.

iii) The preparedness plan shall focus on the vulnerable group and may require special relief items like wheel-chairs, medical gadgets, dignity kits for women and life saving drugs.

iv) Provision of special care will be made for children, especially who have lost their parents and siblings. Special care will be provided to pregnant women, women who have lost their spouse and family members, aged persons and those with physical and mental disability.

v) Relief and compensation shall be provided to these groups on priority basis as they are usually left out because of their physical disabilities and incapacity to access help.

vi) Specially trained professionals and workers along with the health-care workers who provide psycho-social support and mental health services to disaster survivors will be deployed.

vii) Special attention will also be paid to the public health issues like personal hygiene and sanitation, disposal of human refuse and excreta as well as to the means of transportation and evacuation.

4.6.1 Psycho-Social First Aid

Immediately after the disaster there is a need to provide Psycho-social First Aid (PSFA) to the affected population to cope with the psycho-social trauma of exposure to the disaster. PSFA helps the affected population to deal with reactions related to loss and grief providing crisis intervention.

i) PSFA means providing immediate psycho-social intervention helping the affected population to deal with immediate reactions and panic related to loss of life and property.

ii) PSFA is the first basic intervention of PSSMHS and can be given quickly by both professionals and non-professionals. It promotes safety and protection of the survivors to hasten psychological recovery.

iii) PSFA needs to form the first line response to any disasters and there must be adequately trained professionals and non-professionals to provide PSFA in an event of disasters.

iv) PSFA training and skills can be given to hospital emergency paramedics, ambulance crew, community level workers, students and other first responders in the disasters to enhance the reach of the PSSMHS.

v) The SDMA and the DDMA will co-ordinate with the State Mental Health Authorities (SMHA) and District Mental Health Programme authorities to provide traning and services.

4.6.2 Referral System

The psycho-social support and mental health services are long-term interventions not only limited to community level as a primary care but also extends to secondary and tertiary care facilities. The referral system helps to identify and treat the affected people who require a higher level of psychological and mental health care by trained professionals.

The following methods shall be evolved in referral system:

i) The DMHP will co-ordinate and monitor the referral services in the state and district level. The nodal officer of the DMHP will identify the appropriate hospitals and professionals for referral services.

ii) The identified and designated referral centres and the professionals will be networked at the state and district levels. A database of the same will be regularly updated.

iii) The non-professionals and community level workers will be adequately trained to do referral and follow-up of the population.

iv) Periodic reviews shall be carried out on the status of referred people and the various interventions provided.

4.7 Media Management

Media, both electronic and print, plays a vital role in disseminating information and education to the public. Like most first responders who provide information to the public, government and non-government organizations rely on the media for information, and media reports often shape public opinion.

Responsible media not only provides the statistics of the disasters but also the extent of the loss, vulnerability, risks and hazards of the affected area. There is a great potential to tap the media resource for PSSMHS preparedness.

Some important aspects of media management are :

i) The PRO at the district level will be totally responsible for providing authentic reports. He will collect reports from designated nodal officers of the PSSMHS plan and will distribute it to the media for the general public.

ii) Media's role in educating and sharing information about the psychological effects of the disasters and how to take care of oneself in times of stress will be useful.

iii) Dissemination of knowledge, information on positive coping methods through printed material or through visual media has the potential to reach vast majority of the affected population. The aim of such information is to increase the capacity of individuals, families and communities to understand the common ways to cope with difficult situations.

iv) Do's and don'ts of PSSMHS for the media will be prepared.

v) The media should play a responsible role by reporting authentically without sensationalising the issue, thus preventing panic among the public.

5 Guidelines for PSSMHS in the Post-Disaster Phase

Psycho-social response after the disaster is one of the principal areas of health management in disaster intervention. The PSSMHS response starts immediately after the disaster and covers the rescue, relief, rehabilitation and reconstruction phases. It emphasises both short-and long-term needs of the affected community. Well-coordinated and planned preparedness ensures effective PSSMHS response and service delivery.

5.1 PSSMHS in the Response Phase

Effective and rapid PSSMHS response helps to reduce the stress and trauma of the affected community and facilitates speedy recovery by bringing them back to their pre-disaster level. The response will be based on the timely 'all hazard' PSSMHS need assessment focusing all the areas both at the macro and micro levels to respond and manage the psycho-social issues after the disaster. PSSMHS will be part of the health response plan and will be co-ordinated by the central, state and district authorities, all the stakeholders including NGOs, specialised institutions, civil society organizations and the community.

The psycho-social support after the disasters must follow an integrated approach. The PSSMHS response plan is the main responsibility of the Ministry of Health and Family Welfare (MoF&W) at the centre. Other line ministries like Ministry of Defence (MoD), Ministry of Railways (MoR), Ministry of Labour Employees State Insurance Corporation (MOL, ESIC), MoW&CD shall also prepare their response plans based on these guidelines. The efforts from the ministries shall be used to complement the main efforts of the nodal ministry in a major disaster. The response plans for the PSSMHS shall be prepared, based on the National Guidelines, National Health Policy and National Mental Health Programme (NMHP). These plans will be integrated with health plans at all levels.

The following checklist could be followed for the activation of response plan:

i) Emergency meeting of health sub-committee with the nodal mental health officer as member under the chairperson DDMA and representatives from social welfare, department of education and women and child welfare.

ii) A rapid needs assessment based on the data available from the nodal agency and it shall include those from INGOs/NGOs.

iii) Availability of trained manpower for PSSMHS.

iv) Assessment of additional trained manpower requirement.

v) Immediate initiation of emergency psycho-social first aid and evacuation of acute mentally ill persons.

vi) Support to vulnerable groups within the affected community.

vii) Adequate arrangement for PSSMHS for recovery and rehabilitation.

viii) Constitute a co-ordination committee that will co-ordinate and ensure implementation of district mental health response plan. This co-ordination committee will also monitor the quality of services provided, availability of adequate manpower and relief material based on the technical advice received from regional institutions.

5.2 Psycho-social First Aid

During the initial stages of the response, the immediate support for the affected population is provided in the form of psycho-social first aid.

A few salient points about the PSFA are :

i) The psycho-social first aid could be viewed as a process which prevents further deterioration of the coping capacities of the survivors, thereby enhancing the chances for rapid normalisation process.

ii) In the absence of psycho-social first aid, the normalisation to the affected community will be delayed and the process of normalisation prolonged. Hence, psycho-social first aid has a great significance in provision of psycho-social care to the survivors of disasters.

iii) Psycho-social first aid is provided in the initial one to six weeks period. The psycho-social first aid shall be provided by trained CLWs and the relief and rescue workers who are provided training for psycho-social first aid, along with providing general relief services.

iv) The psycho-social first aid could be provided through mass catharsis, undertaking rituals as per local practices and culture, organising regular meetings of the survivors and helping them ventilate their feelings and providing play material to children.

Components of psycho-social first aid include:

i) The basic human response of comforting and consoling a distressed person.

ii) Protecting the person from further threat or distress as far as possible.

iii) Furnishing immediate care for physical necessities including shelter.

iv) Providing goal orientation and support or specific reality based tasks.

v) Facilitating reunion with loved ones from whom the survivor has been separated.

vi) Facilitating the sharing of experiences.

vii) Linking the survivor to systems of support or sources of help that will be ongoing.

viii) Facilitating the beginning of some sense of control over the situation.

ix) Identifying needs for further psycho-social first aid.

5.3 Integration with General Relief Work

Effective psycho-social support and mental health intervention requires an inter-sectoral co-ordination with the various stakeholders. The general relief measures begin, once the evacuation of survivors is over by the concerned authorities. The PSSMHS measures shall start with implementation of the health response plan.

