Preface

The tsunami of 26 December 2004 caused death and destruction on an unprecedented scale affecting hundreds of thousands of people in tsunami-affected regions. The mental health and psychosocial needs of the affected population emerged as a major concern.

Providing psychosocial support to literally millions of people who were in a state of terror, trauma and shock was a key component of WHO’s short, medium and long-term strategy. WHO’s policy is that psychosocial support should be community-based, culturally sensitive and provided by appropriately trained workers who understand the needs of disaster victims. It should take into account the needs of special groups such as children, women, particularly widows and the elderly. Such support can relieve more than 80% of the psychological distress of the affected people. Two excellent examples of this community-based psychosocial support is the Village Health Volunteer programme in Thailand and the Emotional Support Brigade in the Maldives.

With the conclusion of the acute emergency phase of the crisis, affected countries began to implement activities to further support those initiated during the emergency phase. An important component of the intermediate phase was to build up the community mental health system. This would serve the immediate as well as the long-term needs of the community, provided it is sustainable and can become a part of the routine health care delivery system.

Different countries have used different approaches in building their community mental health systems – some traditional and some innovative: for example, the mobile mental health team in Thailand, training of monks in Sri
Lanka or the training of the general practitioners (GP++ programme) in Indonesia. Whatever be the method, a strong community mental health system is the best form of disaster preparedness as it can meet most of the mental health and psychosocial needs in any future disaster.

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

This publication, compiling the experiences of the five most-affected countries in the South-East Asia Region, provides valuable insights on how best to meet the mental health and psychosocial needs of disaster-affected communities. There are many lessons which have been learnt, and which should help us to be better prepared for any future disasters. Building a strong community mental health system can be the best tribute to those who lost their lives in the tsunami, were injured or are missing, and to their families.

Samlee Plianbangchang, M.D., Dr.P.H.
Regional Director
Magnitude of the disaster

The tsunami of 26 December 2004 caused death and destruction on an unprecedented scale in the tsunami-affected regions. The six worst affected countries of the South-East Asia Region are diverse – geographically, culturally and economically. All of them were scarred by the tsunami, although the impact and response were manifest in different ways and in different degrees. The number of people affected was overwhelming.

In Sri Lanka, it was the worst disaster the country had ever experienced. The tsunami displaced more than 515,000 people immediately and took a death toll of around 31,000 lives. As many as 23,000 people were injured while over 4200 people are still reported missing.
The country closest to the epicentre of the earthquake, Indonesia, was the worst affected. In Banda Aceh – the capital city of Aceh province, once bustling urban centres were flattened leaving behind only skeletal outlines of the foundations of human habitation. More than a million people were affected in two of the country’s 33 provinces, predominantly in Aceh, where 14 of the 21 districts were devastated. More than 128 000 people died, and another 93 000 people were officially reported missing. This included almost 700 health personnel. Over 500 000 people were displaced and more than 149 000 were injured.

In India, the Andaman and Nicobar Islands bore the brunt of the tsunami’s fury. On mainland India, the southern Indian states of Tamil Nadu, Andhra Pradesh and Kerala were primary victims of the tsunami, as was the union territory of Pondicherry. Approximately three million people were affected, over 10 000 people died, with more than 5 000 reported missing and 7 000 injured. The major damage was to coastal infrastructure such as dwelling units, fisheries, jetties and shipyards.
Pemilik rumah ini masih hidup

Tsunami
26 Des 2004
In Thailand, six provinces, including popular international tourist destinations like the golden beaches of Phuket, Ranong, Satun, Trang, Krabi and Phang-Nga, were severely damaged by giant waves that came surging in. The tsunami affected 66,600 people, and claimed over 5,300 lives. Another 3,000 people were reported missing and 17,000 were injured. A matter of special concern to foreign governments was the large number of their nationals who were visiting Thailand and who had been killed or injured. Over 1,900 foreigners are known to have died, around 2,300 were injured and 900 were reported to be missing.

The Maldives faced a peculiar predicament due to its geography. The Maldives is a low-lying country, encompassing an archipelago of 198 widely dispersed islands which are at a maximum of 1.5 metres above sea level. Even in normal times, 88 of these islands record perennial beach erosion. It was not surprising, then, that the tsunami affected all the islands, some being destroyed altogether. The death toll reached 82, the highest in the history of the Maldives in a single disaster, with another 26 people reported missing. Over 11,000 were left homeless of which nearly 5,000 had to be evacuated to other islands. Although the number of casualties was low compared to other tsunami-hit countries, the magnitude of the disaster was perhaps greater – one of every three residents of the Maldives was affected. With 2,214 people confirmed injured, it was imperative that adequate health facilities and treatment reach them. Yet, providing relief was a logistical nightmare as many of the islands are not easily accessible.

In Myanmar, the impact of the tsunami was comparatively milder. Even so, at least 61 lives were lost and communities in 12 townships were affected. All the medical and psychosocial needs of the affected community were taken care of by the existing health care delivery system.

Everywhere in the affected areas, people were not merely at a physical risk: emotionally, they were severely traumatized. They had lost families and friends, homes, livelihoods – almost everything that defines human existence. The mental health of the tsunami-affected population emerged as a major concern.

Following the tragedy, the World Health Organization (WHO) was requested by Member Countries to support ministries of health in affected countries to restore health services. The areas of mental health and psychosocial support were among the top priorities. As the apex international agency for
public health, WHO, along with many partner agencies, responded to the disaster which has been termed as the worst natural disaster in recent human history.

**Magnitude of psychological trauma**

Shock, horror, grief, despair: it was a range of emotions that most survivors experienced in the immediate aftermath of the disaster of 26 December 2004. Each and every person was psychologically affected by the disaster to some extent. In terms of numbers, therefore, the magnitude of the problem of psychological trauma of the disaster-affected population could be said to be as large as the size of the population. To medical practitioners this was to be expected, it was even normal.

It was recognized that any neglect of psychosocial support could impair efforts in physical rehabilitation. Providing psychosocial support to communities affected by the tsunami where literally millions were reduced to a state of terror, trauma and shock was a key component of WHO’s short, medium and long-term strategy. Such support was crucial, but to be effective, the support had to be appropriate and culturally sensitive. It was also important not to
‘medicalise’ the problem, that is, to prescribe a pill when sympathetic listening and kind words of support would suffice. Another real, albeit lesser, worry in the frenzied action following the disaster was the possibility of staff burnout. Stress levels and exposure to heart-wrenching scenes posed a psychological hazard for them.

The psychosocial needs of the affected people vary over time, and support has to be provided accordingly. WHO guidelines emphasize this point. The shock, panic, anxiety or confusion immediately after the disaster gives way to feelings such as despondency, guilt and irritability within days to weeks. Sometimes, survivors continue to feel emotions like anxiety, restlessness, pessimistic thoughts and intense sadness for some weeks after the disaster. While such people need support from community level workers, it does not mean that they are suffering from a mental disorder. ‘Psychological first aid’ in the form of empathy and practical support is usually sufficient to set them on the path to recovery. However, after some months, some survivors do show symptoms of full-blown mental disorders, such as grief that may lead to severe depression, alcohol and drug abuse or a relapse of pre-existing mental disorders. Others display psychosomatic illnesses, such as headache, tiredness or unidentifiable pain, which have a psychological basis. Such cases need to be referred to specialist mental health care.

In every society there are some people who would have a pre-existing mental disorder. During an emergency, such as the tsunami, the population rates of mental disorders are expected to go up by 5 to 10%. A misconception is that Post Traumatic Stress Disorder (PTSD) is the main or most important mental disorder resulting from a disaster. PTSD is only one and moreover a small component of a range of common mood and anxiety disorders which can occur after a disaster.

**Terminology: mental health and psychosocial well-being**

It has been noted that different people use the terms *mental health* and *psychosocial well-being* differently. It is proposed that focusing on possible conceptual distinctions between these two terms be avoided, especially because *in practice*, good mental health and good psychosocial interventions tend to be the same. Although ‘mental health and psychosocial well-being’ may sound
odd to some, the term reflects an inclusive, integrated way of approaching this public health issue.

To be precise, the term social intervention is used for interventions that primarily lead to social effects, and the term mental health intervention is used for interventions that primarily lead to mental health effects. It is acknowledged that social interventions have secondary mental health effects and that mental health interventions have secondary social effects (as the term ‘psychosocial’ suggests). Mental health interventions cover both clinical interventions (medication, psychotherapy) as well as basic, non-clinical, psychological support interventions (e.g. psychological first aid).

**WHO framework for mental health and psychosocial support after the tsunami**

Soon after the tsunami, a document was prepared entitled, *WHO Framework for Mental Health and Psychosocial Support after the Tsunami*. This document was produced through the collaborative efforts of country focal points in mental health from tsunami-affected countries, Department of Noncommunicable Diseases and Mental Health, WHO South-East Asia Regional Office (SEARO), and the Department of Mental Health and Substance Abuse, WHO Headquarters (HQ). This document clearly describes the terminology, epidemiology, organization of services and strategies in the post-emergency phase. Sections of this Framework are included in this document.
WHO/SEARO technical documents on mental health and psychosocial support after the tsunami

To assist the country-level relief efforts in mental health and psychosocial support after the tsunami, the Mental Health Unit of SEARO in collaboration with local experts prepared the following documents:

(1) Manual for Community Level Workers.
(2) Manual for Trainers of Community Level Workers.
(4) Caring for Your Own Emotional Well-being – Guidelines for Relief Workers.

These documents were translated and adapted by the tsunami-affected countries.

WHO/HQ publications relevent to the tsunami

WHO/HQ publications related to mental health in emergencies and on developing community mental health programmes were very useful in providing technical support to tsunami-affected countries. The following documents were specifically relevant:

(1) Mental Health in Emergencies.
(2) Mental Health of Refugees.
(3) Atlas: Country Profiles of Mental Health Resources.
(4) The Effectiveness of Mental Health Services in Primary Care: The View from the Developing World.
(5) Women’s Mental Health: An Evidence Based Review.
(6) Rapid Assessment of Mental Health Needs of Refugees, Displaced and Other Populations Affected by Conflict and Post-conflict Situations: A Community-oriented Assessment.
WHO projections and recommendations for mental health and psychosocial support after disasters

The epidemiological projections of the magnitude of mental health problems and psychosocial distress after a disaster (including the tsunami) and the appropriate responses are summarized in Table 1. These projections help communicate the important public health message that problems range from mild distress to a variety of mental disorders, including very severe mental disorders. They also ensure that the information provided to the media by WHO staff and other experts is consistent. However, it should be noted, that these numbers are mere projections based on available literature. It is likely that epidemiologists will conduct studies and find much higher or lower rates of disorders in some tsunami-affected countries. This is because in disasters
the distinction between normal psychological distress and mild mental disorder is unclear. Prevalence rates found in disaster studies tend to be extremely reactive to variations in assessment method, case definition and the population’s willingness to endorse symptoms in studies.

**A population perspective for addressing the magnitude of psychological distress and mental disorders**

A public health perspective (i.e. a population perspective), rather than a clinician’s perspective, of the situation is recommended. Although there are no reliable data on the number of people with mental health problems in the tsunami-affected countries, estimates can be made. These rates vary with the setting (e.g. involving sociocultural factors, current and previous disaster exposure) and assessment method and give a rough indication of what WHO expects the extent of the morbidity and distress to be. There are three groups, each requiring a different response:

1. **People with mild psychological distress that resolves within a few days or weeks**: A rough estimate would be that perhaps 20 to 40% of the tsunami-affected population falls in this group. These people do not need any specific intervention.

2. **People with either moderate or severe psychological distress that may resolve with time or result in mild distress that is chronic**: This group is estimated to be 30 to 50% of the tsunami-affected population. This group covers people that tend to be labelled with psychiatric problems in many surveys involving psychiatric instruments that have not been validated in the local cultural and disaster-affected context. This group would benefit from a range of social and basic psychological interventions that are considered helpful to reduce distress.

3. **People with mental disorders**
   
   *Mild and moderate mental disorder*: In general populations, 12-month prevalence rates of mild and moderate common mental disorders (e.g. mild and moderate depression and anxiety disorders, including PTSD) are on average about 10% in countries across the world (World Mental Health Survey 2000 data). This rate is likely to rise – possibly to 20% after exposure to severe trauma and resource loss. Over a
Table 1: WHO projections and recommendations for mental health and psychosocial support after disasters

<table>
<thead>
<tr>
<th>Description</th>
<th>Before disaster: 12-month prevalence rates*</th>
<th>After disaster: 12-month prevalence rates (projected)</th>
<th>Type of aid recommended</th>
<th>Sector/agency expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe disorder (e.g., psychosis, severe depression, severely disabling form of anxiety disorder, etc.)</td>
<td>2-3%</td>
<td>3-4%</td>
<td>Make mental health care available through general health services and in community mental health services</td>
<td>Health sector and social services (with WHO assistance)</td>
</tr>
<tr>
<td>Mild or moderate mental disorder (e.g., mild and moderate forms of depression and anxiety disorders, including PTSD)</td>
<td>10%</td>
<td>20% (which, over the years, will reduce to 15% through natural recovery without intervention)</td>
<td>1. Make mental health care available through general health services and in community mental health services 2. Make social interventions and basic psychological support interventions available in the community</td>
<td>1. Health sector and social services (with WHO assistance) 2. A variety of sectors</td>
</tr>
<tr>
<td>Moderate or severe psychological distress that does not meet criteria for disorder, that resolves over time or mild distress that does not resolve over time</td>
<td>No estimate</td>
<td>30-50% (which over the years, will reduce to an unknown extent through natural recovery without intervention)</td>
<td>Make social interventions and basic psychological support interventions available in the community</td>
<td>A variety of sectors</td>
</tr>
<tr>
<td>Mild psychological distress, which resolves over time</td>
<td>No estimate</td>
<td>20-40% (which over the years, will increase as people with severe problems recover and have residual mild distress)</td>
<td>No specific aid needed</td>
<td>No specific aid needed</td>
</tr>
</tbody>
</table>

*Median of World Mental Health Survey 2000 data across countries
number of years, through natural recovery, rates may go down and settle at a lower level, possibly at 15% in severely-affected areas. Thus, in short, as a result of a disaster, the population rates of disorder are expected to go up about 5 to 10%.

The low level of help-seeking behaviour for PTSD symptoms in many non-western cultures suggests that PTSD is not the focus of many trauma survivors. Consequently, WHO is concerned that agencies are over-emphasizing PTSD and are creating narrowly defined, vertical (stand-alone) services that do not serve people with other mental problems. This way of working could waste precious resources.

**Severe mental disorder:** Severe mental disorder that tends to severely disable daily functioning (psychosis, severe depression, severely disabling anxiety, severe substance abuse, etc.) is approximately 2 to 3% among general populations of countries across the world (World Mental Health Survey 2000 data). People with these disorders may experience inability to undertake life-sustaining care (of self or of their children); incapacitating distress or social unmanageability. The 2 to 3% rate may be expected to increase to approximately 3 to 4% after exposure to severe trauma and loss. Trauma and loss may exacerbate previous mental illness (e.g. it may turn moderate depression into severe depression), or may cause a severe form of trauma-induced common mental disorder in some people.
WHO recommendations for organization of mental health and psychosocial support services after a disaster (including tsunami)

WHO advocates that disaster-affected persons should be able to find a solution to all their mental health and psychosocial needs within their district (or, when districts are small, within adjacent districts). Within districts, mental health and psychosocial support should be available at four levels, as summarized in Figure 1.
Community mental health teams

(Levels 1 and 2 in Figure 1)

These teams can provide mental health services through mobile/outreach facilities or through the primary health care system. The team may have as base, a small, acute ward at a general hospital but does most of its work in the community. In most districts, such teams do not exist. External technical and financial support is needed for developing these teams. It is recommended that the teams be multidisciplinary, but the exact composition of the team will vary depending on the availability of human resources in mental health in the country.

The minimal size of the community mental health team should be at least 3 to 4 staff (the composition of which can vary), and have clear non-medical (psychosocial) helping skills. The teams could consist of:

- One medical doctor with mental health skills.
- Three nurses of which one nurse is specialized in non-medical (psychosocial) support.
Three technicians (nurse aides/community health workers/paraprofessional health staff) who are trained and supervised in non-medical (psychosocial) support.

Primary health workers (who may have different cadre positions in different countries, e.g. doctors, nurses, community health workers, etc.) should be trained and supervised by the community mental health team. External technical support may be needed to help the community mental health team in training and supervising the primary care workers. These workers should be drawn from within the community so that they have an appreciation of the local culture, its historical roots and the way it has shaped traditional concepts of well-being.

**Care and support activities outside the formal health sector**

**(Level 3 in Figure 1)**

This level is broad and covers numerous activities, some of which are:

1. Strengthening the support provided by pre-existing community resources (e.g. by training traditional healers, teachers, religious leaders, women leaders and other community leaders in providing support).
2. Community participatory activities that involve getting members of the community together and planning community activities to reduce mental and social suffering (local solutions).
3. Activities that address important factors to reduce social suffering (income generation activities, educational activities).
4. Structured social services outside the health sector (e.g. community social work).
5. Strengthening community networks through common group activities that ensure that isolated persons come in contact with others and thus generate mutual support.

The immediate need of the relief operations after the tsunami was to reach out to the hundreds of thousands of people who had been affected. One way to reach such huge numbers of people was through appropriately trained community level workers from within the community who understood
the local culture and could provide psychosocial support to them. Table 1 suggests that as much as 80% of the victims have psychosocial needs that may benefit from this community-based approach. One of the tasks of community level workers is to identify those in need of clinical services which should be provided by mental health professionals.

Mental health and psychosocial support does not necessarily mean providing medication or consultations with counsellors and psychiatrists. It is a health subject as community level workers have to be trained in appropriate methods of psychological first aid, identification of persons who need additional
help etc. Being a health subject, this non-clinical support should be led by WHO, but can be conducted in collaboration with NGOs and other agencies.

It should be noted that the experience of some Member Countries has been that certain NGOs claim to be providing “psychosocial support” by undertaking very arbitrary activities without knowing the local language or the local culture. The experience of Sri Lanka and Aceh shows that it is extremely difficult to coordinate or change the ways of working of these agencies as they have their own mandate, their own budget and their own leadership to whom they report.
Self and family care
(Level 4 in Figure 1)

Workers from the aforementioned three levels (1, 2 and 3 of Figure 1) should increase people’s capacity to take care of themselves and their families through psycho-educational activities.

Components of the 4-level system

There are three important components of the aforementioned 4-level system:

(1) **Referral** should be in two directions: from less specialized to more specialized care and vice versa. Thus, persons with severe depression identified by community leaders (at level 3 in the diagram) may be referred to primary health care (at level 2), who may treat the person or who may refer him/her to care by the community mental health team (at level 1). Conversely, the community mental health team may refer a person with a depression for follow-up care in primary health care (at level 2), encourage the person to join a range of community group support activities (at level 3) and train family members (at level 4) on supporting the person.

(2) **Supervision** is essential. Post-tsunami mental health care without supervision is an increasing problem in some countries. Initially, community mental health teams themselves are likely to need supervision by external experts (e.g. from outside the district or abroad). The teams may also need assistance from outside experts to help supervise the primary care workers. Activities with a clear psychological component (e.g. counselling at level 3) also needs supervision. This may be provided eventually by the community mental health team, but only when it is sufficiently strong in comprehending how non-medical care can be helpfully provided outside the health sector. Meanwhile, supervision may be carried out by NGOs with competence in counselling.

(3) **Competent care for vulnerable groups** should be available at all levels of the system. Women, children and the elderly (among others) have specific issues, and workers at different levels should have the required competency to deal with these issues. The WHO Framework strongly advocates integrating care for vulnerable groups within the overall system. This in turn facilitates access to care for the largest number of vulnerable people.
WHO had declared 2001 as the Year of Mental Health. There were numerous advocacy and awareness creating activities during this year. These activities brought mental health into focus in most of the South-East Asia Region (SEAR) Member Countries. The following sections have been extracted from country information given in the WHO/HQ publication ATLAS.

**India**

The National Mental Health Programme (NMHP), launched in 1982, was re-strategized in 2002 for implementation during the 10th Five Year Plan (2002-2007) with a quantum increase in fiscal allocation. It forms the basis for public health initiatives in the field of mental health.

Mental health is part of the primary health care system and is available as such in 22 districts out of about 600 districts countrywide. It will be extended...
to over 100 districts by 2007. There are regular training courses for primary care workers in the field of mental health. Within the last two years about 600 personnel have been trained. Many workshops for the sensitization/training of programme officers, voluntary agencies, health directorate personnel and mental health professionals have been undertaken. A range of training materials have been developed and field-tested. Mental health facilities in community care are available in some designated districts. In addition, various nongovernmental organizations provide different types of services ranging from telephone hotlines to residential rehabilitative services.

*Future plans:* The re-strategized NMHP, under implementation, aims to provide a balanced mix of closely networked services, with dedicated budgetary support for modernization of government mental hospitals, strengthening of medical college departments of psychiatry, implementation of the district mental health programme in 100 districts across the country, focused information, education, communication strategies, training and research.

**Indonesia**

A mental health policy was formulated in 1999. It forms part of the general health policy. The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The first National Mental Health Programme was formulated in 1995, and updated in 2001. But mental health is not in the mainstream agenda within the health sector.

Human resources for mental health are limited. Currently there are only about 500 psychiatrists, 11 certified clinical psychologists and a few mental health nurses for a population of 210 million. There are only 33 mental hospitals with a total of 8,200 beds. Not all provinces have a mental hospital.

Conceptually, mental health is part of the primary health care system. Training programmes have been developed for primary care physicians to treat mental disorders. Within the last two years about 300 such personnel have been trained. Despite these efforts, mental health services are not available in most primary care settings. Severe and disturbed psychotic patients are referred to mental hospitals which provide custodial care, so families prefer to take the patients to traditional healers, particularly in rural settings. It has been reported that as many as 80% of patients with neuropsychiatric illnesses are first taken to traditional or religious healers. So far, there are no community care facilities for patients with mental disorders. However, nurses from government mental hospitals occasionally make home visits.
**The Maldives**

Mental health is not part of the primary health care system. However, regular training of primary care workers is carried out in the field of mental health. Training in this area is integrated in the community health worker’s training programme. The government plans to make comprehensive mental health services available at the central level in Malé. At the regional level, services are provided by visiting psychiatrists. At the atoll and island levels, trained community health workers and nurses provide basic psychiatric services. As of now, there are no community care facilities for patients with mental disorders.

*Future plans:* Home-based care of psychiatric cases will be given priority over institutional treatment. Emphasis will also be given to the prevention of mental illness and promotion of mental health and well-being.

**Sri Lanka**

More than 90% of the mental health resources are concentrated in Colombo and a few major urban cities. Thus the majority of people have to travel long distances to avail of mental health services. Such inequities in distribution and access to mental health services primarily affect the poor. Most psychiatric facilities offer only a limited range of clinical services and even these are inadequate to meet the needs of most people seeking them. Sri Lanka’s mental health care services have a limited capacity to provide psychotherapy, psychosocial and psychological interventions, education, and counselling or rehabilitation programmes.

With a few exceptions, there is a lack of services at the community level. This includes the absence of a follow-up or referral system for patients discharged into the community, which often results in hardship for patients and family members as well as unnecessary readmissions. Supportive care is successfully undertaken by some NGOs in a few areas.

All patients who avail of mental health services from the government sector receive the services and medications free of charge. However, at present, patients who require follow-up after being discharged from hospitals can only get their medication from the hospital that treated them. As these hospitals are centrally located; patients often need to travel long distances every month to collect their medication.
Although mental health has been identified as one of the 16 areas of responsibility for the primary health care system, implementation is limited. Regular training of primary care workers is carried out in the field of mental health. Within the last two years about 1,500 personnel have been trained. Primary care workers in some regions carry out mental health work including dispensing of medication. The appointment of Medical Officers Mental Health to 30 base hospitals has made mental health services available at the secondary care level. Outreach, liaison, community mental health and school mental health services have been launched. With the assistance of the Nations for Mental Health Programme of WHO, attempts have been made to resettle long-stay patients from mental hospitals in the community. Recently, the Ministry of Health (MoH) has initiated a programme to develop intermediate-stay units at a regional level. Ten such units provide rehabilitation services to patients with mental disability who have been discharged from the psychiatry units at the tertiary care level. Day care services and community care services are also provided from these centres. Health camps are conducted by the MoH medical teams in the community to provide holistic treatments including medication, counselling, etc. A few NGOs also provide residential facilities and conduct rehabilitation programmes in the community. A special effort is being made towards developing primary and community care incorporating policies and programmes that would facilitate the alleviation of the problem of high suicide rates.

**Future plans:** The public health approach of providing mental health care integrated into the general health services, primary health care services and community care is envisaged. The main strategies are to improve material resources, human resources in the periphery and to downsize specialized mental health hospitals. Linkages to promote intra- and intersectoral collaboration for improved care of people with mental health needs is planned. A referral system and continuity-of-care system is to be developed with a good information system for effective monitoring and evaluation.
Thailand

Thailand formulated a mental health policy in 1995. This policy plans to:

- Promote mental health and prevent mental health problems.
- Expand and develop the service system of treatment and rehabilitation.
- Develop mental health knowledge and technology, develop the management system for reformation of all aspects of mental health.
- Develop people’s cooperation in order to achieve the goal of taking care of one’s mental health by applying local wisdom to family assistance, community programmes, etc.
- Develop modern psychosocial and other technical knowledge and apply them successfully to the country’s mental health situation.

Mental health is part of the primary health care system. Regular training of primary care workers is carried out in this field with about 300 general practitioners being trained in the last two years. Training of trainers has been organized for mental health workers. The mental health home visit project trains staff in caring for patients at home. A range of training manuals have been prepared. A total of 182 telephone counselling services, 470 counselling centres and 327 stress-relief clinics provide community services. A pilot project for vocational rehabilitation of mentally challenged and mentally-ill persons is underway. A few halfway houses are available. It is planned to develop home health care centres and other community programmes.
India

Following the devastation caused by the tsunami, the Prime Minister of India immediately made all needed central government resources available to the affected states. The Prime Minister’s Office supervised central level mobilization of support including medical assistance. The Chief Minister of Tamil Nadu herself took keen interest in the relief operations from the very beginning. She issued instructions for senior level administrative service officers to work closely with the district administration to provide whatever help was needed.
**Indonesia**

The President and Vice President of Indonesia visited Aceh province two days after the disaster. Realizing the huge impact it had had, they requested urgent international assistance. They also led the initial relief operations and allocated emergency funds.

Dr LEE Jong-wook, WHO Director-General, surveys damage caused by the tsunami in Banda Aceh, Indonesia.

**The Maldives**

A National Disaster Management Centre was established under the direct supervision of the President’s Office. This centre provided a coordinated response from all governmental and non-governmental agencies. A Psychosocial Unit was formed in the National Disaster Management Centre.

Mr Kofi Anan, UN Secretary-General, inspects damage caused by the tsunami in the Maldives.

**Thailand**

The Prime Minister of Thailand took urgent note of the situation following the tsunami. The Health Minister led the immediate response by constituting a team under his direct responsibility. The Deputy Health Minister, Permanent Secretary, Public Health, Deputy Permanent Secretary, Public Health and Deputy Secretary, Food and Drug Commission were also members of the team. This high-level team provided all needed support to programme managers in the disaster-affected areas.
**Sri Lanka**

The President of Sri Lanka identified psychosocial support to the community as a top priority. She established the National Psychosocial and Mental Health Committee to oversee these efforts.

Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, with H. E. Mr Nimal Siripala de Silva, Minister of Health, Sri Lanka, to discuss WHO/SEARO support for the tsunami relief efforts.
The tsunami simultaneously caused massive damage in five SEAR Member Countries. To support the governments, WHO launched coordinated activities at all three levels including headquarters, regional office and country offices. One of WHO’s first actions was to send a team of high-level experts to Indonesia, Sri Lanka and the Maldives, where the respective governments had requested support.

**WHO-UN mission to Tamil Nadu, India, 12 to 14 January 2005**

Dr Cherian Varghese, Cluster Coordinator (Noncommunicable Diseases and Mental Health) from WR India Office and Mr G Padmanabhan from UNDP held discussions with UNICEF state office, Institute of Mental Health, Chennai, Schizophrenia Research Foundation, Chennai (WHO Collaborating Centre), various NGOs and other stakeholders. They assessed the need and developed a model for providing psychosocial care.
WHO/HQ mission to Indonesia, 17 to 27 January 2005

WHO’s first response in assisting the Government of Indonesia was to send a team consisting of Dr Benedetto Saraceno, Director, Department of Mental Health and Substance Abuse, WHO/HQ, and Professor Harry Minas, Director, Centre for International Mental Health, University of Melbourne, Australia. They visited Jakarta from 17 to 27 January 2005. For logistical reasons, this team could not visit Aceh. In close collaboration with MoH, a comprehensive plan was developed consisting of five components:

- Assessment and monitoring of psychosocial needs and psychiatric morbidity.
- Coordination of activities of local, national and international organizations.
- Evidence-based interventions for psychosocial support.
- Strengthening capacity of communities and health systems in the provision of psychosocial support.
- Building a comprehensive mental health system.

These recommendations were incorporated into the MoH plan of action. However, the plan could not be implemented immediately as the entire health system in Aceh was severely crippled.

WHO/HQ mission to Sri Lanka, 13 to 24 January 2005

WHO’s first response in assisting the Government of Sri Lanka was to send a team consisting of Dr Shekhar Saxena, Coordinator, Mental Health Evidence and Research Unit, Department of Mental Health and Substance Abuse, WHO/HQ, and Dr John Mahoney, a senior manager with many years of experience in national mental health programmes in the UK and working in Palestine in mental health and psychosocial relief efforts.

The tasks they undertook included participation in the meetings of the National Psychosocial and Mental Health Committee established by the President of Sri Lanka. One of the major issues they identified was the lack of coordination between the various agencies working in the community. Thus they attempted to help coordinate the diverse efforts of all professionals and agencies to develop an effective and consistent approach for all mental health and psychosocial activities.
They also assisted in:

- Preparation of preliminary plans for the management of mental health and psychosocial services for the people affected by the tsunami.
- Developing a model plan and material for training of personnel from health and other sectors in providing mental health and psychosocial relief to the victims.
- Developing a long-term strategy for mental health services.

**WHO/HQ mission to the Maldives, 24 to 27 January 2005**

The same team from HQ that went to Sri Lanka, also visited the Maldives to support MoH in developing a plan of action for mental health and psychosocial support to the community.

The consultants concluded that the initial psychosocial support launched by MoH to the disaster-affected victims was appropriate and should be continued. Their recommendation was to focus on developing community mental health systems in the long-term.

**WHO/SEARO mission to Sri Lanka, 15 to 24 February 2005**

Dr Vijay Chandra, Regional Adviser, Mental Health, visited Sri Lanka from 15 to 24 February 2005 and assisted the local WHO country office staff.