Following are the key aspects of integration of PSSMHS with the general relief work :

i) It is essential to integrate emergency psycho-social first aid as a part of health response plan and shall be instituted as part of immediate response and relief.

ii) PSSMHS response team for Psycho-social first aid will work and integrate with other first responders.

iii) While giving psycho-social first aid, cultural sensitivity is kept in mind throughout the response. The first responders who have been sensitised to local cultural, traditional and ethical differences shall be utilized. Some of the well recognised local practices may be included in the first aid with the help of village head or local elected representative.

iv) Community Level Workers who have been sensitised and trained to provide care to vulnerable groups shall be identified and involved in the response and relief.

v) The previous experiences of providing culturally appropriate interventions like MAMATA GRUHA during super cyclone in Orissa in 1999 could be explored keeping the cultural and community sensitivity in mind. This will help in developing culturally acceptable care for the affected community.

5.3.1 PSSMHS in Relief Camps

Relief camps are setup in large numbers in the wake of disasters with survivors being shifted to the camps. These survivors because of their dislocation and displacement from homes, separated from families in terms of gender, socio-religious cultural practices of the family, results in higher amount of psychological distress. Their functionality is reduced due to unEmployees resulting and disruption in daily routine. Further there are basic needs of food, shelter and personal safety that will be at stake, especially for vulnerable groups viz., women, widows, adolescent girls, the aged, the injured, children–orphaned and semi-orphaned.

PSSMHS needs to be provided on priority basis to these vulnerable groups through group and mass activities. Experience suggests that involvement of NGOs and CBOs through health, education activities and by engagement of traditional forms of building support systems. This shall facilitate them to grieve on their losses through mass catharsis, following up rituals, externalisation of interest of the various groups, in building space for recreation and spiritual activities. Further normalisation of children in their routine activities through child care activity centre within the camps will be an important camp intervention. Persons with pre-disaster mental illness and the disabled will be identified by the camp medical teams and provided

available essential medication and, the post-disaster mentally ill can be identified and referred and followed up through secondary and tertiary service sector.

5.4 Integration with the Health Plan

The integration of psycho-social support and mental health services in the general health-care is an effective way of reaching care to the affected people. The PSSMHS focuses on integration of services with the general health-care to facilitate early identification, management, referral and follow-up of PSSMHS along with the medical problems so that they can be dealt together in an integrated manner.

In the process of integrating PSSMHS in general health-care, the important aspects are:

i) The integration of PSSMHS shall start at the primary health care level centres at block and the specialised services at district level. The community health teams will be working together with the local health workers and will provide linkages with DMHP for referral and specialised psychosocial care.

ii) Creating referral system for the identified cases and which can be referred to the nearest specialised hospital/medical college. However, facilitating the follow up of the treatment shall rest with the health department.

iii) Immediately after the rescue and relief phase with the coverage of PSFA the PSSMHS would enter the stage of psycho-social care by providing needed spectrum of care including the compensation, paralegal, health-care, psycho-social care, education, and self-help within the communities through the governmental departments of health, welfare and education. Non-governmental agencies would also be encouraged to extend such psycho-social care through community level workers working with them. This phase would be carried out till the year after the disaster.

iv) The anniversary of disaster event would be carried out to externalize the emotions still prevalent among the survivors. Specific activities be carried out as a part of the same by the GOs and NGOs during the anniversary event.

v) The continuation of PSSMHS after a year would concentrate predominantly on creating a caring community by institutionalizing the psycho-social support activities. They would include moving the survivors to permanent shelters as well as developing support systems within the community.

vi) The PHC workers shall provide psycho-social first aid to those who require PSFA even after 4-6 weeks and need of intensive counselling or with mental health disorders requiring referral. Minimal mental health care by PHC medical officers must be re-activated. District health authorities shall ensure the availability of treatment for the referred cases.

vii) After a year or so, the physical care needs are likely to reduce further, while PSSMHS needs till continue up

to a period of 3-5 years (in case of special situations, the need may continue till 10 years). PHC workers shall devote more time in providing PSSMHS to the survivors on long-term basis. District authorities shall ensure that PHC workers shall deliver PSSMHS on long-term basis to the survivors.

5.5 Referral System

Large number of survivors only require psycho-social first aid while a fair number of them require long-term and special care. Therefore, a referral mechanism will be worked out for their long-term treatment and follow–up. The core aim of the referral is not only to lessen the workload but to facilitate and sustain long-term PSSMHS.

i) Referral is a specialised service which is required when the psycho-social disorders cannot be managed or resolved at the disaster site or at the PHC. The trained PHC team, health teams, community level workers and volunteers, who provide basic psycho-social support after the disaster, can identify the persons with psycho-social difficulties and mental health problems, and refer them for professional support.

ii) Mechanism of referral shall be evolved for referring those already identified, affected person to zonal mental health clinic or hospital or to specialised mental health centres, depending upon the type and level of illness.

iii) Proper documentation with the summary of illness and details of the treatment imparted at the disaster site shall accompany the patient to the referral centre.

iv) Linking the referral to the health facilities in the field and organizations working in traditional healing methods, alternative medicines and Indian systems of medicines shall also be encouraged.

5.6 Role of NGOs in PSSMHS

Non-Government Organizations often play an important role in psycho-social support and mental health services for survivors of a disaster in rebuilding the eroded social support systems. There is a need to create a caring community with the existing resources. Such resources can be found among the Non-Government Organizations (NGOs) and Community-Based Organizations (CBOs).

These organizations can provide an integrated PSSMHS along with their other rehabilitation and developmental activities for the survivors of the disaster and their communities. These organizations and their workers often provide effective care because they have better knowledge of the community, language, and customs. Survivors also readily identify with them and form therapeutic relationships. It is important to ensure that these non-professional workers are appropriately trained, their capacities being built with support and supervision to ensure better standards of care to the survivors. These organizations need to be regulated in terms of their PSSMHS practices and the services they provide.

Currently, a large number of such NGOs are working in various States of the country. Action Aid India, CARE India, SEWA, Oxfam,

Lutheran World Services India, Swayam Sevak Prayog, Plan International, Medecins Sans Frontieres, Everychild India, Terres de Hommes, Mennonite Central Committee, Malteser International, Aga Khan Foundation are some of the NGOs that are working in the area of PSSMHS. There are large numbers of other State level or local NGOs and CBOs who have integrated PSSMHS as part of their other rehabilitation and rebuilding work with disaster affected communities.

5.7 Integration of Community Practices with PSSMHS

Community practices play a crucial role in the process of normalisation in post-disaster period. The bereavement process of healing depends on many factors because of local cultural, religious practices and beliefs. Well-tested and good community practices shall be encouraged and integrated with PSSMHS.

Community practices strengthen the psycho-social support in many ways as given below :

i) Integration of community practices with psycho-social support shall help in developing faith in the service providers and will result in better development of linkages between community and service providers irrespective of caste, creed and religion. This builds mutual faith and enhances better and effective rapport between the service providers and survivors.

ii) Certain community practices like mass prayers in gatherings at religious places and singing spiritual songs have significant preventive and promotive mental health impact on the community. Most of these practices have an inbuilt psycho-social coping aspect within themselves, which shall be taken into consideration while providing PSSMHS.

iii) Indian society has a very rich strength of family bonding. The strength of family bonding is aptly described as root organization (family bonding) in comparison to roof organization (nuclear family) prevailing in the developed countries. This strength factors need to be taken into consideration while providing support to the survivors as it plays an important role in the support systems for the members of the family during disasters and other adverse circumstances. This family bonding is very strong in the rural areas but this gradually decreasing in the urban areas. Therefore those affected in the urban areas will require additional support from the community and NGOs.

iv) The traditional cultural practices in the community including family rituals and practices shall be encouraged and facilitated. The group activities like community kitchen, community group services, mass prayers, spiritual discussions shall also be encouraged in consultation with the community.

v) CLWs and other PSSMHS personnel shall participate in these activities as much as possible to express their oneness with the community, which in turn will enhance the acceptability of PSSMHS by CLWs and other service providers.

vi) CLWs and other care providers should not discourage/stop people/families who wish to carry out faith related activities along with the PSSMHS interventions.

vii) Well-tested community practices need to be encouraged to be part of the PSSMHS. However, if certain community practices are clearly harmful to the mental health and psycho-social well-being or violate human rights of the survivors e.g., gender discrimination, communal discrimination, not giving medicines to diagnosed mentally ill, restricting personal freedom, such practices shall be reported immediately to superiors in the PSSMHS chain of command for appropriate tactful non-confrontational intervention.

viii) The CLWs and elected community representatives will monitor such practices and inform the district authorities (nodal officer) to take appropriate action.