The following urgent needs were identified:

- Enhance and organize community level work.
- Provide appropriate training to community level workers (CLWs) to enable them to deliver support to the community.
- Ensure continuity of support to the affected communities through CLWs.
- Conduct a needs assessment of the psychosocial distress in the community, so the response is evidence-based in terms of quantity and quality.
- Ensure that adequate clinical services are available for persons identified by the CLWs as being in need of mental health services.
To address the issues identified, extensive meetings were held with MoH, mental health professionals, UN agencies, Medical Officers at the PHCs and other partners. Based on these discussions, the following conclusions were reached:

- Development of a structured community-based programme for psychosocial support

  There is an urgent need to develop a structured community-based programme using appropriately trained local CLWs who would be assigned a fixed number of families to whom they will provide continuing psychosocial support. All workers will be trained using SEARO technical material and will be supervised by the divisional Medical Officer Health. Each CLW will be trained to provide psychological first aid to all affected members of the assigned families. They will also be trained to conduct a structured needs assessment.
based on which the CLW will decide what additional support the affected person needs. The CLW will also be trained to identify those people who need urgent medical attention.

- **Development of back-up community-based clinical services**
  The CLWs will identify a certain number of affected persons who need medical attention. Since the existing back-up services for mental health care in most of the affected districts are scarce, several suggestions were made to enhance these clinical back-up services. These include training and deployment of the following groups of personnel in the affected areas: general physicians; Public Health Inspectors; Medical Officer Mental Health; psychiatry registrars.

- **Development of needs assessment instrument**
  A draft of a structured needs assessment instrument based on the General Health Questionnaire 12 (GHQ12) is already available in Tamil and Sinhala languages. However it needs to be tested in the community.

**WHO/SEARO mission to the Maldives, 24 February to 11 March 2005**

WHO/SEARO sent a team consisting of Dr Vijay Chandra, and Dr Rajesh Pandav, Short-term Professional, Mental Health Unit. Dr Chandra visited the Maldives from 24 February to 4 March 2005 while Dr Pandav stayed till 11 March 2005 to provide training to community health workers and nurses on identification and management of common neuropsychiatric conditions. This team took note of the Government of the Maldives’ ongoing psychosocial relief operations and its interest in developing a community mental health system which is suitable to its culture and its unique geographical layout.

Based on a review of the situation and the needs of the government, the following conclusions were reached:

1. **Development and testing of a needs assessment instrument for psychosocial distress in the community:** The GHQ12 was translated into Dhivehi and then translated back into English. It was then tested on a sample of people affected by the tsunami in one island.

2. **Training of physicians to enhance their capacity in delivering mental health care to the tsunami-affected community:** Technical material including power point slides were prepared by WHO/SEARO for the training of physicians. MoH is considering using a consultant in the future to conduct the training in regional and atoll hospitals.
Future country needs in developing the mental health system in the short- and long-term were identified under the following headings:

- Strengthening the Ministry of Health.
- Developing mental health services at the Indira Gandhi Memorial Hospital, Malé.
- Providing community mental health training at the regional hospital, atoll hospital and all smaller islands.
- Development of a school mental health programme.
- Undergraduate training in clinical psychology.
- Mental health activities in other ministries.
  - Strengthening the Faculty of Health Sciences.
  - Enhancing the management and staff capacity of Home for People with Special Needs at Guraidhoo.

**WHO/SEARO mission to Thailand, 13 to 18 March 2005**

The Government of Thailand identified psychosocial support to the tsunami-affected communities as a high priority. To work closely with the Thai mental health experts, WHO/SEARO assembled a team consisting of Dr Nimesh Desai (Professor of Psychiatry, Institute of Human Behaviour and Allied Sciences, Delhi), Dr Dinesh Bhugra (Dean, The Royal College of Psychiatrists, UK and Professor of Psychiatry, Institute of Psychiatry, London), Dr Myron Belfar, Department of Mental Health and Substance Abuse, WHO/HQ and Dr Vijay Chandra, WHO/SEARO.

The SEARO team noted that the response of the Government of Thailand in meeting the mental health and psychosocial needs of the affected communities was outstanding. Some of the reasons for this were:

- A well established chain of command including at the political, bureaucratic, technical levels.
- A well developed existing health and mental health care delivery system which could be rapidly scaled up during the disaster.
- A comprehensive data and information gathering system which is optimally used by decision-makers.
- The ability of the mental health system to reach each and every village through its network of mobile teams and health volunteers.
- Participation of many other partners (teachers, monks etc.) who could supplement the efforts of the health team.
WHO/SEARO mission to Sri Lanka, 6 to 11 June 2005

WHO/SEARO sent a team consisting of Dr Than Sein, Director, Department of Noncommunicable Diseases and Mental Health, and Dr Vijay Chandra, to review the progress on mental health and psychosocial aspects of the tsunami relief efforts. They visited affected communities to review the training of community level workers and met all partners involved in mental health and psychosocial relief efforts. The overall observation of this team was that the mental health programme and psychosocial support in Sri Lanka was progressing well. The local consultants working closely with the SEARO team prepared a detailed plan of action for the ongoing phase and the transition phase.

WHO/SEARO mission to the Maldives, 10 to 16 September 2005

Dr Vijay Chandra and Dr Rajesh Pandav, of the Mental Health Unit and an external consultant, Dr Dinesh Bhugra, participated in a review and evaluation mission to the Maldives to assess the impact of the mental health and psychosocial relief efforts for tsunami victims. A field visit to disaster-affected and host islands was also conducted where discussions were held with the island health centre staff, island leaders, internally displaced persons and host families.

SEARO facilitated a two-day national workshop on current status and future preparedness in mental health and psychosocial aspects in disasters in Malé, 14 to 15 September 2005. The Maldives was the first tsunami-affected country to host such a workshop. Participants included representatives from various ministries of the Government of the Maldives, UN agencies, national NGOs and affected community members. Every agency had the opportunity to make its views heard in a frank and cordial manner. The discussions brought out several issues and led to definitive recommendations to address each issue in future.

A detailed review of the tsunami relief operations implemented by all agencies in the past as well as the present was conducted. Recommendations were made for:

- Activities in the next four months.
- Long-term plans for development of mental health systems.
- Mental health and psychosocial aspects of disaster preparedness.

An independent impact evaluation of the Maldives tsunami relief operations was conducted by the SEARO mental health team. Information for this impact evaluation was obtained from discussions with ministry officials,
UN agencies, NGOs and a review of documents. Valuable information was also obtained by interviewing internally displaced persons and host families. The evaluation was based on a structured questionnaire prepared in advance by the SEARO Mental Health Unit.

**Conclusion**

- The psychosocial aspects of the response of the Government of the Maldives was excellent.
- Efforts are being made to develop the community mental health system which will link to the psychosocial work in the community.
- Appropriate long-term plans for the development of mental health programmes, policy and legislation are also being made.

In summary, the Government of the Maldives should be complimented for its mental health and psychosocial relief operations after the tsunami.

**WHO/SEARO mission to Indonesia, 18 to 27 September 2005**

WHO/SEARO sent a team consisting of Dr Than Sein and Dr Vijay Chandra to review the implementation of the mental health and psychosocial plans and programmes related to the post-tsunami response in Indonesia. They also visited the province of Aceh to study the impact of the mental health and psychosocial relief efforts in the community. Their conclusions were:

- Building a community mental health system is a strong focus of the Indonesian response to meeting the mental health needs of the tsunami-affected community. The MoH hopes to use the momentum gained in Aceh to reform the mental health system not only in Aceh but also the rest of the country. Although some issues remain to be resolved, this experience should be supported and studied for future disaster preparedness.
- MoH and WHO country office in Indonesia have decided to concentrate on building community mental health systems while leaving the community level work to NGOs, with the hope that the two programmes will link to and support each other. This strategy should be studied in detail to determine the optimum way of delivering mental health and psychosocial support to communities in future disasters.
- More reliable population-based data are needed on the level of psychosocial distress and mental health morbidity in the community.
WHO Support to the Ministry of Health

**India**

The UN team for recovery after the tsunami in India nominated the WHO India country office to lead the psychosocial relief efforts in collaboration with the Department of Social Welfare of the Government of Tamil Nadu. They developed a framework for providing psychosocial support to affected populations together with UNICEF and UNDP. Technical support was provided for the establishment of a psychosocial monitoring cell in the Department of Social Welfare of the Government of Tamil Nadu. Technical support was also provided to the States of Kerala, Andhra Pradesh and the Union Territory of Pondicherry.

**Indonesia**

WHO has provided all technical support requested by MoH in the post-tsunami operations. Four Short-term Professionals have been recruited to support MoH.
They covered the areas of project design and management, coordination, assisting the mental hospital and nurses training programme.

The Maldives

One of the recommendations of the SEARO mission to the Maldives was to develop a community mental health system in which GPs and paramedical health workers will be trained in providing basic mental health care. To implement this recommendation, the Government of the Maldives recruited a consultant in mental health who accomplished the following:

- Developed training programmes for identification and management of common mental disorders in the community.
- Conducted a number of training workshops for physicians, nurses and community health workers on the identification and management of common mental disorders in regional and atoll hospitals.
- Worked with the Faculty of Health Sciences to assist them in the development of a curriculum for psychiatric nurses, community mental health workers and psychiatric social workers and conducted the first training programme.
- Trained the staff of Home for People with Special Needs at Guraidhoo in rehabilitation and clinical services.

Sri Lanka

WHO has worked very closely with MoH in providing both technical and financial support. WHO assisted MoH in developing a comprehensive plan of action for mental health and psychosocial support to the community. This plan was accepted by the National Psychosocial and Mental Health Committee. WHO has also assisted in the implementation of the proposals outlined in this report in all tsunami-affected districts. Three technical experts have been recruited in support of MoH. They include:

- A consultant in mental health with substantial experience in disaster mental health in Palestine and in management and policy-making with the National Health Service in the UK.
- A professor of psychiatry and previously the President of the Sri Lankan College of Psychiatrists. He assisted in getting support from all partners
for the plan for mental health and psychosocial support to tsunami survivors.

- A psychologist fluent in English, Tamil and Sinhala. He has provided local inputs to the development of mental health and psychosocial support activities and to the WHO country office.

**Thailand**

The Government of Thailand mobilized its own resources to deal with the mental health and psychosocial needs of the tsunami-affected victims. They did not request any external assistance.
In the past, mental health programmes were not given high priority in interventions during emergencies. However, recent emergencies, particularly complex ones (e.g. Kosovo, Timor-Leste) have seen a turning point in the priority given to mental health needs of the affected population. During the tsunami, as part of gaps being addressed in the affected populations, mental health and psychosocial support was considered a high priority due to the magnitude of the devastation and specific requests from the affected countries.

The Emergency and Humanitarian Action (EHA) Unit was the main focal point for the operations which included: mobilizing resources, managing information, coordinating needs and launching appropriate support responses.

A UN Flash Appeal was developed to mobilize resources. It was through this joint mechanism that funds were mobilized and managed. Specific resources were also negotiated with individual donors (e.g. with UK Department
for International Development for mental health activities in Indonesia). Reporting and monitoring was done through SEARO and the WHO country offices. Efforts in resource mobilization were also conducted by the WHO country offices and their respective Tsunami Operations Teams and mental health project managers (e.g. Irish funds for Sri Lanka and Italian government funds for Indonesia).

Information linkages and sharing were also addressed by the SEARO Operations Team where there was a need. Through coordinated visits, any gaps in technical and managerial issues that were identified, or requests from the field, were dealt with as promptly as possible. A reporting and coordination system was also established. This system feeds into donor, partner or UN reporting system and later in the year will contribute to evaluation activities.

**EHA Unit advocates that disaster preparedness plans should include:**

- Preparing the health sector and communities.
- Responding to crises promptly and appropriately through existing health resources.
- Incorporating best practices in service delivery, recovery and rehabilitation.
- Mitigation of impact of disasters.
- Prevention where and when applicable.

*Mental health and psychosocial relief efforts should be an integral part of disaster preparedness plans.*

Clearly, further collaboration is needed between the two units (Mental Health and EHA), as also with other units such as Water, Sanitation and Health, Nutrition and Chemical Safety. This will ensure that risks and public health needs in emergencies are tackled more comprehensively by WHO in all aspects.
India

Consultative meeting on psychosocial support for tsunami-affected populations in Tamil Nadu, 24th January 2005

The Department of Social Welfare, Tamil Nadu, along with WHO, UNDP, UNICEF and UNODC organized a state level consultation with all stakeholders that had accepted the framework for psychosocial support in Tamil Nadu as advocated by WHO. In addition, the State Mental Health Authorities of Kerala and Andhra Pradesh organized state level consultations at Trivandrum and Hyderabad and adopted the same framework.

Linkage workshop, Chennai, Tamil Nadu, 2 to 3 August 2005

A key meeting of mental health personnel (including representatives of MoH and doctors) and the Department of Social Welfare was held from 2 to 3
August 2005 at Chennai to develop an action plan for coordination, referral linkages and sustainability of community-based psychosocial relief efforts.

**Key tasks identified in the linkage workshop:**

- Mapping of personnel and services available and sharing of this information.
- Sensitization and capacity building of staff in the health services.
- Regular interaction between health and social welfare departments at all levels.
- Appropriate linkages for referral of persons needing more intensive care.
- Training and retraining of workers at various levels.
- Monitoring.

Based on the recommendations of this workshop, it is hoped that the work of the health and social welfare departments will be well coordinated.

**Indonesia**

**Coordination meeting, Jakarta, 7 to 8 February 2005**

A meeting led by the Directorate of Community Mental Health, MoH, in collaboration with WHO, was held in Jakarta. It was attended by representatives of the Provincial Health Office of Aceh, other concerned ministries and international and national NGOs. The main objective was to share WHO’s recommendations, the MoH strategic plan on mental health in Aceh and build consensus on the guidelines that had been developed. NGOs were requested to inform their field staff in Aceh about these guidelines.

**Inter-governmental meeting, Jakarta, 4 to 5 April 2005**

The Government of Indonesia, through the Ministry of Foreign Affairs and in cooperation with the Non-Aligned Movement Centre for South-South Technical Cooperation (NAM CSSTC) hosted the Inter-Governmental Meeting of Experts to Formulate Psychosocial Programme for Rehabilitation of Tsunami Survivors in Jakarta from 4 to 5 April 2005. The MoH, with technical assistance from WHO, played an active role in the meeting. Experts from tsunami-affected countries in SEAR (India, Indonesia, Sri Lanka and Thailand), other countries
(Australia, Iran, Malaysia, Japan, Turkey, USA), UN agencies including WHO/ HQ and national and international NGOs shared their experiences. The recommendations of this meeting were:

- Governments should take a strong leadership role in coordinating all partners involved in providing assistance to tsunami survivors.
- Efforts should be made to increase awareness of governments regarding the importance of mental health. The tsunami experience could be used to reform mental health services in countries and to integrate these services into the existing health and social service delivery systems.
- Governments should be encouraged to accept the four-strata model for organization of services advocated by WHO.
- Special programmes should be developed both in formal and non-formal education to build community resilience which should be culturally and socially appropriate. Furthermore, to achieve the optimum impact of psychosocial interventions, there should be simultaneous focus on economic development in the affected areas.

**Planning workshop, Banda Aceh, 10 to12 May 2005**

A planning workshop on Building Consensus in Mental Health Programmes was held in Banda Aceh from 10 to12 May 2005. It was hosted by the Provincial Health Office and attended by the Director of Community Mental Health, MoH and staff of the Provincial and District Health Office, other concerned departments of the local government, national and international NGOs, WHO and UN agencies. The participants identified existing problems in implementing mental health and psychosocial programmes in the affected communities. Every agency accepted the six levels of services (which include the four levels advocated by WHO) to be provided to the community. This was an important meeting as consensus emerged on how to implement the mental health and psychosocial programme in the community. The leadership role of the Provincial and District Health Office was established and all agencies including NGOs agreed to abide by the recommendations.