5.8 PSSMHS during Recovery, Rehabilitation and Reconstruction Phases

A successful PSSMHS effort during a disaster, goes through multiple steps and stages for a considerable period of time and involves multiple stakeholders. The holistic recovery of survivors shall require a considerable period of time during which a number of important actions and involvement of multiple stakeholders shall be required for PSSMHS. The recovery, rehabilitation and reconstruction phases in disaster could stretch for a few years depending upon the magnitude of the disaster and its effects on the community.

Therefore, PSSMHS efforts shall not be limited to psycho-social first aid only but will extend for a longer period during the recovery and rehabilitation to cater for long-term efforts of psycho-social trauma. Such efforts will aim at enhancing individual and community capability for a better development at personal and community levels to bring back normalcy in the affected community to a maximum level as well as to provide intensive support to the high risk groups.

The following PSSMHS activities are to be carried out during this phase:

i) The rehabilitation and reconstruction interventions need to be flexible and based on affected community and community assessment needs. Periodic assessment of mental health and psycho-social needs shall be carried out to define physical, social and economic factors and factors which perpetuate mental health disorders. Based on the assessment, special attention and care will be given to more vulnerable and high risk groups in the community.

ii) The effective service delivery of PSSMHS during this phase shall require proper inter-sectoral co-ordination and networking among the government, non-government organizations and civil society. The concerned authorities at the state and the district levels shall co-ordinate with the organizations working on livelihood generating activities, and vocational training to

ensure the integration of PSSMHS with general recovery and health.

iii) For long-term follow-up, the district authorities shall ensure a development of Standard Operating Procedures (SOP) so that a proper rapport is established between care- providers and survivors in the community.

iv) The PSSMHS support services shall be strengthened to the extent that appropriate outreach services can also be provided to those who are suffering from mental Illness. It would be necessary to activate the services to adopt self-care methods at the individual, family and community levels.

v) The main premises of PSSMHS are to strengthen the co-ordination and to streamline the efforts of institutions providing PSSMHS. Appropriate outreach services should be planned and implemented to identify those in need of mental health services. A structured need assessment is to be done on individual, family and work aspects of the care-givers to provide a holistic care.

vi) All the activities related to PSSMHS both by government and non-government organizations need to focus on the larger development of the community to improve the quality of life (QoL) after disasters.

vii) Stress due to life events subsequent to the disaster needs to be taken into consideration during the recovery phase. The PSSMHS teams need to be sensitive on these dimensions while planning interventions for the survivors and their families.

viii) Special attention shall be given to the effect of the life events subsequent to disaster and life style changes that may occur subsequent to disasters. Increased uses of alcohol, substance abuse, family violence are some of the issues that shall be addressed by PSSMHS during this phase.

ix) The rights of the children among survivors as well as the international convention stipulations for this vulnerable group shall be taken into consideration. Child Trafficking and violence against children need to be tackled.

x) Caring for the orphan children and semi-orphan children needs to be given priority and the emotional and behavioural issues arising among the children need to be addressed by the PSSMHS professionals available at the district level.

xi) The cultural sensitivity is crucial component of PSSMHS intervention, while providing intervention, the organizations as well as the care giver need to be sensitized towards the individual, family and community cultural sensitivity.

xii) Ensuring care to the care-givers must be part of the intervention plan. The help and support must start from day one of the intervention and must be continued throughout rescue, relief, and rehabilitation and recovery phases.

xiii) Monitoring and Evaluation of PSSMHS are essential to track the progress of

the intervention. The district authorities will work out a well-structured mechanism in collaboration with the national and zonal nodal agencies for technical inputs for developing well structured measures. The developed mechanism shall be rehearsed during the mock drills and simulation exercises.

xiv) Human rights needs of the disaster survivors shall be adequately taken care of during the recovery and rehabilitation phases of disaster at macro level. A code of conduct to preserve human rights while providing intervention shall be formulated as part of response plans by government and non-government organizations. Cultural sensitivity being a crucial component of PSSMHS intervention, the organization with care-givers shall be sensitised towards individual, family and communities accordingly.

5.9 PSSMHS for Vulnerable Groups

The vulnerable groups in disasters are at higher risk for psycho-social and mental health consequences due to a number of reasons and PSSMHS to them shall focus on the following:

i) Special attention shall be given to the vulnerable groups on priority basis.

ii) Trained teams will look after the special needs of the vulnerable groups and provision of Psycho-social First Aid and Psycho-social Support subsequently.

iii) The intervention shall focus on the long-term treatment and interventions and special emphasis will be given to the referral and follow-up.

iv) The rehabilitation of these groups will be taken up on priority basis through various organizations for facilitating their early recovery.

v) Mass uprooting of orphan children or widowed women outside the state be prevented as it would add further psychological impact to these survivors.

5.10 PSSMHS for Care-Providers

The care-providers generally perform multiple functions beginning with rescuing the survivors from their life-threatening situation to distribution of various relief materials, transporting the survivors to safe destinations, managing safe living spaces, delivering psycho-social first aid and providing support in the hour of crises at the place of family. This work usually stretches for a longer period and continued exposure to the survivors and their difficulties will multiply the care-givers, stress.

The following aspects shall be incorporated in disaster response for the care-providers at all levels.

i) Providing the care-givers with proper Personal Protective Equipment (PPE) and other basic needs.

ii) Providing continuous stress management training and skill- updates.

iii) Severely affected care-givers will be spared from the work responsibilities and will be referred for a higher level of care.

iv) A proper training and preparation for the assignment where the care-givers are educated in all hazard disaster work.

v) The first responders will be provided adequate rest by placing alternative teams after scheduled time.

vi) Team leaders of first responders and crisis group shall monitor and keep a vigil on their emotional and physical stress. Those showing physical or clinical signs of psycho-social trauma, illness or fatigue shall be immediately evacuated to nearest mental health centre/hospital.

6 Approach to Implementation of the Guidelines

The National Guidelines on psycho-social support and mental health services are an essential part of the health plan as an integrated national 'all hazard' disaster management approach. It is ensured that all aspects of preparedness are covered for a quick and efficient PSSMHS response, including measures pertaining to post-disaster phases of disaster management. The objective is to develop capacities of the community that is rightly and adequately informed, resilient, trained and capable to face the psycho-social consequences of a disaster. Therefore, it will be the endeavour of the central and state governments and local authorities to ensure its implementation in an efficient, co-ordinated and focused manner. All relevant institutions are also clearly identified for providing technical support in each phase of disaster management. This can be achieved by forging a multi-sectoral partnership as envisaged by the institutional mechanism, set up through the Disaster Management Act, (2005) viz. the NDMA, SDMAs and DDMAs.

The primary responsibility of preparedness and response shall continue to remain with the state and district authorities. Further capacity enhancement and reinforcement of the system, whenever required, will be provided by the central and state governments. Initiatives like community participation and Public-Private Partnership (PPP) will be encouraged to integrate with the existing health plan at the community level, for further revamping the system. In order to optimise the use of resources while ensuring effectiveness and promptness, the response to PSSMHS will be highly structured and co-ordinated at every level. The following factors are considered critical for ensuring a flawless and harmonious functioning of all concerned stakeholders during the management of PSSMHS:

i) Institutionalisation of programmes and activities at the ministry/department level.

ii) Identification of various stakeholders/ responsibilities, a clear chain of command and work relationships.

iii) Rationalisation and augmentation of the existing mental health programmes, resources and infrastructure.

iv) Matching infrastructure, capacity development and response mechanisms for overall preparedness.

v) Improved inter-ministry and inter-agency communication, co-ordination and networking at all levels.

MoH&FW, as the nodal ministry, will over see implementation of the Guidelines at the national level. The other stakeholders in PSSMHS management are Ministry of Defence

(MoD), Ministry of Railways (MoR), Ministry of Labour, Employees State Insurance Corporation (MoL, ESIC), and Ministry of Women and Child Development (MoW&CD) departments of health of the states/UTs; mental health technical institutions, academic institutions in social work, psychology, professional bodies, corporate sector, NGOs and the general community.

Implementation of the Guidelines will begin with the formulation of a PSSMHS disaster preparedness plan as part of an 'all hazard' medical preparedness DM plan in all districts, states/ UTs and central ministries. The enabling phase will be used to build necessary capacity, taking into consideration the existing elements such as techno-legal regimes, stakeholder initiatives, emergency plans and gaps. The existing DM plans at various levels will be further revamped/ strengthened in central ministries/ departments, states/UTs and all levels that address the strategic, operational and administrative aspects through an institutional, legal and operational framework.

These Guidelines have set modest goals and objectives of PSSMHS in disaster preparedness to be achieved by mustering all stakeholders through an inclusive and participative approach. All concerned ministries of Government of India, the state governments, UT administrations and district authorities will allocate appropriate financial and other resources, including dedicated manpower and targeted capacity development, for successful implementation of the Guidelines.

6.1 Implementation of the Guidelines

6.1.1 Preparation of the Action Plan

Implementation of the Guidelines at the national level will begin with the preparation of a detailed action plan (involving programmes and activities) as part of 'all hazard' medical preparedness Disaster Management plans by MoH&FW that will promote coherence among different PSSMHS practices and strengthen the community level capacities at various levels. Line ministries such as MoD, MoR, MoL, ESIC MoW&CD shall also develop preparedness plans based on the Guidelines as part of the 'all hazard' Disaster Management (DM) plans and the action plan. In view of the expected role of these important line ministries in management of PSSMHS in the event of national calamities, they should also cater for developing additional capacities, besides meeting their own requirements, in their preparedness plan.

The plan will be simple, realistic, functional, flexible, concise, holistic and comprehensive, encompassing networking of psychological and social components. The plan would lay special emphasis on the most vulnerable groups to enable and empower them to respond to and recover from, the effects of disasters.

The National Plan needs to include:

i) Measures to be taken for minimisation or reduction of psycho-social effects of disasters (leading to zero tolerance), or mitigation of their effects (leading to avoidable morbidity and mortality).

ii) Measures to be taken for integration of mitigation procedures in the development plans.

iii) Measures to be taken for preparedness and capacity development to effectively respond to any threatening mass casualty situation.

iv) Role and responsibility of the nodal ministry, different ministries or

departments of the GoI, institutions, community and NGOs in respect of the measures specified in clauses i), ii), and iii) above.

The action plan will spell out detailed work areas, activities and agencies responsible, and indicate targets and time-frames for implementation and be continually reviewed and updated. The identified tasks, to the extent possible, will be standardized to have SOPs and resource inventory, etc. The action plan should have an in-built mechanism to co-ordinate with other ministries and NEC. The plan will also specify indicators of progress to enable their monitoring and review within the ministry and by the National Authority. The plan would be sent to NDMA through NEC for approval.

The ministries/agencies concerned, in turn, will:

i) Issue guidance on the implementation of the plans to all stakeholders.

ii) Obtain periodic reports from the stakeholders on the progress of implementation of the DM plans.

iii) Evaluate the progress of implementation of the plans against the time-frames and take corrective action, wherever needed.

iv) Disseminate the status of progress and issue further guidance on implementation of the plans to stakeholders.

v) Report the progress of implementation of the plans to the nodal ministry.

MoH&FW will keep the National Authority apprised of the progress on a regular basis. Similarly, concerned state authorities/ departments will develop their state-level PSSMHS plan as a part of 'all hazard' medical preparedness plans and dovetail it with the national plan and keep the National Authority and SDMA informed. The state departments/ authorities concerned will implement and review the execution of the DM plans at the district and local levels along the above lines.

6.2 Implementation and Co-ordination

6.2.1 National Level

Planning, execution, monitoring and evaluation are four facets of the comprehensive implementation of the Guidelines. If desired, the nodal ministry can co-opt an expert nominated by the National Authority during the planning stage so that the desired results are achieved through the action plan. The consultative approach increases ownership of the stakeholders in the solution process by bringing clarity to various preparedness activities. Detailed documentation of the monitoring mechanism to be employed for undertaking a transparent, objective and independent review of the National Disaster Management Guidelines : Psycho-social Support and Mental Health Services in Disasters, will be worked out. A separate group of experts may be earmarked for evaluation to get an objective, third-party feedback on the effectiveness of the activities based upon the Guidelines.

The important issues while preparing the action plan include:

i) Adopting a single window approach for conducting and documenting the activities outlined in the guidelines in each of the stakeholder ministries, departments, state governments, agencies and organizations.

ii) Laying down the roles and responsibilities of all stakeholders at the state and district levels to assist them in terms of the required resources.

iii) Developing detailed documents on how to ensure implementation of each of the activities envisaged in the Guidelines to attain a synergy among various activities and ensure co-ordination.

iv) Ascertaining PSSMHS measures, including capacity development to effectively respond to incidents of psycho-social and mental health disorders due to disasters.

v) Incorporating measures for the prevention of psycho-social and mental health disorders by integration of mitigation measures in the development plans.

vi) Co-ordinating with line ministries such as MoD, MoR, MoW&CD and MoL (ESIC) networks for maintaining their resources and ensuring these are available during major disasters.

vii) Ensuring professional expertise for the dissemination, monitoring and successful and sustainable implementation of the various plans at all levels.

viii) Ensuring that the skills and expertise of professionals are periodically updated corresponding to global best practices according to the guidelines on PSSMHS.

The national plan would lay emphasis on identified critical gaps in management of PSSMHS programmes and would strengthen the government hospitals and Mental Health Institute to assist the states in putting up the requisite infrastructure. A co-ordinated and synergistic partnership with non-government, private sector, corporate and community will help in providing critical resources during response.

6.2.2 Institutional Mechanism and Co-ordination at the State and District Levels

The respective state/UT/district authorities will develop PSSMHS plans based on the 'all hazard' medical preparedness DM plans. The measures indicated at the national level may be adopted to ensure effective implementation by regular monitoring at the state level by the concerned authorities. The state will also allocate resources and provide necessary finances for efficient implementation of the plans. Since most activities under the Guidelines are community-centric and require the association of professional experts for planning, implementation and monitoring, the SDMAs and DDMAs will formulate a suitable mechanism for their active involvement at various levels.

The India Disaster Resource Network database will be strengthened by the states by continual updating, enhancement and integration with the respective DM plans. These activities are to be undertaken in the project mode with a specifically earmarked budget (both for plan and non-plan) for each activity.

6.2.3 District Level to Community Level Preparedness Plan and Appropriate Linkages with the State Support Systems

A number of weaknesses have been identified with regard to awareness generation,

response time and actions like emergency psycho-social first aid. It also includes detection of psycho-social problems, identification of vulnerable groups, providing care to the care-givers, referral systems and specialised facilities for the disabled, co-ordination among the PSSMHS providers and the need for long-term interventions. This is specially observed in the district DM plans and has been found to be a weak link in emergency management. The central and state governments will evolve mechanisms through mock exercises, awareness and training programmes, etc., with a view to sensitise and prepare the officers concerned for initiating prompt and effective PSSMHS response during such emergencies.

The PSSMHS nodal officer will be appointed and Chief Medical Officer (CMO) of the district will be in charge of overall response and management of PSSMHS. He will be responsible for preparing the district psycho-social and mental health plan as part of the district plans based on the PSSMHS guidelines.

Disaster resilience is the ability of the community to anticipate disasters and react quickly and effectively when they strike. The process of building resilience will be made through awareness generation, street shows and other community and mock exercises in which PSSMHS shall form an important component in the response.