**The Maldives**

**Meeting of the Forum for Partners in Mental Health, Malé, 6 to 9 June 2005**

MoH brought together all stakeholders working in the field of mental health from 6 to 9 June 2005 with the aim of exchanging information regarding the
work of individuals/organizations/institutions with special emphasis on issues related to mental health. This group was entitled the “Forum for Partners in Mental Health”. It was a major initiative of the Government of the Maldives. The forum paid particular attention to existing policies, regulations and research.

The participants were: government organizations (Ministry of Health, Ministry of Gender, Family Development and Social Security, Ministry of Education, National Narcotics Control Bureau, Department of Public Health, Indira Gandhi Memorial Hospital, the Maldives Police Services, Psychosocial Unit of National Disaster Management Centre), nongovernmental organizations and UN agencies (Society for Health Education, Care Society, MANFAA Center of Ageing, UNFPA, UNICEF, WHO).

**Recommendations made by the Forum for Partners in Mental Health:**

- Identify a national level key agency to coordinate the wide-ranging mental health activities in the country.
- Develop a national policy on social issues and mechanism to deal with these issues.
- Standardize the life skills training programme and develop a manual applicable across different organizations, but differing in content, based on the objective of the programme.
- Develop a mechanism for registering and licensing counsellors.
- Ensure easy accessibility of counsellors, who should be placed in hospitals, island offices or ward offices.
- Work towards reducing the stigma of mental and psychosocial problems in the community by educating and changing attitudes.
- Strengthen judicial and legal systems to advocate appropriate social security and support for those with mental and other psychosocial problems.

The Forum pledged to continue its deliberations till such time that a national coordination mechanism is established and starts functioning.
Sri Lanka

National Psychosocial and Mental Health Committee meeting, Colombo, 9 March 2005.

The basis of psychosocial support activities is a plan agreed to and approved by the National Psychosocial and Mental Health Committee. WHO country office staff assisted MoH in its work. A final report of this committee was completed and agreed upon on 9 March 2005. The report has been produced following extensive consultation with MoH, WHO/SEARO, WHO country office, UNFPA, the Sri Lankan College of Psychiatrists and other health staff (including consultant psychiatrists, Medical Officers Health and Medical Officers Mental Health. The report covered activities for future work including training, future coordination and proposals for mental health systems development.

The psychosocial support programme launched jointly by MoH and WHO aims at reaching every survivor of the tsunami, and providing them with appropriate services. This is a massive programme involving multiple partners each with an important role.

A summary of the recommendations of the plan is as follows:

1. **Community level action**
   Psychosocial support must reach every survivor wherever they may be. The optimum way of reaching every person is through an optimally trained community level worker (CLW), who is from within the community, understands the culture of the people and speaks their language. As per the plan, each CLW will be assigned to a fixed number of families. The duties of the CLW will be to provide social support (meeting the needs of day-to-day life, obtaining aid, etc.), providing psychological first aid and identifying those who need additional mental health services. These CLWs will be supported by mental health professionals.

2. **Support at the primary health care level**
   The next level of support involves providing essential mental health training to existing primary health workers. These workers will be trained in the identification of common mental illnesses and providing treatment for common mental health problems under the supervision of the Medical Officer Health. They will also identify those who need to be referred to the secondary level.
(3) **Support by mental health professionals**

The highest level of support will involve training and recruiting additional mental health staff who will work at the secondary level and be part of the mental health team, supervised by consultant psychiatrists. They will concentrate on people with severe mental illness such as schizophrenia, bipolar disorder and chronic depression. When people cannot be looked after safely in the community, they will be admitted for inpatient care and treatment for a short period in a facility as close to home as possible.
India

The overall responsibility for organization and coordination of all relief efforts was under the District Collector (DC) who is the administrative head of the district. No activity could be undertaken in the district without the DC’s permission. Several cells, under the supervision of the DC, were established such as health, public health, NGO cell, etc. Each cell reported its progress and needs to the DC on a daily basis. The DC was in constant touch with the administration in Chennai on all matters including supplies. Immediately after the crisis of dealing with the dead, the district administration was in complete control. Thus there were minimal, if any, coordination problems between different relief operations.

Village-level activities were under the supervision of a village administrative officer while health matters were dealt with by a village health nurse. Both of them were appointed by the government. This structure worked very efficiently in the state of Tamil Nadu and played a key role in tsunami relief operations.
Observation

The administrative control and coordination has been an outstanding feature of the Government of Tamil Nadu’s response to the tsunami. Within this administrative structure the mental health and psychosocial activities have been able to function without any hindrance.

Indonesia

The Provincial Health Office was severely damaged by the tsunami and became operational only in May 2005. At the provincial level in Aceh, there is no specific section for mental health and therefore a Programme Officer for Family Health is also responsible for mental health. Currently, a new officer has been assigned to take care of the mental health programme. The operational unit for health administration is the District Health Office and with the policy of decentralization, all planning and programme implementation must be at the district level. However, prior to the tsunami there was extremely limited technical capacity or priority given to mental health in the District Office. Other than the District Health Office, psychosocial matters are also dealt with by ministries of religious affairs, education and social welfare.

After the tsunami, there has been a significant change in the attitude of senior staff in favour of mental health. The Vice Director of the Provincial Health Office who was previously skeptical about the need for mental health services, has now become convinced of the usefulness of such services. A focal point for mental health is being created at the district level in some districts. The head of the District Health Office of Pidie has agreed to assign a specific budget to mental health in 2006.

Observation

- Change in attitude of senior staff, appointment of focal points in mental health and allocation of budget is a clear indication of increased attention being given to mental health in the respective health offices. This momentum should be maintained and optimally utilized.
- The commitment of District Health Offices is reflected in their enthusiasm to conduct nurses’ and primary care doctors’ training even during the Ramadan (fasting month for Muslims).
The Maldives

All island-level activities are coordinated in Malé by the Government of the Maldives. A National Disaster Management Centre was established within days of the tsunami to provide a coordinated response from all governmental and nongovernmental agencies. A Psychosocial Unit was formed at the Centre and a coordinator appointed. This was the only unit providing psychosocial relief to the affected islands. They visited each affected island and established Emotional Support Brigades for the island. Thus the psychosocial relief efforts were technically appropriate and well-coordinated.

Sri Lanka

Immediately after the tsunami, numerous international NGOs arrived in Sri Lanka and began conducting diverse activities which they claimed provided psychological relief to the victims. The effectiveness of the activities of these agencies was limited because of their lack of knowledge about the local culture and language. Also, many NGOs worked in the same areas leading to a lot of duplication of efforts. A major issue of concern has been limited control by the local administration over the activities of these NGOs leading to significant problems in attempting to coordinate such a large number of agencies and organizations. However, there were also significant successes in community level work as described in the section on Coordination.

Thailand

In order to estimate the magnitude of human suffering and channel resources to the persons in actual need, the Government of Thailand developed an “official” definition of “affected person”. For official government programmes, an “affected person” is defined as a person whose:

- Close family member died, is missing or seriously injured.
- Place of residence has been damaged so that the family cannot live there anymore.
- Means of income generation has been lost.

Following the tsunami a Command Centre (‘War Room’) was immediately established at Takuapa Hospital in Phang-Nga province to coordinate the activities of all the six affected provinces. All the eight departments of the Ministry of Public Health were represented in the Command Centre at the Deputy Director-General level. In addition, each of the three affected districts of Phang Nga had an operational centre within the district. There were daily video conferences between the Command Centre and the central ministry in Bangkok. Very detailed and current information was available at the Command Centre. Coordination of all field activities and coordination between the eight departments was excellent.
Relief efforts during the emergency phase

Initial response

India

Immediately after the disaster, the highest priority of government officials was to bury the dead, provide treatment to the injured, restore water and electricity and find adequate shelter and food for the affected persons. This crisis period lasted about one week.

All affected people were taken to relief camps which were established away from the affected site. In these camps, people were provided all their basic needs including food, clothing, shelter and medical assistance.
Indonesia

When the tsunami struck, people immediately ran to high places to save their lives. When the water subsided, they came back to look for their family members and belongings.

Initially the internally displaced persons were housed in tents. Later they were moved to semi-permanent camps. People from the same village were initially scattered around in different camps, but they gradually found each other, so that now people from the same village are living together. Each camp has selected a camp leader.

As an initial response, MoH sent staff to assist the local health system which was completely destroyed. MoH set up a satellite health post in each internally displaced person’s barrack, manned by local health staff or health staff on contract, but their capacity to deal with mental health issues was limited.

The Maldives

The immediate response to the disaster at the island level was led by local community leaders of the islands and involved the entire community. The magnitude of injuries and extent of damage was quickly assessed. Information from neighbouring islands was obtained by VHS radio which continued to function. By the afternoon of the same day most of the severely affected islands were evacuated by boat and people were moved to neighbouring less-affected islands. At the less-affected islands, the displaced persons were warmly received by the local community and provided food and shelter in private homes. Support at the island-level was also provided by the atoll chiefs.

Observation

- The immediate island-level response was excellent.
- The success of the island-level response and the warm reception by the host community points to the need for developing community resilience, coping skills and promoting community relationships and harmony.
- The concept of community resilience is evolving and may play an important role in disaster preparedness in the future.
Sri Lanka

The magnitude of the disaster in Sri Lanka was completely overwhelming. An important issue which hampered relief efforts was that many of the affected areas were in conflict zones. Although the President of Sri Lanka identified psychosocial support to the disaster-affected community to be a high priority, it took a while for the government and professionals to organize a large-scale programme as there were only 30 psychiatrists (most of whom were based in Colombo) and virtually no other trained mental health professionals.

The initial response was mainly by the affected communities, NGOs and expatriate mental health workers. Within 24 hours the majority of displaced people were in shelters provided by schools, temples and local NGOs. In the immediate aftermath of the disaster, the emphasis was on social interventions. As a first priority during this phase, documents on public health approaches to psychological trauma were made available to key health, education, social welfare, humanitarian and relief workers. Soon INGOs arrived in large numbers and provided whatever support they considered appropriate.

Thailand

All affected persons were moved into temporary shelters which were termed as ‘Community Rehabilitation Centres’. This term was used to avoid the stigma of labelling a person as a “displaced” person. The camps were set up by the government on its own land or on temple land. There was no social discrimination within the camps on the basis of religion, occupation or social standing. Temples were also used to collect dead bodies. It should be noted that temples play a central role in Thai society and temples and monks are held in high esteem. They are also socially active in the welfare of the community.

Food was provided by the government and NGOs. Immediately after the disaster, there was an excess of food and clothes. The media played a key role in communicating to donors the actual needs of the community, so aid was provided as needed.

The first mobile mental health team visited the affected community on 29 December 2004. This team functioned in rehabilitation centres and in the special area established for the identification of the dead. These teams provided both medical and non-medical psychological support as needed.
Psychosocial support to affected communities

India

The Department of Social Welfare of the Government of Tamil Nadu was designated as the nodal department for providing psychosocial support to the tsunami-affected victims. They received financial support from UNDP and technical support through the UN team for recovery led by the WHO India country office.

The programme on psychosocial support has been structured as follows:

Step I

- State-level coordinating mechanism was established.
- Meeting of all stakeholders was held in the state capital.
- Strategy and training schedules were established.
- Mapping of service providers in affected geographic areas was done.
- Trainers for the districts were identified.

Step II

- District level training and service delivery was conducted.

Step III

- Monitoring and evaluation is in progress.

Community level workers (CLWs) were trained at a two-day workshop to provide the first level of care to all tsunami-affected victims. Each CLW was drawn from within the affected area and he/she was made responsible for approximately 20 families. CLWs were identified from among health workers, Auxiliary Nurse Midwives, youth groups, community volunteers, NGOs, retired teachers, etc. Training material for CLWs was developed, based on technical material prepared by SEARO and adapted and translated into Tamil. Resource persons serving as master trainers were drawn from local professional organizations, various UN agencies and social work professionals. These resource persons conducted four workshops, each of three days, for training of trainers who in turn would train CLWs.

The duties of CLWs include:

- Providing information on resources available to the victims and assisting them in getting the relief package from appropriate government departments.
- Integration of psychosocial support with overall relief activities.
- Help with physical injury.
- Support for vulnerable groups such as children, adolescents and widows by referring them to appropriate services being provided by the government and NGOs.
Assessment of psychological suffering of the affected people.
Psychological first aid to affected persons.
Identification of people needing additional psychological/ psychiatric support.

In addition to training CLWs, District Social Welfare Officers were also imparted a two-day residential training on disaster management in general, and implementation and monitoring of the psychosocial programme in particular. Modules were also developed for training teachers who can take care of the needs of the children.

In Tamil Nadu 2 813 CLWs were trained. They provided psychosocial support to 46 148 subjects. In Kerala, 125 CLWs were trained. They provided psychosocial support to 25 857 subjects, and 1 297 required further mental health care. In Andhra Pradesh 53 CLWs were trained. They identified 91 people who needed further referral for care. Similarly, in Pondicherry 319 CLWs were trained and 232 subjects were identified who required second level care.

Observation
The highly organized community level work providing psychosocial support to the victims at their doorstep is a strong point of the relief operations in Tamil Nadu. If carried forward successfully, this will be a model programme in providing relief to the affected people. The impact of this activity needs to be objectively evaluated and documented.
Indonesia

Acehnese people had already been affected psychologically by the prolonged civil conflict, and the tsunami trauma was the second, shattering attack. The MoH set up a Task Force on Mental Health consisting of representatives from MoH, Indonesian Psychiatric Association, Indonesian Psychologist Association and Indonesian Nurses Association after the tsunami to develop guidelines for psychosocial support. These guidelines were distributed to volunteers in Aceh.

In addition, batches of trainers consisting of mental health professionals were sent to Aceh to train community leaders, teachers, religious leaders and women leaders in mental health and basic counselling techniques in January and February 2005. However, these training programmes were restricted to Banda Aceh and some north coast districts because of transportation problems. After training about 300 people, this programme was stopped as survivors and trainees moved from camp to camp and were difficult to trace.

Immediately after the tsunami, it was noticed that numerous NGOs were providing “counselling” in a variety of ways. At one time there were over 300 NGOs working in the field of psychosocial support. A sub-group on mental health/psychosocial aspects as part of the general health coordination forum was set up in Banda Aceh. It held its first meeting on 24 January 2005, and subsequent coordination meetings every two weeks.

In February 2005, a document entitled, (I)NGO Basic Principles of Best Practice for Psychosocial Programme in Aceh was prepared jointly by the WHO consultant and UNICEF. This document was signed by 25 NGOs as agreement of acceptance. This document will soon be replaced by a more authoritative document entitled, Agreement for Management with Provincial Health Authorities which is under preparation. NGOs will be required to accept it or their visas will not be renewed.

The WHO consultant based in Banda Aceh also made extensive visits to affected districts, in a programme called the “North Coast Road Show.” This programme involved visiting all affected districts in the north coast for discussions with District Health Offices, district hospitals and (I)NGOs about ideas, challenges and plans for implementing community mental health and psychosocial services. This programme was successful and linkages were established between NGOs working in the field and the local primary health care centres (puskesmas) where there would be trained mental health nurses and a GP also trained in mental health.
Since a large number of NGOs were already working in the community providing psychosocial support services, MoH and the WHO country office decided to concentrate on the development of a mental health system and leave the community level work to NGOs with the Provincial and District Health Offices (assisted by WHO) trying to coordinate their work. Although the linkage has not yet been established, it is hoped that this community level work will in future link to the community mental health services being developed by MoH. This policy of leaving community level work to NGOs is different from what has been done in other tsunami-affected countries, where MoH with support from WHO has been directly involved with community level psychosocial support programmes.

**Challenges in community-level work in Aceh**

NGOs working in the community point out some of the challenges they face in the course of their work:

- People do not believe in mental health services. They prefer to go to traditional healers.
- Most affected people are more concerned about physical needs such as house, jobs, etc. People have been reported to say: “If I get a house, my headache will go away.”
- Most puskesmas staff have limited knowledge of mental health.
- There are very few local psychologists.
- NGOs themselves complain about lack of information regarding what others are doing.

**Observation**

Whether MoH and WHO should be directly involved with community level work needs to be carefully considered. The alternative, as was done in Aceh, is to leave the community level work to NGOs.

**The Maldives**

The Government of the Maldives mobilized its own resources very rapidly. It was quick to seek assistance from select UN agencies to support its efforts, including providing technical material, personnel and funds.
The government launched a well-organized, community-based programme to provide psychosocial support to disaster-affected persons. The Psychological Unit at the National Disaster Management Centre conducted numerous activities including psychosocial interventions in the islands, training programmes for volunteers in psychological first aid, media awareness, outreach programmes to the islands and a helpline for information and crisis management. Their activities were facilitated by UNFPA, UNICEF and American Red Cross. WHO provided technical material for training.

The mobilized volunteers were all local Maldivians who knew the local culture and spoke the local language. These included some previously trained counsellors working with different agencies and other volunteers interested in providing psychosocial support to the disaster-affected community. The American Red Cross conducted a training programme in psychological first aid for these volunteers. Seventy counsellors were trained at a two-day workshop. The volunteer teams then went to the islands and formed “Emotional Support Brigades” consisting of youth, teachers, and health care providers in each affected island. Through this outreach programme, all affected islands have been reached, and every affected person has been provided at least some emotional and psychological support.

The American Red Cross has also conducted another programme called the ‘Tsunami Operation Teachers Training Programme’ in which one teacher from each inhabited island was trained to provide psychological support to students.

Staff at the Indira Gandhi Memorial Hospital were also trained to support traumatized patients from other islands coming to the hospital. A helpline was established with four lines on a central number. This programme received support from UNFPA and UNICEF who also provided toys and relevant educational material for schools.

All the activities undertaken in the mental health and psychosocial area have followed the basic approach recommended by the Sphere guidelines (these were developed with assistance from WHO/HQ, and are entirely consistent with the WHO approach). Formal counselling has been recognized to be unnecessary for the vast majority of affected individuals and offers of counsellors from other countries were declined or deferred by the government. Care has also been taken to avoid labelling of affected individuals as psychologically abnormal or damaged.
Observation

- The government launched a well-organized community-based campaign to provide psychosocial support to the disaster-affected persons.
- The immediate response of the government in establishing a Psychosocial Unit is highly commendable and indicates the government’s recognition of the issue as important for the community.
- All members recruited and trained by the Psychosocial Unit were local Maldivians who spoke the local language and were familiar with the local culture.
- Through the “Emotional Support Brigades” all affected islands have been reached, and every affected person has been provided at least some emotional and psychological support.
- The technical content of the psychological first aid was appropriate and in keeping with WHO guidelines.

Sri Lanka

Consultant psychiatrists from the College of Psychiatrists and other mental health professionals trained a wide range of health workers (Public Health Midwives, Public Health Inspectors and Public Health Nursing Sisters). Initially this training was on case definition, case identification and referral. Many organizations (such as Red Cross, Institute of Migration, UNICEF, etc.) were also involved with training community level workers in providing a diverse range of psychosocial support programmes. All major agencies involved in community-based psychosocial work met in the WHO office in Colombo once a month. WHO was assigned the task of coordinating the plans for all UN agencies for the reconstruction phase for mental health and psychosocial activities.

Following a debate on the benefit of community level work, a plan drafted by WHO endorsing the mobilization of community level workers was accepted by the Government of Sri Lanka, local technical experts, NGOs and international organizations. These community level workers will link to a proposal to develop a community mental health system. The plan calls for the recruitment of Senior Community Support Officers (SCSOs) and Community Support Officers (CSOs) in each affected area, the number of people to be recruited being based on
the number of people affected in the community. The CSOs will be from within the community, with some experience in community work. The initial recruitment will be for a period of six months, and each CSO will be paid a stipend. Funds for the stipends have been made available by WHO to the Deputy Provincial Director Health Services. CSOs will be trained using WHO technical material and other material such as problem solving skills presently under development. Five hundred people have been appointed under this programme to date. CSOs will concentrate on the following activities:

- Prioritize those people with ongoing mental health and psychological problems.
- Provide regular and practical psychosocial support.
- Provide support with activities of daily living.
- Help people gain access to resources/allowances etc., to which they may be eligible.
- Provide health promotion and general information.
- Help identify early signs of relapse of mental illness and psychological distress.
- Support people who receive treatment for mental illness.

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<th>CSOs</th>
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Table 2: Number of SCSOs and CSOs to be recruited
An innovative programme in Sri Lanka

Buddhist monks have been trained in providing psychosocial support to relieve the distress of the community. This programme has been launched through Shanthi Padanama, a religious NGO. About 100 monks have been trained in four regions.

A group of NGOs and other experts will train master trainers who will in turn train the CSOs in each operational area and provide ongoing hands-on supervision and support.

Observation

The plan for community level work based on the size of the affected population was highly structured and well planned. The impact of the work of these community level workers in providing relief for psychological distress should be evaluated in the future.

Thailand

The Thai programme of psychosocial support to the community is based on a pre-existing extensive network of village health volunteers. Each volunteer is assigned a fixed number of families in the village. These volunteers are from within the village, and donate their time for social activities. They are trained by the Department of Mental Health on basic mental health issues of relevance to the community. After the tsunami, a special programme has been set up to train these volunteers in providing basic psychological first aid to the affected communities.

The village health volunteers were supported by a mobile mental health team which worked in the community and provided both medical and non-medical mental health services to the people referred to them by village health volunteers. These mobile mental health teams were headed by a psychiatrist, and included a counsellor, a pharmacist, a psychiatric social worker and community health centre staff. They visited villages and rehabilitation centres on fixed days and attended to the needs of the community and provided whatever support people needed, including medication (carried by the team). These mobile teams will remain in place for the duration of the emergency phase and then the usual mental health care delivery system will take over.
Observation

The Thai government’s response can be seen as a model for providing psychosocial support to disaster-affected communities. One of the main reasons for the success of the programme was that the country already had a well-developed mental health care delivery system integrated within the health system. After the tsunami, hundreds of pre-existing village health volunteers were mobilized for community-based psychosocial support. Coordination between the authorities and the service providers was exemplary. Now that the emergency phase is over, the Thai government is ready with clearly-defined long-term objectives.
**Coordination**

Generally, the local government should take the leadership role in coordination as it has the power to enforce its rules and regulations. Coordination, whether it be between NGOs, different ministries or UN agencies, is extremely difficult. Experience in all tsunami-affected countries uniformly shows that coordination is extremely time-consuming and even then, less than optimal.

**India**

All NGOs wishing to work in the affected community had to first register themselves with the NGO coordination cell in the DC’s office. They were required to inform the NGO cell of what they proposed to do, and what medicines and other supplies they had brought. If their activities were found appropriate, they were permitted to work in the affected communities. All medicines brought by NGOs were deposited with the Tamil Nadu Medical Supplies Corporation where they were tested and supplied as needed, based on requests from the districts. All civil supplies brought by NGOs were also catalogued by the district administration and provided as required. Additional coordination of NGO activity was done by a daily meeting chaired by the DC and attended by the relief commissioner, the DIG police, a revenue official and a NGO coordinator. In addition, a meeting of senior officials reviewed the work of all NGOs.

**Observation**

The frequently observed ad hoc activities of NGOs in some other tsunami-affected communities were avoided by the administrative control of all activities by the civil administration in Tamil Nadu.

**Indonesia**

Numerous international NGOs came to Aceh immediately after the disaster to provide mental health and psychosocial support to the affected community. Based on western experience and considering the magnitude of the disaster, they believed that “trauma counselling” would be a big need in the community. They brought their own psychiatrists, counsellors, social workers and even medications. Coordination of the activities of these NGOs has been almost impossible as each NGO has its own agenda, its own funds and its own leadership to whom they report.
After two months an attempt was made by MoH, WHO and UNICEF to map these NGOs – who they were, what they were doing, their geographical area of work, target population for intervention, how long they planned to stay, and to coordinate their activities. An initial mapping was produced and used as the baseline information for coordination. However, the ground situation was found to be constantly changing: there was a high turnover of international NGOs, some NGOs also moved from one area to another and there was a high turnover of personnel within the NGOs creating a major challenge for meaningful coordination.

The sub-group on mental health/psychosocial aspects met periodically but not all NGOs would come for these coordination meetings. Similar coordination meetings were held with the NGOs in Jakarta and with other ministries, e.g. Ministry of Religious Affairs, Indonesian Red Cross, Directorate of Community Mental Health, Association of Psychiatrists, Psychologists and Nursing, etc. These meetings did not produce any substantial solution to the coordination problem.

Badan Rehabilitasi dan Rekonstruksi (The Rehabilitation and Reconstruction Body) is trying to play the role of a coordinator in Aceh, but they are focused on infrastructure which leaves the coordination of mental health and psychosocial activities wide open, although the Provincial Health Office is now in a position to take a leadership role.

**Observation**

Coordination of the work of NGOs in Aceh has been difficult because of many reasons: the magnitude of the disaster, destruction of the health care delivery system, limited capacity of the central, provincial and local government and low priority given to mental health in the past. WHO has supported the capacity of central, provincial and district health offices to coordinate NGO activities, as far as possible.

**The Maldives**

External agencies, particularly INGOs, were not permitted to work in the community on the premise that they were not familiar with the local culture and language. Thus the problem of coordinating external agencies did not arise.

Although the overall response of the government to the tsunami was excellent, local Maldivians who worked in the community mentioned the lack
of information sharing between ministries and agencies on who was doing what e.g. many assessments were done by different ministries each for its own specific mandate. It has been mentioned that many of these could have been combined.

**Observation**
- The Government of the Maldives requested support from select agencies and denied access to numerous INGOs. This prevented problems of coordination between agencies.
- Overall, the coordination of relief efforts was good, but perhaps one lead agency serving as the coordinator of ministries would have been more effective.

**Sri Lanka**

Other than the problem of coordinating INGOs, most mental health and psychosocial activities in Sri Lanka had a clear plan and chain of command.

The Directorate of Mental Health Services of the Ministry of Health was the central coordinating unit for the mental health and psychosocial response and was supported by WHO. To ensure a multisectoral, multi-level approach at the central level, the Directorate of Mental Health Services and WHO staff worked together with representatives from different stakeholders:
- Centre for National Operations.
- Relevant ministries, departments and authorities.
- Medical professional associations and colleges.
- Religious groups.
- The Psychosocial Forum of the Consortium of Humanitarian Agencies.
- Representatives of other coordinating agencies.
- Sri Lankan universities.
- Nongovernmental Organizations.

At the national level, UN and other agencies (WHO, UNICEF, UNFPA, UNHCR and IOM) also agreed to define responsibilities and met weekly to coordinate their activities. The main coordinating role was managed by UNFPA. The Sri Lankan Consortium of Humanitarian Agencies was assigned the responsibility of coordinating the activities of different NGOs.
At the district level, the Deputy Provincial Director Health Services, supported by Medical Officers Mental Health or consultant psychiatrists took on the coordinating role. They worked in close liaison with representatives from the relevant district level authorities and NGOs. Their role was to:

- Improve links with all sectors.
- Provide immediate psychosocial assistance to the affected population and to identify individuals with high risk for psychosocial problems and mental disorders.
- Strengthen the health care system to take adequate care of people with newly developed mental health needs as well as of people with existing mental problems and disorders.

Coordination groups at regional/district level functioned effectively such as MHTF in the North, CENT in Trincomalee, MANGROVE in Batticaloa, a district coordinating body in Ampara/Kalmunai, another coordinating group facilitated by AMI in Pottuvil, and coordinating groups in Hambanatota, Matara and Galle facilitated by UNICEF. In addition, Vavuniya and Mannar have had psychosocial coordination groups (called Psychosocial Sub-committees of the NGO Consortium) for about two-three years. The Psychosocial Forum has been functional in Sri Lanka since 1997. In addition, to involve new partners, there was a parallel Psychosocial Coordination Group set up post-tsunami, which met once a week from January till May, twice a month from June to August and now meets once a month.

**Observation**

Given the scale of the disaster, there were immense difficulties in coordinating activities. This was compounded by a scarcity of mental health professionals. Despite initial problems, Sri Lanka was able to set-up coordinating mechanisms at multiple levels. Coordination of activities even in the conflict affected north and eastern parts was effective.

**Thailand**

The entire mental health and psychosocial response was managed and implemented by the Department of Mental Health. Coordination of activities was not an issue.
Experiences of different countries in coordination which have succeeded include:

- Strong civil administration which effectively controls the activities of all agencies (Tamil Nadu, India): the District Collector is the highest civil administrator in every district of India with power to control the activities in his/her district. All unwanted agencies in the affected areas were asked to leave and this order was enforced by the police if required.

- Restricted entry to affected areas (the Maldives): Visas and entry permits were given only to selected agencies after careful screening.

- Categorically announcing that no external assistance is needed (India and Thailand): If governments publicly announce that no external aid is needed, flow of NGOs will be limited.

- Excellence of the local response (Thailand): if the response of local governments and agencies is so good that there is nothing left for external NGOs to do, they will either not come or leave soon.

- Strengthening the WHO country office (Sri Lanka): If the scale of the disaster is such that the resources of the country find it impossible to cope, national and district coordinating mechanisms need to be put in place as soon as possible. The coordination of health activities was supported by the WHO country office.
Assessment of psychological distress in the community

**India**

A structured form has been developed under the supervision of the WHO India country office, which is being administered by CLWs of the Department of Social Welfare to each family member. This form obtains information on the social needs of the victims, an assessment of the psychological suffering and what help they have been given. Data analysis is in progress. The Indian Council of Medical Research is conducting a formal quantitative assessment of the psychosocial distress of the community. This project is also in progress.

**Indonesia**

In the first week after the disaster, MoH and the WHO country office formed a Task Force on Mental Health consisting of psychiatrists, clinical psychologists and mental health nurses. This team conducted a rapid assessment of needs in Aceh using the WHO instrument, *Rapid Assessment of Mental Health Needs*. They assessed how much damage there was and what should be done. A report was presented to decision-makers at MoH as an input to the development of a plan of action.

**Observation**

- The University of Indonesia study is the only objective measure of psychological distress in the community. It suggests that the affected community does have more psychological distress than non-affected individuals, but the magnitude of the distress cannot be quantified because of limitations in data analysis.

- Efforts should be made to obtain additional data on the level of psychosocial distress in the affected community and the level of mental health morbidity. The new data could link into the health information system being developed for Aceh. Two practical recommendations for obtaining current population-based data are:
  - Establish a reporting system at the puskesmas level so that nurses and GPs will report all cases with mental illness on a monthly basis. Local health authorities are considering such a plan and will implement it after the primary care doctors and nurses have been trained.
  - Collaborate with NGOs working in the field to obtain objective assessment of the level of psychosocial distress in the community using a standardized instrument such as GHQ12.
The Department of Psychiatry of the University of Indonesia, Jakarta, did an assessment of the level of psychological distress in the community. The study was conducted between 25 February and 15 March 2005. The instruments used included the Self Reporting Questionnaire 20 (SRQ20) plus 9 questions that had not been validated prior to the survey due to time constraint. The study obtained data on neurotic and psychotic symptoms, post-traumatic disorder-like symptoms and alcohol abuse. The study also included the Connor-Davidson Resilience Scale-2 and Strengths and Difficulties Questionnaire which has 25 items to assess psychosocial problems and strengths in children.
Analysis of the data showed that the affected people displayed significantly greater number of symptoms of psychological distress than the controls as assessed by SRQ20. Participants from Aceh and Nias tend to be more resilient than participants from Jakarta as measured by the Connor-Davidson Resilience Scale. Despite limitations in data analysis, this study also showed that although children suffered from psychological distress as measured by the Strengths and Difficulties Questionnaire, they showed positive coping behaviour.
The Maldives

The Ministry of Planning is the nodal agency which conducts all population-based surveys in the Maldives. Generally any survey to be conducted should be approved by this ministry. These guidelines prevent duplication of efforts since one ministry is aware of all surveys.