6.3 Financial Resources for Implementation

With the paradigm shift in the government's focus on mitigation activities, adequate funds shall be allocated for capacity development in addition to fund allocation for PSSMHS provisions in the post-disaster phase. Financial strategies will be worked out so that necessary finances are in place and the flow of funds is organised on a priority basis for quick and effective support and service provision. Important strategies include:

i) Specific allocations will be made by Central ministries/departments and state governments in the annual plan for capacity development and training in PSSMHS.

ii) The developmental and social sector plans and agencies and private stakeholders will have specific funds to carry out PSSMHS in post-disaster situation and pre-disaster research and capacity development

iii) Whenever necessary and feasible, the central ministries/departments, Panchayati Raj Institutions/Urban Local Bodies in the states may initiate discussions with the corporate sector to take up mitigation related activities as a part of PPP and Corporate Social Responsibility.

iv) Whenever necessary, the International and National Funding agencies will be involved, especially in case of longer service provision, longitudinal research studies, and major capacity building projects.

To conclude, the present system of PSSMHS is required to function in a more pro-active and co-ordinated manner at all levels.

6.4 Implementation Model

Planning, execution, monitoring and evaluation are four essential facets of comprehensive implementation of National

Guidelines on PSSMHS. The activities in each of these facets in disaster mitigation-preparedness and post-disaster phases at national, state and district levels are different and covered in detail in previous chapters.

Irrespective of the scale and type of the disaster, PSSMHS services shall ensure the normal state of mind of all affected, which could take a minimum of 2 years and maximum of five years or more. While the post-disaster service provision shall be converged with the short and long-term rehabilitation and rebuilding activities at a micro level, at a macro level PSSMHS activities shall be integrated into the larger developmental projects for the affected region so that the services are sustainable for the required duration of 2-5 years and their impact is sustained even after 5 years when the specific PSSMHS are withdrawn.

All identified activities under PSSMHS action plan will be planned as listed below for their implementation. The time-lines proposed for the implementation of various activities in the Guidelines are considered both desirable and feasible, especially in cases where financial and technical constraints are not limiting factors. The detailed action plan will be submitted by the National Sub-Committee later on, after publication of the Guidelines on PSSMHS.

A) Phase-1 (0-3 years)

i) Regulatory Framework

a. Dovetailing of existing Acts, Rules and Regulations with the DM Act, (2005).

b. Ensuring implementation of PSSMHS in NMHP and DMHP.

c. Integration of the PSSMHS in disaster Mental Health programmes and General Hospital Programmes as part of hospital and district health plan.

d. Enactment/amendment of any act, rule and regulation, if necessary, for better implementation of PSSMHS across the country.

ii) Mitigation

a. Formation of a National Sub-Committee on PSSMHS.

b. Developing/strengthening a mechanism for quick and effective referral system

c. Training of NDRF/QRTs/DMTs with all basic psycho-social support skills

d. Integrating with DM mental health plans and Health/Hospital DM Plans

e. Inclusion of PSSMHS in the minimum standard of medical care in disasters.

f. Establishing linkages with all stakeholders identified to play important role in PSSMHS.

g. Strengthening the government agencies and NGOs; devloping Public Private Partnership and the partnership mechanism in capacity development, research and service provision on mutually agreed terms and conditions.

iii) Capacity development

a. Sensitising and training (Basic and advanced) on PSSMHS

across identified departments, sectors and levels.

b. Strengthening of the national, regional and nodal capacity building institutions and resource centres at state and district levels.

c. Developing PSSMHS need assessment indicators and templates.

d. Strengthening of District Counselling Centres under the Department of Social Welfare/ Ministry of Women & Child Development.

e. Strengthening the resource base and data management/ documentation in PSSMHS.

iv) Education and Training

a. Inclusion of Disaster PSSMHS in Post-graduate Curriculum of Psychiatry, Psychology, Social Work, Disaster Management, Emergency Medicine and Health Education.

b. Inclusion of PSSMHS in Medical under graduate studies.

c. Integrating with all training programmes in the area of Psychology, Social Work, Mental Health, Emergency Medical Response, Hospital Administration, Nursing and Paramedics.

v) Community-Based Disaster Management

a. Inclusion in the CBDM Plan and training of PRI team members.

b. Developing awareness material for the community.

c. Evolve a mechanism for community outreach education programmes on PSSMHS.

B) Phase-II (0-5 years)

i) Capacity Building

a. Strengthening nodal institutions/ hospitals.

b. Developing database management and evidence-based research.

c. Evolving a mechanism for follow up response.

d. Establishing a National Accreditation System for quality assurance.

e. Continuation and updating of human resource development activities.

f. Developing community resilience.

ii) Preparedness

a. Creation of a core group of master trainers at district level.

b. Strengthening public-private partnership in research and development.

c. Formation of National PSSMHS Resource Inventory as part of National Health Resource Inventory.

d. Initiation of distance learning courses for sensitisation across different categories of disaster management stakeholders.

e. Development and standardisation of uniform training packages for various designated target groups.

f. Incorporation of PSSMHS in DMHP, district health and hospital plans.

C) Phase-III (0-8 years)

The long-term action plan will intensify the areas identified in phase-I, along with the important issues that have been raised in chapters 4 and 5. A detailed action plan will be prepared by the National Sub-Committee and submitted to the NDMA and Ministry of Health & Family Welfare. The long-term planning will also include the following important aspects of PSSMHS:

i) Evolving a mechanism to include disaster-induced psychiatric disorders/ physical disability in the disaster insurance and medical/health insurance.

ii) Intensive PG Diploma/PG courses in PSSMHS.

iii) Streamlining of institutions and their activities.

6.5 Monitoring and Evaluation of PSSMHS

In the absence of any structured monitoring and evaluation procedures and indicators for PSSMHS available in India, the Co-ordination Committee shall be responsible for preparing criteria and methodology for the same.

i) While the DDMA and the district administration, along with respective line departments, shall be the implementing agencies, the regional nodal agencies would be the monitoring agencies and the Co-ordination Committee shall be the evaluating body.

ii) While monitoring shall be done regularly at 3-month intervals, evaluation of any specific programme shall be done on yearly basis. Evaluation and monitoring should be preferably done on the specific format prescribed by the Co-ordination Committee.

iii) Depending on the yearly evaluation, duration of PSSMHS shall be decided upon for determining the funding support. Monitoring and evaluation of programmes have to be done in relation to planned activities with pre-defined indicators.

7 Summary of Action Points

The present chapter provides a summary of all the guidelines mentioned in Chapters 4 to 6 for the management of PSSMHS in disasters. The important action points enumerated are as follows :

1. Legislative Framework

The policies, programmes and action plans need to be supported by appropriate legal instruments, wherever necessary, for effective management of PSSMHS in disasters. The important means to develop a robust, though flexible, legal framework for achieving the above objectives, the existing Acts, Rules, Regulations at various levels will be reviewed and amended by the nodal ministry, state governments and local authorities.

Policies and Guidelines issued by NDMA will be the basis for developing PSSMHS in DM Health Plans by various stakeholders and service providers both in the government (nodal and line ministries, state government and district administration) and private set-up at each level. The PSSMHS response to various disasters will be co-ordinated by NDMA/ NEC/NCMC, SDMAs and DDMAs.

Para 4.1 - 4.1.2

2. Planning and Preparedness

The PSSMHS for disaster-prone and vulnerable areas shall be planned much ahead of any disaster. The planning shall be a component of overall planning for disaster management with the aim of providing PSSMHS integrated with health- care and general relief work.

The planning should emphasize appropriate inter-sectoral as well as intra-sectoral collaboration among various agencies, involved in disaster management. The planned preparedness programme needs a systematic and periodic monitoring at district, state and national levels.

The planning of PSSMHS services should include national, state and district levels to complement and facilitate each other. The Ministry of Health & Family Welfare (MoH&FW) shall constitute a National Sub-Committee on PSSMHS to co-ordinate, implement, monitor and evaluate the PSSMHS plan, based on national mental health policy. This plan will integrate with general health plan for disasters right up to the district level.

In order to respond effectively in disasters, a well to planned integrated and co-ordinated effort shall be made for PSSMHS preparedness, based on the existing national and international best practices and incorporating lessons learnt from past experiences. The preparedness activities for PSSMHS can be formally linked with various health programmes.

The framework for PSSMHS at the state level may be most beneficially evolved and

operationalized, keeping in mind the linkages with the larger relief, recovery and rehabilitation activities being carried out by district administration and the state level general medical services and mental health programmes.