The Ministry of Planning has previously conducted two Vulnerability and Poverty Assessment (VPA) surveys in the Maldives. One was conducted in 1998 and the second concluded in October 2004. These surveys were well designed and included a nationally representative sample. The questionnaire design, data collection, entry and analysis were exceptionally good.

After the tsunami, a third partial VPA, called the Tsunami Impact Survey, was conducted from July to August 2005. This survey questionnaire consists of some of the relevant household questions, new household questionnaire to assess tsunami damage and two new modules, one on psychosocial issues and the other on reproductive health. The survey has been conducted only in the 14 officially designated most-affected islands. The psychosocial module was developed by UNFPA, MoH and the technical group for psychosocial issues. Data analysis is in progress.

Immediately after the tsunami multiple assessments were carried out by different agencies (UNICEF, Care Society, International Federation of Red Cross, Save the Children, Ministry of Planning, Ministry of Gender, Family Development and Social Services). Essentially each agency was trying to assess the field situation in terms of its own mandate. The surveys used different methods in sample selection and study design (quantitative and qualitative measures).

MoH requested WHO assistance in developing and validating an instrument for the assessment of psychological distress in the community. WHO/SEARO advocated the use of the GHQ12 which has been used in numerous countries around the world. This questionnaire essentially assesses the magnitude of anxiety and depression in a person. In addition to the questions in GHQ12, five additional questions have been drafted by a committee of experts that will also help to identify persons who need to be referred to a counsellor or a psychiatrist. The entire instrument was translated into Dhivehi and validated for use in the Maldives.
The Ministry of Gender, Family Development and Social Services in collaboration with UNICEF conducted a survey to determine the effects of the disaster on the population with particular focus on children, parents and caregivers, to determine the needs of the affected communities and to recommend actions for the future. A qualitative assessment in the form of educational workshops was conducted. The findings clearly point to the tremendous psychological morbidity in children, adolescents and adults. Based on this survey, they recommended urgent measures to provide psychosocial support to the affected communities.

Care Society, an NGO based in Malé, is conducting a quantitative assessment of psychosocial distress and mental health needs in five islands in Raa, Baa, Laamu and Gaa atolls. They will be using the GHQ12 as an assessment tool. The study is in progress.

**Observation**

People working with relief efforts in the Maldives point out that some surveys duplicated information. Also, the lack of normative data made interpretation of the findings difficult. However, some officials of the government feel that being the first experience with such a disaster, multiple assessments helped corroborate findings of other surveys leading to evidence-based responses.

**Sri Lanka**

GHQ12 has been used previously in Sri Lanka and both Tamil and Sinhala versions are available. However, to make it a useful tool for needs assessment of the affected persons and in identifying who should be referred for additional support, the instruments need to be validated in the field to establish appropriate cut-off points. However, no large community-based assessment of psychological distress has yet been done after the tsunami.

**Thailand**

Community health centre staff visited every affected family and asked them about their physical health. If they mentioned any symptoms related to mental health, then a GHQ12 was administered. If the GHQ12 score was five or more, the person was referred to the mobile mental health team for assessment and appropriate care. This instrument has been used very effectively in the
affected community to identify in an objective manner as to who to refer for additional psychological support. Detailed tabulations of these data are available with the Department of Mental Health.

The GHQ12 is also being used to monitor the condition of the community prospectively. Repeated administration of the same questionnaire to the same people has objectively documented that the level of psychological distress is diminishing (as indicated by a drop in distress scores in the GHQ12). This also suggests a positive impact of the psychosocial relief efforts being implemented.

A formal epidemiological study of the prevalence of PTSD symptoms, using standard (though not Thai-adapted) questionnaires has been conducted in a tsunami-affected community. The rates of PTSD were within the range of those reported in similar situations from western countries. Thai experts are aware that the study conducted an assessment of PTSD symptoms and not the formal diagnosis of PTSD.

**Observation**

Thailand is the only tsunami-affected country to have carried out a structured quantitative assessment of the psychological distress in the community. They effectively used this information in the emergency phase for evidence-based psychological support and have also used it to show objective evidence of the success of their relief efforts.
Lessons learnt

- An objective assessment of psychosocial distress of the community can serve several useful functions:
  - The mental health and psychosocial relief efforts can be based on an objectively assessed need of the community and individual.
  - Periodic re-assessment of the mental health and psychosocial needs of the community which provides objective evidence of the decline in levels of psychological distress will be a measure of the success of relief efforts.

- A clear plan should be in place to determine which instruments will be used, when and by whom in case of future disasters.

- Validated questionnaires (quantitative) for needs assessment and mental health status of the affected population should be readily available to all partners.

- Instruments to be used in assessment must be culturally appropriate and locally validated.
Unique issues in select countries

The Maldives: communication and transportation between islands immediately after the tsunami

The geography of the country and distance between islands makes communication and transportation a critical issue. Immediately after the tsunami, communication equipment was damaged and power plants were switched off to prevent electrocution. Thus, communication between islands and Malé was interrupted. Only the VHF instruments continued to function. The community has complimented the government for providing regular public information through the media. Senior government officials spoke on radio providing information and suggestions to the affected.

Fishing boats belonging to the local residents were out at sea when the tsunami struck and thus were not damaged. When the boats returned to the islands, they discovered the magnitude of the disaster. These boats were used to evacuate people from affected islands. Moreover, many people were able to resume fishing as their means of income generation as soon as they recovered from the shock.

Observation

- Modern communication equipment should be installed/upgraded regularly.
- Use of modern technologies such as e-mail, web-cam, wireless and satellite communication should be made available, particularly in remote areas.
- Public information provided by senior officials of MoH helps to reassure the public and avoid rumours.
- A ‘risk communication’ strategy for disseminating essential information during emergencies using damage resistant technologies should be prepared.
- Some thought should be given to damage-resistant water transportation such as inflatable boats or earthquake proof houses as a form of disaster preparedness.
Thailand: Dead Victims Identification (DVI) Centre

A unique issue for Thailand was the large number of foreign tourists who died in the tragedy. Foreign governments demanded identification of all dead bodies.

Two Dead Victims Identification (DVI) Centres have been set up in Phang-Nga in order to identify dead victims of the tsunami. One of these is for foreigners and one for local Thai people. In the strong social tradition of the Buddhist culture, temples made their land available to establish these centres which are headed by the Thai police department. There are many foreign teams assisting the Thai government in the identification of dead victims. The teams consist of a fingerprint expert, a DNA expert, a preservation expert, a forensic pathologist and a dental record expert.

All information including detailed photographs are loaded on to a computer which relatives can access in a viewing area to see if they can identify the missing persons. Once a match is made the bodies are released to relatives for last rites. This activity is extremely stressful both for the family members and the staff as they must view thousands of extremely disturbing photographs in their search for family members.
In accordance with European law, there is a proposal to preserve all unidentified bodies for seven years before disposing them off. Thai law requires only three years before disposal of an unidentified body, but the government has decided to preserve even the bodies of Thai victims for seven years. A special centre will be built to preserve all these bodies. Local experts have expressed their concerns over the cost of the infrastructure which will be needed.

Observation

- The organization of the DVI Centre is an outstanding example which should be documented for others to study.
- The expertise to identify large numbers of victims that is technologically advanced and expensive to develop and maintain, has now been built in Thailand. This expertise will be available to other Member Countries.
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**Relief efforts during the intermediate phase**

With the conclusion of the crisis that marked the acute emergency phase, affected countries began to implement activities which would further support those initiated during the emergency phase, and would also be useful in the long-term to make the mental health and psychosocial relief efforts sustainable. An important component of the intermediate phase was to build up the community mental health system. This would serve the immediate as well as the long-term needs of the community, provided it is sustainable and can become a part of the routine health care delivery system.

**Building community mental health services**

*India*

The community level psychosocial relief efforts in the tsunami-affected areas of Tamil Nadu were implemented by the Department of Social Welfare. Clinical back-up mental health services were the responsibility of the Department of Health. Initially mental health services were provided by clinicians of the Institute of Mental Health, government hospital psychiatrists and NGOs such as Schizophrenia Research Foundation and SNEHA. It was proposed that a workshop be conducted in the near future to establish a link between community level workers and mental health professionals.
A meeting of mental health personnel (including representatives of MoH and doctors) and the Department of Social Welfare was held on 2 to 3 August 2005 at Chennai to develop an action plan for coordination, referral linkages and sustainability of community-based psychosocial relief efforts.

The meeting decided that priority for implementation of the linkage efforts will be set at the state level depending on the extent to which the districts have been affected. Clear responsibilities were framed at each level of operation. The responsibilities established are as follows:

**Responsibilities of the District Health Department**

- Issue appropriate administrative orders (Director of Medical Services, Director of Public Health and Director of Medical Education).
- Identification of nodal psychiatrist for the district.
- Mapping of the district health facilities (sub-centre, PHC, block PHC, district hospital, other hospitals with mental health services both public and private) and NGOs providing counselling and mental health services.
- Preparing a list of health workers by affected PHC.

**Responsibilities of the District Social Welfare Department**

- Preparation of a list of CLWs with name, background (teacher, retired, etc.) and area of work.
- Providing all CLWs with photo identity cards in Tamil, signed by the DSWO.
- Preparation of a list of all the schemes and services available for the affected people and sharing this list with the CLWs.

**Joint responsibilities of the Departments of Health and Social Welfare**

- Matching the CLWs to the PHCs where their area of work lies.
- Ensuring that all health workers have the list of CLWs in their area.
- Ensuring that all CLWs have the health service map of the district and the list of health workers.

To facilitate further coordination in the field between the two departments, it was decided that issues related to psychosocial relief efforts should be
discussed at all appropriate forums including staff meetings of the departments at district and sub-district levels.

**Figure 3:** Referral linkage between the Departments of Health and Social Welfare, Government of Tamil Nadu, India

- **District level**
  - Coordination committee meeting – once a month

- **Block PHC level**
  - BMO meeting – once a month

- **PHC level**
  - PHC meeting – once a month

- **Sub centre**
  - Meeting once in two weeks

† DDHS: Deputy Director Health Services
† DSWO: District Social Welfare Officer
† BMO: Block Medical Officer
† PHC MO: Primary Health Centre Medical Officer
† VHN: Village Health Nurse
† EO-SW: Extension Officer Social Welfare
† RWO: Rural Welfare Officer
† CLWs: Community Level Workers
Appropriate referral linkages

A system of forward and back referral, record keeping and follow-up was established as follows:

- Once the CLW identifies a subject as needing further care, the information will be conveyed to the health worker of the area who will then be responsible for providing whatever care is needed by the subject.
- The health worker will inform the CLW of the outcome of the consultation and instructions for follow-up.
- The CLW will record the details of the persons referred and their follow-up.
- The health worker will also keep a record of such people and trace their health care in the system.
- Linkage should be established with school health programmes.

The entire scheme of operation is summarized in Figure 3.

Indonesia

Mental health services, specifically community mental health services, have not been optimally developed in Indonesia in the past. Although, some primary health workers had been trained prior to the tsunami, there was no supervision and appropriate psychotropic drugs were not available in the primary health care centres. After the tsunami, the Directorate of Community Mental Health in collaboration with WHO has been concentrating on building a mental health care delivery system that reaches out to the community. The community mental health system would provide back-up clinical support to community level work.

The proposal is to have a hierarchy of services with the mental hospital as the final back-up for the system, followed by the district level mental health team consisting of a doctor with advanced training (termed as GP++), community mental health nurses with advanced training (CMHN++), a psychologist and a social worker. At the community level, puskesmas GPs and nurses will be trained to provide care. It is planned, that nurses will become the backbone of the system which is being developed, since there is a high turnover of doctors at the primary care level. At this time, there are no psychiatric social workers or psychiatric occupational therapists in Indonesia. This cadre will be created in future.
**Mental hospital**

There is only one mental hospital in Aceh. Prior to the tsunami this was the main and perhaps only provider of mental health services to the community in the province of Aceh. The bed occupancy is more than 100% with 320 patients in 280 beds. The patients are cared for by one psychiatrist and 18 GPs who do not have any special training in mental health. Thus the quality of care is not optimal.

The mental hospital was severely damaged by flooding in the tsunami. To save the patients, the locked wards were thrown open. Many of the patients escaped from the hospital but soon returned. Now all patients are back in the hospital. The hospital has been cleaned and repaired. Equipment has been obtained including the addition of a new car and the periphery wall has been repaired.

The total number of patients (including OPD visits) currently under treatment in the mental hospital can be used as an estimate of the current number of patients under treatment for mental health problems in the entire province of Aceh. In the next step, by calculating the additional number of patients under treatment at the puskemas, one can estimate the increase in the total number of patients being treated in the whole province of Aceh due to provision of care at the puskesmas level. This increase will be a valuable impact indicator of the community-based training programme.

**Observation**

- The number of patients being treated at the mental hospital is only a very small fraction of all the patients in Aceh province who need treatment. For a variety of reasons (whether it be distances, lack of awareness or stigma) those in need do not come to the mental hospital.
- The mental hospital has a specific role in a mental health system (teaching, training, treating cases which cannot be managed in the community, research, etc.). It cannot be the primary care facility for all persons needing mental health care.
- The number of patients currently being treated in the mental hospital can be used as a baseline to assess the success of community mental health teams. The impact indicator for the community mental health programme could be the reduction of treatment gap.
- The number of mental health professionals working in the hospital needs to be increased.
Training of GP+ and GP++

One of the recommendations of the WHO document *Framework for Mental Health and Psychosocial Support* is the provision of mental health care and services at the primary care level. To implement this recommendation, appropriately trained health professionals are required.

**GP for the puskesmas (GP+)**

At the primary health centres (puskesmas) located in the affected areas, all GPs and nurses will be trained. The trained GPs will be termed as GP+. Training is based on the existing MoH curriculum for GPs. It covers 14 conditions listed in the ICD Primary Care classification. Training is conducted locally at the district level, and will last four days – three days of classroom training plus one day for practical training in a local hospital. Such training has been conducted in 11 tsunami-affected districts. In general, there is an increasing interest among primary care doctors in mental health. Some of them have applied to become mental health specialists.
GP for the district hospital (GP++)

The Directorate of Community Mental Health hopes to place a more highly trained GP at the district level. This GP is to be termed GP++. This is modelled on the UK’s GP with Special Interest or Medical Officer Mental Health in Sri Lanka. The goal is to train GPs to a high level of knowledge and skill in psychiatry so that they can serve as consultants for the doctors in the puskesmas, be a part of the community mental health team at district level and, at the same time, provide acute psychiatric care at district general hospitals.
Discussions at MoH revealed that many issues remain to be finalized. A curriculum is yet to be developed. Discussions are pending regarding the duration and venue of training, recruitment process, salary as well as official certification. Moreover, the position of GP is temporary since most go on to become specialists. Some GPs may not be interested. GPs may get transferred to other sites where there is no trained nurse, no medications or administrative support available for mental health.

**Observation**

- Basic training of GPs located at the primary health care level is important. How this training will be implemented remains to be decided.
- The issues being discussed are important not only for Indonesia but other countries as they develop plans for community mental health care at the primary care level.

**Training of nurses in mental health**

**Community Mental Health Nurse**

A 10-day curriculum for Community Mental Health Nurses (CMHN) has been developed by the School of Nursing, University of Jakarta. The course requires that classroom teaching be followed by three months of supervised work at the puskesmas. The curriculum consists of 11 core issues, two on children, seven on adults and two on the elderly. The candidates are nurses who currently work in the health centre. The head of the health center is involved in the recruitment process to create local ownership of the programme. The trained nurses will be placed in the puskesmas. They will also be required to go out into the community when informed about a patient, and follow-up on known patients. It is reported that when nurses visit the community, patients often come to them voluntarily. A card describing the important signs and symptoms of mental illness is also distributed to community members with the instruction that if they know of such a patient, these should be brought to the attention of the nurse.