Para 4.2 - 4.3.2

3. Capacity Development of Human Resource

The development of human resource will be based on hazard, vulnerability, and risk assessment of the districts in the country to cater to 'all hazard' situations. The human resource for providing PSSMHS will be planned and developed at all levels with a well focused mechanism of developing infrastructure and creating both professional and non-professional resources keeping in mind the long-term implication of the psycho-social issues arising out of disasters that will be a priority. Centre and state governments shall create adequate capacity in a phased manner for human resource development with the help of national institutions like NIMHANS and other regional nodal institutions like IHBAS, MIMH, LGBMH, TISS etc. in the states.

District-wise resource list of all skilled and trained manpower available with all government and non-government organizations, who will be working in the field of psycho-social support and mental health, shall be prepared and shared with all the organizations and government functionaries. Uniform training modules will be developed and standardized by central and nodal professional institutions and will be used for training at each level by districts, states and ministries.

Para 4.4 - 4.4.1

4. Education

Basic education on psycho-social support is essential and must be included in the syllabuses of courses run by various regulatory bodies. Mainstreaming the disaster management knowledge in the education system will facilitate in prevention and mitigation of adverse psycho-social effects of disaster. Education on PSSMHS may be included at the graduate and post-graduate levels in various courses in humanities and other professional courses.

Para 4.4.2

5. Training

Regular training programmes in the form of CMEs, workshops and symposiums shall be carried out for regular updating and knowledge enhancement. The training content of these training programmes must be designed to suit the particular culture and ethnic needs of the community. Training of the community, especially CLWs, has enhanced the reach of PSSMHS to the communities and there is a need to sustain it in all the phases of disaster. An 'all hazard' approach shall be adopted while training the CLWs. In addition to the CLWs, other members of community like panchayati raj functionaries, NGOs and other community-based organizations like Civil Defence will be involved in training for PSSMHS. NIDM, ATIs and other training institutions at the district levels will carry out such training programmes, in addition to the programmes run by various professional institutions for medical and other professionals.

Para 4.4.3

6. Research and Development

The scientific and systematic study of disaster-affected community and intervention needs to be incorporated as a part of PSSMHS. The research also needs to identify the risks and protective factors among the population during and after disasters. The research must focus on the community needs and community best practices. The vulnerability and epidemiological factors need to be studied in detail to ascertain the hazard, risk and vulnerability of the community. The centre of excellence NIMHANS and other nodal and zonal professional institutions like IHBAS, MIMH, LGBMH, TISS etc. will develop appropriate methods.

Para 4.4.4

7. Documentation

Systematic documentation procedure will be evolved at all levels to capture every detail of all the interventions and best practices. R&D will cater for evidence-based operational and applied research. The research also needs to identify the risks and protective factors among the population during and after disasters. Case control studies will be helpful to determine the extent of psychological effects. Research findings related to PSSMHS should be widely disseminated in appropriate forums for various user groups ranging from mental health professionals to policy makers and to the general public.

Para 4.4.5

8. Community Participation And Role Of Community Level Workers

Community is the first responder in the event of any disaster and it plays an important role in response and rehabilitation of the community. A large number of community level workers (CLWs) participate as important team members for providing psycho-social support to the community. These community level workers must be utilized in all phases of disasters especially in preparedness phases to create awareness and information dissemination among the community. Promotion of group work in the community to inculcate the belief that majority of the problems in the community are shared, rather than individual problems and hence need collective response. These workers generally perform multiple functions beginning with rescuing the survivors from their life-threatening situation to distribution of various relief materials, transporting the survivors to safe destinations, managing safe living spaces, delivering psycho-social first aid and providing psycho-social support in the hour of crises.

Para 4.4.6 - 4.4.7

9. Infrastructure for PSSMHS

Development of well-equipped infrastructure will provide a good environment for psycho-social support and mental health services (PSSMHS) both for preparedness and response. These facilities need to be designed and built on state of the art infrastructure keeping in mind the enhanced requirements of PSSMHS. Further upgradation of existing

hospital facilities, adequate networking with other hospitals, medical colleges, zonal and national institutes to share and pool resources to meet the challenges of larger disasters. The responsibility of such activities will lie with the nodal ministry at the centre and the state departments.

Para 4.4.8

10. Hospital Preparedness

Hospital preparedness is an important part of disaster management where PSSMHS forms an integral part of it. All the designated hospitals must enhance their capacity to respond in an event of disaster, both in government and private corporate sectors. Hospital disaster management plan shall include the PSSMHS as one of the components. The presently available psychiatric wards of hospitals shall be upgraded to meet the enhanced requirements during disaster, based on vulnerability and risk assessment. A network shall be established amongst hospitals, medical colleges, zonal and national institutes to share and pool resources to meet the challenges of larger disasters. State governments and departments of health in the respective states shall be responsible for the preparedness for PSSMHS in their states.

Para 4.4.8.1

11. Networking of Institutions

Proper networking of existing institutions shall be established for capacity development of human resources for proper management of PSSMHS for the entire country. NIMHANS as a centre of excellence and other national center like IHBAS will act as the national referral centre for formulating and designing standardized intervention models for all the professionals engaged in the area of PSSMHS. Existing mental hospitals, general hospitals with psychiatric departments, medical college psychiatric units and mental health clinics shall be strengthened and networked with DMHP programme. SDMAs and departments of health shall identify and designate universities and medical colleges for imparting education/skill training on PSSMHS.

Para 4.4.8.2

12. Public-Private Partnership

Private sector has substantial capacity and infrastructure and it plays a vital role in the management of disasters. Government and the private organizations, based on mutually agreed goals be encouraged to utilize their manpower and infrastructure for the purpose of PSSMHS. Private medical health facilities, paramedical staff, non-government organizations and community-based organizations should be made part of the total resource available in the area. The PPP also will enhance the community participation in provision of PSSMHS. Appropriate actions may be taken in advance by the authorities at all levels to facilitate such collaboration with the private sector. Attention is also drawn to Section 34 of Disaster Management Act (2005) where the district collector can act in the time of a major disaster.

Para 4.4.8.3

13. Technical and Scientific Institutions

Centre and state authorities will identify and designate technical institutions who have resources and expertise in disaster mental health. NIMHANS will be designated as a centre of excellence, because of its long time association with various mental health

interventions and expertise in the field of PSSMHS in the country. In addition IHBAS and other regional Institutions will be identified and designated as nodal Institutions. These institutions will function as key responders in the PSSMHS, conducting need assessment, developing standardized and structured need assessment tools, conducting scientific research on the affected community and developing specific intervention modules.

These institutions will develop appropriate intervention modules to suit general as well as region-wise requirements and importance will be given to develop models based on a preventive strategy, essentially focused on preventing the vulnerability of the community and mitigate the post-disaster effects. The preventive strategy prepared by these institutions will include both preparedness as well as long-term interventions based on community's coping capacities and enhancing the resilience factor.

Para 4.4.8.4

14. Communication and Networking

Communication is a vital component of PSSMHS. Emergency control rooms shall be established at district, state and national levels to co-ordinate between various responders and stakeholders. Print and electronic media shall also be linked for proper dissemination of information related to the disaster and its effects. Creating awareness about PSSMHS through the media will enhance the information and knowledge level among the communities to alleviate their trauma arising out of any disaster.

The media also helps to destigmatize the psycho-social effects. This helps in education of the community about the psycho-social effects and prepares the community to face rumours, panic and the impending disaster. The NGOs play a very vital role at the community level in disaster intervention. Their knowledge of local people and terrain makes them a handy tool to reach the information about the psycho-social effects of disasters. These organizations play a very important role in sensitizing and educating the community and preparing it for providing PSSMHS. Such agencies shall also be networked with International organizations such as WHO, a nodal agency for health in providing information, communication and alerts on health-related issues and technical experts in disasters.

Para 4.4.8.5

15. International Co-operation

International co-operation is a necessary element in the management of PSSMHS. International mental health institutions and organizations, involved in PSSMHS interventions can be collaborated with, in the field of PSSMHS research, material development, to bring in more cross-learning. Adaptation of international best practices in PSSMHS intervention can bring more quality services at the local level. Incorporation of the international best practices into PSSMHS will enhance the understanding of the intervention. Encouraging the conducting of workshops, seminars and conferences for direct interaction, exchange of ideas and policy enhancement periodically at international level can bring more quality services at the local level.

Para 4.5

16. Special Care of Vulnerable Groups

Vulnerable groups like women, children, the aged and the less abled are more susceptible to stress and trauma. Generally their special needs are not taken care of, adequately, in the disaster situations due to a number of reasons. The proper care of, and attention to, these vulnerable groups, shall be given on priority basis. The PSSMHS assessment will comprehensively study the hazard, risk and vulnerability factors of the vulnerable groups to provide specific need based intervention to them. It is essential to identify these vulnerable groups based on the GIS mapping and it is essential to define the vulnerable groups and categories so that these group can be provided with immediate relief and be attended first. Provisions for providing special care will be made for children especially who have lost their parents and siblings. Special care will be provided to pregnant women, women who have lost their spouse and family members aged persons and those with physical and mental disability.

Specially trained professionals and workers, along with the health-care workers, who provide PSSMHS to disaster survivors shall be deployed.

Para 4.6

17. Psycho-Social First Aid in the Disaster Preparedness Phase

The PSFA in the preparedness phase shall be given to both professionals and non-professionals to promote safety and protection of the survivors to cope with the psycho-social trauma of exposure to the disaster and to promote psycho-social recovery. It is the first line response that needs to be integrated with the general response and it can be given by any type of responders in disasters. The PSFA training and skills can be given to hospital emergency para-medics, ambulance crew, community level workers, students and other first responders based on the modules prepared by the nodal agencies. The SDMA and DDMA will co-ordinate with the SMHA and DMHP authorities to provide the services.

Para 4.6.1

18. Psycho-Social Support and Mental Health Services in the Post-Disaster Phase

The PSSMHS response plan is the main responsibility of the Ministry of Health and Family Welfare (MoH&FW) at the centre, other line ministries like Ministry of Defence (MoD), Ministry of Railways (MoR), Ministry of Labour (Employees State Insurance Corporation) shall also prepare their response plans based on these Guidelines. The efforts from the ministries shall be used as complementary to main efforts of the nodal ministry in a major disaster.

Effective and rapid PSSMHS response helps to reduce the stress and trauma of the affected community and facilitates speedy recovery by bringing them back to their pre-disaster level. The response will be based on the timely 'all hazard' PSSMHS need assessment focusing on all the areas both at the macro and micro levels to respond and manage the psycho-social issues after the disaster. The PSSMHS will be part of the health response plan and will be co-ordinated by the central, state and district authorities, all the stakeholders including government, professional and academic

institutions. The response plans for the PSSMHS shall be prepared based, on the National Guidelines, National Health Policy, National Mental Health Programme (NMHP) and District Mental Health Programme (DMHP).

Para 5.1

19. Psycho-Social First Aid in Post Disaster Phase

The psycho-social first aid is a process which prevents further deterioration of the coping capacities of the survivors, thereby enhancing the chances of rapid normalization process. In the absence of psycho-social first aid, the process of normalization for the affected community will be delayed and prolonged. In the response phase, PSFA will be provided by duly trained skilled first responders who form part of PSSMHS care team. Psycho-social first aid is provided in the initial one-to-six week period. Trained CLW's from the affected community shall be more successful in mitigating the effects of acute psycho-social distress. This will go a long way in preventing major psychological and mental health problems.

Para 5.2

20. Integration with General Relief Work and Health Plan

Effective psycho-social support and mental health intervention requires an inter-sectoral co-ordination with the various stakeholders. The PSSMHS shall remain as an integral part of emergency health response plan.

An integrative mechanism will be developed with the focus on integrating PSSMHS with the general health-care to facilitate early identification, management, referral and follow-up of PSSMHS problems along with the medical problems so that they can be dealt together in an integrated manner. The PSSMHS in disasters envisages the long-term care and help to the survivors and special emphasis on referral in all the phases of disaster. PSSMHS service providers shall form an important constituent of relief and health teams. The first responders, providing general relief and health- care will be trained to provide psycho-social support till the skilled specialized PSSMHS teams take over to comphrensively address the immediate and long-term care of the affected people.

Para 5.3 - 5.4

21. Referral; Integration with the Community Practices

Large numbers of survivors require only psycho-social first aid whereas a fair number of them require long term and special care. Therefore a referral mechanism will be worked out for them for long term treatment and follow-up. The core aim of the referral is not only to lessen the workload but to facilitate and sustain the long-term PSSMHS. Special attention shall be given to vulnerable groups, particularly the long-term treatment and interventions.Special emphasis will be laid on the referral and the follow-up.

Community practices play a crucial role in the process of normalization in post-disaster period. Integration of community practices into psycho-social support will help in developing faith in the service providers and will result into better development of linkages between community and service providers, irrespective of cast a creed and religion. This builds mutual faith and enhances better and effective rapport between the service providers and the survivors.

Para 5.5 - 5.7

22. Psycho-Social Support and Mental Health Services during Recovery, Rehabilitation and Reconstruction Phases

The recovery, rehabilitation and reconstruction phases in disasters will require long-term PSSMHS to enhance individual and community capability for a better development at personal and community levels to bring back normalcy in the affected community to a maximum level as well as to provide intensive support to the high risk groups. In this phase care-givers must be part of the intervention plan. The help and support must start from day one of the intervention and must be continued throughout the rescue, relief, rehabilitation and recovery phases. Special care and attention will be given to the vulnerable groups in both short and long-term PSSMHS. The PSSMHS interventions will also focus on the care of care-givers from the beginning of the intervention. Appropriate referral and follow-up services will be provided on priority basis to those care-givers who need professional care.

Para 5.8

23. Care of Care-Givers

Taking care of care-givers is as important as providing care to the survivors. The care-givers generally perform multiple functions beginning with the rescuing phase to the rehabilitation and reconstruction phase by providing a range of help to normalize the lives of survivors. Generally, in disaster interventions of the care-givers' needs are given inadequate priority and attention, it will have an adverse effect on their well-being, which in turn, will affect the quality of service delivery. A proper training and preparation for the assignment is essential when they are required to be prepared for 'all hazard' disaster work. The care-givers should be provided proper training, adequate Personal Protective Equipment (PPE) and other basic needs. Severely affected care-givers will be spared of the work responsibilities and will be referred for higher level care. Provision of stress management to the care-givers will be an integral part of the training.

Para 5.10

24. Development of 'All Hazard' Implementation Strategy

The strategy outlines the requirements for development of a PSSMHS action plan by the nodal ministry, measures to implement and co-ordinate various activities at the national level, framework and co-ordination at the state and district levels. Adequate strategy will be evolved to develop linkages and state support systems. Necessary financial arrangements will be made for implementation of all the plans developed at district/state/national levels. An implementation model with broad time-frames as short, medium and long-term plans for 0-3, 0-5 and 0-8 years, respectively, are recommended.

Para 6.1 - 6.4

Annexures

Annexure-A

(Refer to Chapter 1)

Table 1.1 Common Psycho-Social and Mental Health Consequences of Disasters

(A) Psycho-social consequences

1. Exacerbation of pre-existing (pre-disaster) social problems (e.g. extreme poverty, belonging to a group that is discriminated against or marginalised)
2. Disaster induced social problems (e.g. family separation; disruption of social network; destruction of the community structure; resources and trust; unEmployees, homelessness, increased gender-based violence)
3. Humanitarian aid induced social problems (e.g. undermining of the community structure or traditional support mechanism).

(B) Mental health consequences

1. Exacerbation of pre-existing problems (e.g. severe mental disorder; alcohol abuse)
2. Disaster induced problems (e.g. grief, non-pathological distress, depression and anxiety disorders, like post-traumatic stress disorder (PTSD);
3. Humanitarian aid related problems (e.g. anxiety due to lack of information about food distribution).

It should be noted that mental health and psycho-social problems in disasters encompass far more than the experience of PTSD.