The training modules were pilot tested in the district of Aceh Besar, prior to being implemented in other districts. The training has been completed in all affected districts and 226 community mental health nurses have been trained. Presently, the trainers are from Jakarta. Soon local trainers who are currently undergoing training themselves, will conduct the courses.
The nurses undergoing training will be closely monitored and supervised. There are four local facilitators in each district. These are senior nurses who have attended the same course, with special sessions in the evening on the teaching of the module. It is expected that through this mechanism the capacity of the CMHN nurses will be further improved to enable them to become the backbone of the system.

*Community Mental Health Nurse with advanced training (CMHN++)*

This cadre of nurses is still under consideration. The curriculum is yet to be developed. It is planned that these nurses will receive a higher level of training than the CMHN, and they will be placed at the district level.

**Success story**

A 40-year old patient with schizophrenia had been chained for the last 25 years. During this period, she had been bathed only five times. Her limbs had begun to atrophy. After intervention by the CMHN and being provided treatment, the patient was unchained. She now looks clean and happy and is able to help the family in daily household chores.
Observation

- CMHN can provide a vital link between patients in the community and doctors in the puskesmas.
- The link between CMHN and the community beyond the patient remains to be established. It is believed that the main reason for the high treatment gap in developing countries is the low level of health-seeking behaviour in the community. Reasons for this are many and vary from community to community. Thus the link between the community and the health system at the community level is crucial.
- Indonesia’s efforts at developing a strong community mental health system is laudable.

**The Maldives**

In the aftermath of the tsunami, the Government of the Maldives recruited a WHO consultant in mental health for three months to enhance the capacity of the primary care staff in basic mental health and psychosocial issues, specifically related to relief for tsunami-affected persons. The consultant supported MoH in the following activities:

**Training of health workers in mental health and psychosocial relief in tsunami-affected populations**

Primary health care workers including nurses, community health workers and family health workers were trained. UNFPA and National Narcotics Control Bureau (NNCB) were partners in the training along with WHO.

The modules for the workshop included mental health and psychosocial well-being, gender-based violence (prepared by UNFPA) and substance abuse (prepared by NNCB). For mental health issues, four case vignettes on common mental disorders and four on severe mental disorders, were prepared in English and later translated into Dhivehi by health professionals. These were found to be appropriate as per the Maldivian culture. The case vignettes were selected keeping in mind the prevalence of specific mental disorders in the Maldives.

As a result of this training, participants were able to:

- Understand abnormal behaviour and differentiate this from normal behaviour.
- Identify symptoms of common and severe mental disorders.
- Refer cases requiring specialist mental health opinion.
- Provide psychosocial support to tsunami-affected populations.

**Interactive session with doctors working in island hospitals**

Interactive sessions were held with doctors working in the island hospitals. The objective of these sessions was to discuss the following with them:

- Resolving problems that doctors had been facing while managing mentally ill patients.
- Determining if the tsunami had made any difference in numbers and clinical manifestations of mental disorders.
- Determining their desire to get additional training in mental health.
- Discussing any mentally-ill patient who was not responding to treatment.
Doctors in the islands who attended the sessions, recognized the need for additional training in mental health including psychosocial interventions. Overall, they had not noticed any significant change in the number of patients reporting to their clinics, however, there had been some increase in psychological problems occurring in select groups like school children and internally displaced populations due to overcrowding in temporary shelters.

**Development of curriculum for training psychiatric nurses, community health workers and psychiatric social workers to be taught by the Faculty of Health Sciences**

The consultant reported that the existing curriculum for diploma in general nursing is adequate but implementation needs to be strengthened. At this time, there is only one nurse faculty to cover the entire module and there is insufficient practical exposure of trainee nurses in mental health. The technical material developed by WHO/SEARO on identification and management of generalized tonic clonic seizures which has already been implemented in two regions of the Maldives can become a part of the curriculum for training nurses and community health workers.

**Training of staff and care-givers at the Home for People with Special Needs**

A two-day training workshop was arranged for staff and care-givers in day-to-day clinical problems. Thirty-five trainees participated in the workshop, including one doctor, one staff nurse, auxiliary nurses and care-givers.

Training of nurses and care-givers included information on how to manage problems such as violence, aggression, refusal to accept medicines and how to approach a mute or non-communicative patient. They were trained in the skills of daily living for the aged and mentally challenged patients. They were given practical demonstrations of how to communicate, how to feed, and how to use physical restraints when necessary. They were informed about the principle of token economy to be used for chronic mentally-ill patients in managing difficult behaviours and how positive and negative rewards help in learning socially acceptable behaviours. The importance of having a daily activity schedule for in-patients was emphasized and an outline was suggested for the development of such a programme for the special home.
Training of facilitators in mental health and psychosocial care for tsunami-affected populations

One faculty nurse from the Faculty of Health Sciences and one senior nursing staff from the Indira Gandhi Memorial Hospital were given a two-day briefing about the methods, contents and delivery of basic mental health and psychosocial care modules. They were also provided with the draft Manual for training community health workers. These facilitators will be the resource persons for future training of health workers in mental health as well as for the proposed training courses in psychiatry for health workers to be conducted by the Faculty of Health Sciences.

Observation

Mental health infrastructure in the Maldives needs to be further strengthened. Trained mental health professionals are scarce. If basic mental health care is to be brought within reach of the entire population, this will have to be provided by non-specialized health workers at all levels, from community health workers to nurses or doctors working in close collaboration with, and supported by, more specialized personnel. The efforts already made in this direction should be lauded.

Sri Lanka

There was a paradoxical situation in Sri Lanka after the tsunami. There appeared to be a great shortage of specialized mental health practitioners to meet the “anticipated” need of thousands of people, yet existing mental health services in government health centres was not in demand in the first few weeks after the tsunami. This however changed after people found basic shelter and essentials of every day living and became aware of the need to take care of their psychological distress. The demand for mental health care has continued to rise with outpatient clinics reporting an increase in patients presenting with mental health problems. The tsunami disaster brought into focus the need to develop community mental health services in addition to training existing workers.

Training of Medical Officer Health

Training of Medical Officers Health in Ampara, Kalmunai and Batticaloa was funded by the International Medical Corps (IMC). They recruited a full-time psychiatrist to train 18 Medical Officers Health in these areas in basic mental
health skills and to teach them to train public health workers. It has been jointly developed by IMC, WHO and the Nivahana Society and the General Hospital, Kandy. There is a long-term plan to train Medical Officers Health in all affected districts but this will depend on the availability of funds.

Training and deployment of Medical Officer Mental Health (MOMH)

Initially MoH agreed to recruit and train 100 MOMHs, but this was later scaled down to 20. These are qualified doctors who will be given two weeks of classroom training in Colombo, followed by 3 to 6 months of supervised deployment in clinical services. These MOMHs will be deployed in the tsunami-affected areas. Efforts will be made to send some of these doctors to the north and the east, but difficult working conditions remain a problem. There was a delay in recruiting doctors for this type of training due to a protracted court case. This court case has since been resolved, and recruitment is expected to proceed.

Observation

Recruitment, training and deployment of MOMHs in the north and the east is an urgent issue. Considering the need for fluency in Tamil and the difficult working conditions, finding suitable candidates is a challenge. Innovative solutions will have to be considered.

Training of pre-interns in basic mental health skills

Pre-interns are doctors who have just completed their final MBBS examination, but still need to complete one year of internship to get their degree. MoH is considering recruiting 20 of these doctors for mental health work in tsunami-affected areas.

Deployment of psychiatrists in north and east Sri Lanka

North and east Sri Lanka are among the areas worst affected by the tsunami. It is also extremely underserved by mental health services. It has only three psychiatrists and only one Medical Officer Mental Health to serve a population of approximately three million people in this region. It is almost impossible to attract Tamil-speaking mental health professionals to work in the northern and eastern parts of Sri Lanka. In order to overcome this shortage of psychiatrists, consideration was given to recruiting three Tamil-speaking psychiatrists from overseas to supplement clinical services in areas where there are no psychiatrists.
Deployment of psychiatrists in southern Sri Lanka

Most affected areas in the southern part of Sri Lanka do not have adequate psychiatric services. The College of Psychiatrists of Sri Lanka has been providing these services with their members travelling to the underserved areas from Colombo. Initially these services were provided free of cost but to continue with the programme, some reimbursement for travel and accommodation was considered so that the consultant psychiatrists and other staff could provide clinical services and training of primary care staff.

Training of hospital medical staff in recognizing somatic symptoms

Patients with psychiatric disorders often present themselves at general hospitals with somatic complaints all over the world. Such patients can place a heavy burden on the health care system through disproportionate use of health care resources. This becomes much more common after disasters. Therefore increasing awareness and skills on the detection and management of such cases in general hospitals is needed to reduce the load on clinical services. A representative of the NGO Forum for Research and Development has submitted a proposal to conduct such training in select hospitals and develop IEC material to be placed in all hospitals.
Training of nurses in psychiatric nursing
At present, nurses in Sri Lanka have minimal exposure to psychiatric nursing during their training. There is an urgent need to improve their skills. In addition to basic training for all nurses, the government has also agreed to consider forming a new cadre of psychiatric nurses. A consultant from the UK visited Sri Lanka and assisted in developing a programme to train general nurses in psychiatric nursing skills. He also worked with the Deputy Director General (Workforce and Training) to develop training programmes for nurses working in a new cadre of psychiatric ward nurses. This consultant has also prepared a training programme in problem identification and problem solving skills for primary care nurses and other staff.

Training other mental health professionals
The government has agreed to the appointment of 17 psychologists, 34 psychiatric social workers and 34 psychiatric occupational therapists. There is no training or curriculum for psychologists. The existing social work and occupational therapy courses need improvement. There is an urgent need to develop plans for training psychologists.

Development of rehabilitation services for in-patients in all mental hospitals
None of the psychiatric hospitals has any staff trained in rehabilitation. This training is urgently needed if the plan to rehabilitate and discharge the long-stay patients is to be successful.

Two activities are proposed for capacity building in rehabilitation services:
- Training of 16 nurses and junior medical staff in rehabilitation strategies at the National Institute of Mental Health and Neurosciences, Bangalore, India.
- Developing rehabilitation facilities within the hospitals. This project is currently in progress.

Thailand
Restarting the lives of affected persons
The Thai government took note of the need to provide not only essentials such as food, clothing and medicines, but also to provide permanent housing and a means of livelihood. Entire villages are being reconstructed. The structure
of these centres is such that the original village members can stay together. The houses being built have the original Thai design. In addition, the re-established villages will include places of worship, a special centre for children’s activities and activities for income generation. Fishermen are being provided new boats which are also of the original Thai design. This physical and social support is crucial for the mental well-being of affected persons.
Special programme for children and adolescents

Official government records reveal that there were 928 documented orphans. The success of the Thai programme for children is reflected in the observation that only two orphans had to be placed in a situation where they could not be cared for by relatives. This speaks well of the Thai society and the importance of the extended family which is still the norm in the rural areas which were most affected by the tsunami.
No attempt was made at the central level to develop special programmes for orphaned children, but they are being tracked in a variety of ways so interventions can be made later should that become necessary. “Tracking” is done through family records kept at the local health centre and sub-district health centre which allows for the identification of affected families and individuals for possible intervention by mobile mental health teams.

Thai child psychiatry experts are aware that there are no specific child-focused mental health interventions in the immediate aftermath of the tsunami, although social interventions for children and adolescents are very important. However, a symptom checklist was developed (but not validated in the tsunami setting), that is given to all “affected” children. From the screen, “high risk” children were identified, but as yet there has not been any specific intervention with this group. The group will become part of a follow-up programme which is being developed.

An effort was made to address possible problems among school-age children through the previously established School Advisory Programme which exists in all schools and offers the opportunity for students to share their concerns and for teachers to identify children they are concerned about. Once identified, there is an established protocol for accessing services. In this protocol each child in school has a “school folder” which contains information gained from routine “home-room meetings” that take place everyday in every school for 30 minutes before classes begin. This is now being used to identify high-risk children through spontaneous responses or through teacher enquiry. Almost all schools have a guidance teacher trained by child psychiatrists from the Department of Mental Health who can further identify the problems in children and provide group therapy.

Thus, there are two routes for tsunami-affected children to receive health care services. The first is through the community clinic system and the second through schools. The former can be accessed by those adolescents and very young children who are not in school. To date, through either mechanism, only a few children have been referred for hospital-based care where a child psychiatrist is used for further diagnosis and treatment. It was reported that medication is rarely used with children and that counselling is the method of choice. It has been noted that a formal diagnosis of PTSD is uncommon, but symptoms associated with this disorder are identified.
**Observation**

Thailand is the only country in the Region to have developed a focused programme for tsunami-affected children and adolescents. Perhaps this is because of the availability of child psychiatry mental health professionals and the priority of the Department of Mental Health. The caring Thai society is a good example of community resources which are valuable in times of need. This programme is highly commendable.

**Mental Health Recovery Centre**

Sustainability of the mental health and psychosocial relief efforts in Thailand are being ensured by the establishment of the Mental Health Recovery Centre. This centre is located in the community in Phang-Nga province and staffed by professionals from the Department of Mental Health, including a psychiatrist. The centre has a mobile van so that they can reach out to the community for services and for training programmes.

The objectives of the centre are:

- Coordinating the work in the community of all departments of the Ministry of Public Health.
- Capacity building of the local community e.g., training of health workers.
- Facilitating community mental health work.
- Supporting village health volunteers.

**Transition strategy and long-term plans for mental health and psychosocial services**

**India**

**District Mental Health Programme (DMHP)**

It is anticipated that the initiatives launched during the tsunami relief efforts will link into the ongoing DMHP. The focus of DMHP is to enhance community-based mental health care and to transfer mental health services outside of institutionalized settings. Thus, by training health professionals working in clinics and hospitals within the community, DMHP could encourage movement of treatment away from larger psychiatric hospitals.
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Transition strategy and long-term plans for mental health and psychosocial services

India

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The Government of India has made a budgetary allocation in the 10th Five Year Plan (2002-2007) to be used for:

- Funding 50 districts to implement DMHP.
- Strengthening and modernizing government mental health hospitals, including grants towards construction and repair of existing buildings, purchase of equipment, provision of infrastructure such as water tanks and toilet facilities and purchase of cots and medical equipment.
- Upgrading of every medical college to include a Department of Psychiatry and out-patient facilities that can provide various forms of psychiatric therapy.
- An awareness campaign to increase understanding of the Mental Health Act and provide funds to NGOs for increasing community awareness.
- Enhancing research and training in mental health, including an update of manuals to train doctors and health workers.

**Indonesia**

The Director of Community Mental Health is considering some innovative ideas for developing a community mental health system not only in Aceh, but the whole of Indonesia. He advocates: “Reform the mental health services in Indonesia: start from Aceh.” The momentum generated in Aceh for mental health should be carried forward.

The Head of the Department of Psychiatry at the University of Indonesia agreed that the need for mental health care is high in Aceh, but this may not be the highest priority in other provinces of Indonesia. He suggested that it may be easier to enhance the current medical school curriculum in mental health. The University of Indonesia already has such a curriculum, but not other faculties. He recommended that the first step should be to develop a mental health policy for Indonesia. The training programmes for nurses and GPs being developed should be continued and expanded to other provinces.