Reference : Inter-Agency Standing Committee Guidelines on Mental Health and Psycho-Social Support in Emergency Settings, Geneva, (2007)

Table 1.2 Common emotional reactions and behavioural responses after disasters

1. Shock
2. Denial
3. Numbness
4. Fear
5. Anger
6. Crying
7. Apathy
8. Disorientation
9. Flashbacks and Nightmares
10. Anxiety
11. Worrying
12. Helplessness
13. Feeling Sad
14. Withdrawal
15. Frustration
16. Negativity
17. Inability to Think
18. Sleeplessness
19. Leaving the Place
20. Apprehensive about Future
21. Remembering / Praying to God
22. Participating in Rescue / Relief Work
23. Feeling of Brotherhood
24. Hostility
25. Impulsiveness
26. Violence
27. Alcohol and Drug Abuse

Reference: Sekar, K., Bhadra, S, Jayakumar, C., Aravind, R., Henry, Grace, Kishore Kumar, Psycho-Social Care in Disaster Management : Facilitator's Manual for Training of Trainers in Natural Disasters. TOT Information Manual - 1 (2007) NIMHANS, Bengaluru and Care India, New Delhi.

Annexure-B

(Refer to Chapter 3)

Indicators of PSSMHS after Disasters

Objectives and Indicators for measuring the impact of PSSMHS:

Objective 1

Improved psycho-social well-being of the target group as measured by level of awareness of personal and community issues regarding pro-social behaviour, cognitive/emotional functioning, performance of daily tasks (livelihood), coping, self-esteem and self-efficacy.

Indicators:

1 Change in the proportion of target group, displaying culturally defined pro-social behaviour.

2 Change in the proportion of target group, able to express fears or concerns and seek care from others during stress.

3 Change in the proportion of target population who express a locally defined "optimal" level [on a measurement scale, score X or higher] of a sense of control in their daily functioning.

4 Change in the proportion of target population using positive coping strategies, during times of stress–as defined by local cultural norms.

Notes on Methods for Measurement:

While various standardized quantitative measurement scales are available, most are not yet validated cross-culturally or within contexts of crisis, emergency, or displacement. However, they can be adapted and utilized, and it is best if such measures are developed locally and validated with complementary qualitative data collection and analysis. Where feasible, and where resources permit, it is best to work with local communities and different beneficiary groups within communities in order to derive locally defined measures of functioning, coping, pro-social behaviour, and other measures of psycho-social well-being.

Objective 2

Increased capacity of families/households, community organizations and service providers to support community members to cope with stress/trauma.

Indicators:

1 Change in the percentage of families/households, community organizations or service providers, using positive coping strategies during times of stress.

2 Change in the proportion of opportunities for marginalised groups.

3 Change in the proportion of local service providers with capacity to support target group to cope with stress/trauma in a specific way.

4 Change in proportion of citizens engaged in activities that support families and households to cope with stress/trauma.

5 Change in proportion of community leaders and/or community groups with an adequate [or desirable, or optimal] level of knowledge and understanding regarding psycho-social needs and the elements of appropriate community responses.

Notes on Methods for Measurement:

Capacity can be measured quantitatively, as in the indicators mentioned above, or through qualitative measures. Individuals and the target groups may display a capacity to provide support to others in ways that are measured through variety and depth of creative responses. Such qualitative measures might be gathered through observation as well as open-ended questions and discussions with individuals or groups.

Objective 3

Enhanced awareness among local authorities, NGOs, communities and community leaders of protection principles and rights, risks and appropriate psycho-social responses for children, families and at-risk groups, with a view to create a healthier environment for social integration.

Indicators:

1 Change in the proportion of local authorities, NGOs, communities and community leaders aware of protection principles, rights and risks faced by the target group

2 Change in the number of protection, rights and advocacy groups formally registered and active in the community

3 Change in the per cent knowledge improvement in protection, rights and risk issues among local authorities, NGOs, communities and community leaders

4 Change in the number of response mechanisms (i.e., community action plans, interventions, information sharing) to address protection, rights and risk issues initiated by local authorities, NGOs or community groups.

Notes on Methods for Measurement:

Change in the level of knowledge and the results of having acquired knowledge about protection, rights, and risks can be measured quantitatively through questionnaires and observation. If the budget and other resources allow, the important dimension of quality of enhanced awareness should not be overlooked. Qualitative methods, such as open-ended interviews and various mapping/visual/spatial exercises with local authorities, community members, children, etc. can offer a fuller measure of achievement of this objective. Methods might include: asking leaders in a relief camp to draw a diagram of the protection risks women face while carrying on their daily tasks (e.g., gathering firewood, collecting water, picking up food rations); or encouraging various community members to make an outline using a pie-chart and then analyse the time youth typically spend in the company of adults, peers, or in situations that might put them at increased risk. In the process of carrying out such exercises, we can derive a qualitative measure of the depth of understanding of protection issues.

Objective 4

Identification and reduction of threats to the protection and psycho-social well-being of the target group

Indicators:

1 Change in the number of threats and risks to the psycho-social well-being of the target group identified by the community (this indicator is also appropriate for objective 3).

2 Change in the number of community identified response mechanism to address threats to protection.

3 Change in the level of knowledge and attitudes regarding conflict resolution and anger management in the target group.

4 Change in the level of knowledge and attitudes regarding sexual and gender-based violence among youth in the target schools.

5 Change in the number of incidents/reports of gender-based violence.

6 Change in the number of reported incidents of problems caused by anger/violence.

7 Change in the level of perceived safety or security.

Notes on Methods for Measurement:

The indicators suggested above are primarily quantitative, with the exception of perceived level of safety or security. However, the development of quantitative questionnaires is

not as simple as asking a direct question; most of the quantitative measures mentioned above must be derived from a set of indirect questions and observations. For example, asking someone if they "feel safe" may not result in as valid a measure as a set of questions or ranked responses to perceived danger or risk associated with specific places, activities, times of the day, or in the presence of particular individuals. Various mapping exercises may also prove useful in identifing indicators like: perceived levels of safety and security among children and youth by giving them an opportunity to rank their choice.

- Number of CLWs trained in Psycho-Social Support (PSS).
- Number of NGOs, GOs involved in Psycho-Social Support (PSS) activities.
- Number of families attended by CLWs.
- Type of PSS whether vertical or integrated and horizontal.
- Number of persons normalised during various phases of the disaster.
- Reduction in impact, distress, disability.
- Improvement in quality of life and quality of community life.
- Health seeking behaviour among the affected community.
- Incidence of alcohol, addictive substance use/abuse in the survivor community.
- Incidence of family violence, child neglect, wife battering, child trafficking.
- Number of suicides with relevance to disaster distress.
- Number of persons with mental illness pre and post-disaster, provided Mental Health Services.
- District Mental Health Programme take-over of disaster mental health issues.

Some Additional Indicators:

- Number of vulnerable groups identified (women, children, etc.).
- Number of persons given interventions.
- Types of interventions.
- Types of referral services : Primary, Secondary and Tertiary.
- Number of persons Rehabilitated.
- Number of Self Help Groups (SHGs) formed.
- Number of Women provided with alternative activities.

Annexure-C

Important Websites

Ministry/Institute/Agency	Website
Armed Forces Medical Services	www.indianarmy.gov.in/dgafms/index.htm
Indian Council of Medical Research	www.icmr.nic.in
Institute of Human Behaviour & Allied Sciences	www.ihbas.delhigovt.nic.in
Ministry of Defence	www.mod.nic.in
Ministry of Health and Family Welfare	www.mohfw.nic.in
Ministry of Home Affairs	www.mha.nic.in
Ministry of Labour (Employees State Insurance)	www.labour.nic.in
Ministry of Railways	www.railnet.gov.in
Ministry of Women and Child Welfare	www.wcd.nic.in
National Disaster Management Authority	www.ndma.gov.in
National Institute of Disaster Management	www.nidm.gov.in
National Institute of Mental Health and Neuro-Sciences	www.nimhans.kar.nic.in
Tata Institute of Social Sciences	www.tiss.edu
United Nations Children's Emergency Fund	www.unicef.org
World Health Organization	www.who.int

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