With Indonesia’s policy on decentralization, advocacy to provincial and district governments is essential in order to ensure sustainability of the mental health programmes and to keep mental health in the mainstream of health development. At the same time there is a need to develop an information system on mental health to enable evidence-based planning of future programmes.
The Maldives

Building community resilience

The Community Resilience Project is being developed by the American Red Cross, in coordination with the Ministry of Gender, Family Development and Social Security of the Government of the Maldives. This comprehensive programme will provide the community (such as religious groups, women’s groups, teachers and community leaders) with general information on emergencies, specific information about mental health, and build community resources. It aims to develop the skills of community facilitators (there will be one community facilitator per 50 population) to:

- Conduct risk assessment.
- Promote resilience through community recreational activities.
- Facilitate participatory planning for action that enhances the entire community’s well-being.
- Work with diverse groups in the community.

The Community Resilience Project will contribute to the development of a community through:

- Community ‘maps’ with detailed analyses of risks and resources in the community.
- Building a strong sense of community characterized by open relationships between people and good inter-personal communication.
- A plan focused on development of all groups, supported by local systems such as schools, health posts, women’s self-help groups, and religious and local organizations.
- Acknowledging its problems of poverty and conflict as shared rather than individual problems and therefore committing to develop collective responses.
Mental Health and Psychosocial Relief Efforts after the Tsunami in South-East Asia
Mental Health and Psychosocial Relief Efforts after the Tsunami in South-East Asia
This programme is one of the proposed strategies for disaster preparedness. All these community resources will link into the community mental health system.

**Observation**

Considering the fact that in most disasters, the community itself must respond in the most crucial first 6 to 12 hours, community resilience and preparedness is very important. This programme, if successful, will be a good model for other countries.

**Technical Advisory Committee for mental health**

After the meeting of the Forum for Partners in Mental Health, MoH proposed the formation of a technical group to serve as its advisory body for developing the mental health system in the country. An informal group has already been set up to advise MoH on these issues. Currently the committee includes one elected representative (MP), people in decision-making capacity in various ministries, counsellors, community leaders, etc. The formal Terms of Reference (ToR) of this technical body are likely to be developed in the next two months. The ToR will be sent to all ministries for comments before finalization.

**Development of mental health policy**

A mental health policy can set the priorities and guidelines of the national government with appropriate financial commitment to ensure the development and maintenance of the community mental health programme. Such a policy can be revised as more amenities and resources become available. The Forum for Partners in Mental Health and the Technical Advisory Committee recommended that a national policy on psychosocial issues be developed. This recommendation has been accepted and is being implemented by MoH. The Technical Advisory Committee will advise MoH on the process and content of the Mental Health Policy. All individual activities will be combined into a national mental health plan. A coordinator for mental health has already been appointed within MoH.

**Development of mental health legislation**

There is no specific mental health legislation at this time in the Maldives. Mental health laws are included under the general health law and essentially describe the criteria for declaring a mentally ill patient “dangerous”. It does
not address specific needs of patients such as optimum quality of care or ensuring the availability of psychotropic medication.

A WHO consultant has reviewed the Health Act and has strongly recommended that the section relating to mental health be revised and separate mental health legislation be created. This recommendation has been accepted in principle by the Attorney-General’s Office.

Long-term recommendations by the WHO consultant for developing mental health services

After a thorough review of the current status of the mental health scenario in the Maldives, the WHO consultant made the following recommendations:

1. Develop a general hospital psychiatric unit at the Indira Gandhi Memorial Hospital.
2. Develop two community outreach facilities, one in the northern and one in the southern part of the country.
3. Expand mental health facilities in regional and atoll hospitals by training a community psychiatric nurse, backed up by periodic visits by the consultant psychiatrist.
4. Streamline the referral system for patients from the islands to the tertiary care centre in Malé.
5. Provide care for the wandering mentally-ill patients in the community.
6. Ensure the availability of psychotropic medications at the primary care level.
7. Ensure proper record keeping and follow-up of all patients.
8. Implement mental health promotion activities in schools.
9. Continuously educate health staff at all levels in mental health and psychosocial well-being.
10. Train clinical psychologists, psychiatric social workers and occupational therapists, at appropriate centres overseas.
11. Study post-tsunami psychiatric morbidity among internally displaced populations.
12. Develop a mental health policy and plan for the Maldives.
Long-term recommendations of the SEARO mental health team for developing mental health services

To carry forward the work already done by MoH, the SEARO mental health team made the following recommendations:

(1) Nurses from regional hospitals and the Indira Gandhi Memorial Hospital should be trained in psychiatric nursing skills to enhance community-based mental health care.

(2) The training programme developed by the WHO consultant on managing the most common neuropsychiatric conditions should be converted into a self-learning video-based training programme to facilitate training of newly-recruited GPs for island health centres.

(3) A training programme should be conducted for parents and teachers on identification and management of common learning and behavioural problems in schools and at home.

(4) Local capacity for delivery of community-based mental health care (epilepsy as an example) can be enhanced through training of community health workers and nurses.

(5) Long-term plans should be prepared for the development of mental health systems which include development of a mental health policy, legislation and community-based mental health services.

Observation

The tsunami has been instrumental in motivating the Government of the Maldives to give high priority to mental health and psychosocial services. Moreover, such services will be delivered in a coordinated manner in the long-term. The government should be complimented on the well-organized immediate response to the tsunami and the development of clear long-term plans. For a small country like the Maldives, to consider modern mental health legislation reflects the farsightedness of the government. Whether or not these plans will be implemented remains to be seen.

Sri Lanka

Development of a mental health policy for Sri Lanka

Prior to the tsunami, the biggest gap was the lack of mental health resources in the community and there were no immediate plans for resolving the situation.
Both MoH and WHO concluded that development of a National Mental Health Policy was a high priority. A WHO consultant with substantial experience in developing country-specific strategies for mental health worked with a broad range of stakeholders to develop a draft National Mental Health Policy in May 2005. Highlights of the policy include:

- Management of mental health programmes at national and provincial levels.
- Organization of services to meet the needs of the community. Patients in large hospitals will move to a range of new local facilities and all existing staff will be trained.
- Human resource to be developed to cater to a comprehensive network of services.
- Tackling stigma and promoting good mental health.
- Updating mental health legislation in Sri Lanka.

There was extensive consultation on the policy in June and the early part of July 2005. Over 60 organizations and individuals responded. There was significant support for the policy. The final document was agreed upon by the Cabinet in its meeting on 19 October 2005. An Action Plan has been produced showing milestones for the implementation of the new Mental Health Policy.

**Observation**

The tsunami has motivated the government to act on issues which have been pending for a long time. Not only has a final draft of the National Mental Health Policy been prepared, it has been officially accepted. This is a significant positive outcome of the tsunami.

*Developing a revised draft mental health legislation*

The current National Mental Health Legislation dating back to 1873, was based on the British Lunacy Act. It was partly revised in 1956. This was an era when people with mental disorders were incarcerated in large institutions, which promoted stigmatization, discrimination, isolation and ostracism.

Efforts have been underway to completely revise this legislation since the mid-1970s. At the request of the MoH and DGHS, a consultant was recruited
after the tsunami to assist in redrafting the legislation. The WHO consultant worked with the parliamentary draftsperson, the College of Psychiatrists and the National Mental Health Planning Committee and prepared a new draft Mental Health Legislation, which will protect and promote the rights, needs and interests of people with mental disorders and tackle the stigma and discrimination they experience.

Discussions on the new draft are currently being held with the Human Rights Commission, the police authority, the magistrates, judges associations and Child Protection Authority. After adequate debate and discussion, a final draft of the Mental Health Legislation will be prepared by the parliamentary draftsperson and submitted to Parliament.

Rehabilitation programmes for long-stay psychiatric patients in mental hospitals in Colombo

There are three long-stay hospitals in Colombo serving the whole of Sri Lanka. There are approximately 3 000 patients in these hospitals of which about 1 700 are long-stay patients. It is believed that up to 90% of these patients can be discharged from the hospital if they are provided continuing care in their community. Thus, there is an urgent need to rehabilitate patients in the hospitals and prepare them to return to their communities. At the same time, community
services need to be developed to support the discharged patients. As a first step, it was decided to undertake a comprehensive assessment of every patient to document their current status, abilities, support needs on discharge and risk factors for continued hospitalization. This project is currently in progress.

**Developing strategic alliances for re-building infrastructure, training and service development**

Several donors have expressed an interest in supporting mental health and psychosocial activities in Sri Lanka specifically related to the tsunami. Donors have expressed their priorities. Some donors who have expressed interest are:

- **Government of Finland**: Developing mental health services in one or two districts in the north and one other district probably in the south.
- **Spain**: MDM, an international NGO, is building an acute inpatient ward in Trincomalee and appointing a community outreach team. They are considering a similar scheme in one other district.
- **Australia**: Victoria State has allocated Aus$ 4 million for health care development, including mental health, in the southern province.
- **Ireland**: The Government of Ireland is interested in supporting community-based mental health activities (as described under community level action). They have already funded this project for 2006.
- **World Bank** has allocated US$ 2 million to the government to reduce suicide.

**Observation**

Sri Lanka collectively achieved some strategically important steps such as developing the agenda for mental health as opposed to psychiatry and bringing the public health perspective and multi-disciplinary perspective to the fore and translating policy into practice. The repositioning of the overall agenda in the right direction was a major achievement.

**Thailand**

The Thai response to the tsunami is the model of an ideal response to a massive disaster. SEARO proposes to conduct an intercountry workshop in Khao Lak (the most affected province) to enable other Member Countries to share experiences and to study the Thai response as a learning experience for their own disaster preparedness.
**Mental Health Steering Committee in the community**

Each affected provincial authority in Thailand has set up a long-term Mental Health Steering Committee consisting of both provincial and community leaders. Technical support will be provided by the Department of Mental Health. This committee has established guidelines for long-term mental health work in the community. These include:

- The community should not be re-traumatized.
- There should be a clear gain to the community.
- The programme should link into existing infrastructure.
- There should be community ownership.

**Long-term plans for children and adolescents**

The mobilization for the tsunami has given child and adolescent mental health added prominence and will result in the development of further diagnostic and treatment services. Child psychiatrists are relatively scarce in the South-East Asia Region, but are present in far greater numbers in Thailand.

The long-term plan is to refer those children identified as “high risk” to be seen by child psychiatrists for further evaluation. Until the need arises for referral to the child psychiatrist, the child or adolescent may receive some form of counselling (possibly group counselling) at the community level or in school. This cohort of “at risk” children will be evaluated at three months, six months, one year and two year intervals.

**Observation**

The tsunami will lead to the development and implementation of an enhanced child mental health training programme from the community clinic level of care to the community volunteer level and vice versa. This training is already being implemented. The entire programme will be backed by mental health experts. This model can be studied by other SEAR Member Countries.
Lessons learnt

The strengths of the Thai response to the tsunami were:

- A well-established chain of command including at the political, bureaucratic, technical levels.
- A well-developed existing health and mental health care delivery system which could be rapidly scaled up to meet the needs of the disaster.
- A comprehensive data and information gathering system which is optimally used by decision-makers.
- The ability of the mental health system to reach each and every village through its network of mobile teams and health volunteers.
- Participation of many other partners (teachers, monks etc.) who can supplement the efforts of the health team.
Evaluation of Mental Health and Psychosocial Relief Efforts

National Workshops on “Current status and future preparedness in mental health and psychosocial aspects in disasters”

The Mental Health Unit of SEARO developed a proposal to conduct national workshops in select disaster-affected countries. Two issues were considered important at the stage of about 10 months after the disaster:

1. To carefully study the mental health and psychological impact of the disaster on the community, the response at every level and the impact of the rehabilitation efforts in progress.

2. Based on the experiences in the existing disaster within and between affected countries, develop a plan for disaster preparedness for any future disasters. The plan will necessarily vary from country to country and depend on the type of disaster.
Rationale for national workshops

It has been observed that international workshops may not permit the participation of large numbers of people from different strata within the country who were affected by the tsunami. Also, representatives are sometimes reluctant to be critical about their own country in large international gatherings.

Thus, country-specific workshops have been proposed where representatives of the affected communities, NGOs, professional organizations and policy-makers will be invited to present their experiences.

Based on these experiences a plan for mobilization in any future disasters will be prepared.

Core themes of the workshops

Observations from the current tsunami suggest that there were several controversial issues in mental health and psychosocial relief efforts. Psychosocial relief was sometimes provided by a wide range of NGOs some of which did not speak the local language nor did they understand the local culture. There was virtually no coordination between these multiple agencies. Sometimes even the need for psychosocial support and the mode of its implementation was a matter of disagreement. On the other hand, some affected countries launched an excellent well-coordinated psychosocial support programme. This raises an important question for the future: **What is psychosocial relief and how should it be administered?** Similarly the limited back-up community-based mental health support was very apparent in most affected communities. But much to everyone’s amazement, even existing mental health services were not optimally utilized. This clearly points to a lack of linkage between community-based services and back-up mental health services. This raises the second important question for the future: **What should be the framework of community mental health systems?**

Objectives of the workshops

1. Study the impact of ongoing mental health and psychosocial rehabilitation efforts.
2. Determine if any midcourse correction is needed.
3. Develop plans for disaster preparedness for mental health and psychosocial aspects in future disasters.
Structure of the workshops

In order to learn from the experiences of the current tsunami, the following segments of the community will be invited to present their experiences and make recommendations for the future:

- Affected community members.
- Community leaders from affected areas.
- NGOs who provided relief efforts.
- Professional organizations.
- Representatives of local, state and central administration (health, social welfare and other sectors involved in tsunami relief operations).
- UN Agencies.
- WHO/SEARO and country office.

During the first two days, members from each of the above categories will be invited to present their views using case studies as examples. On the third day, all participants will participate in group discussions to prepare a plan for mental health and psychosocial support for future disasters.

A national workshop has already been conducted in the Maldives. There is a proposal to conduct such workshops in Tamil Nadu, India in January 2006 and in Sri Lanka in February 2006.

National workshop on “Current status and future preparedness in mental health and psychosocial aspects in disasters”, Malé, the Maldives, 14 to 15 September 2005

The meeting was inaugurated by the Deputy Minister of Health of the Maldives, Dr Abdul Azeez Yoosuf, who welcomed the participants and provided some background information on the mental health and psychosocial programme in the Maldives. The WHO Representative to the Maldives, Dr Jorge Luna, complimented the Government of the Maldives for its foresight and vision in recognizing the importance of psychosocial support to the tsunami-affected communities. He mentioned that the Maldives was the first country to hold such a national workshop.
The workshop was attended by representatives from:

- Ministry of Health: Emergency Psychosocial Support Response Team and Department of Public Health.
- Ministry of Education: Educational Development Centre.
- Ministry of Youth and Sports: Youth Counselling Services.
- Ministry of Gender, Family Development and Social Services.
- Indira Gandhi Memorial Hospital.
- UNICEF.
- UNFPA.
- American Red Cross.
- Community representatives.
- National NGOs: Care Society and Society for Health Education.
- Representatives from WHO the Maldives country office and WHO/SEARO.
- External consultant Dr Dinesh Bhugra, Professor of Mental Health and Cultural Diversity, Institute of Psychiatry, London, UK and Dean, The Royal College of Psychiatrists, UK.

Each organization participating in the workshop made a brief presentation of its activities in mental health and psychosocial issues related to the tsunami. The activities of all the organizations have been summarized in this document under appropriate sections. WHO/SEARO made a presentation on such activities in the other tsunami-affected countries. The need for having a plan for mental health and psychosocial aspects of disaster preparedness was emphasized. The Emergency and Humanitarian Action Unit of SEARO made two presentations on strategies for disaster preparedness, stressing the need to have these plans prepared in advance and periodic practice drills to be conducted and the ongoing work of the Government of the Maldives to prepare plans for future disasters includes policy, contingency plan, standard operating procedures, simulation trainings, development of awareness and research. It was emphasized that emergency preparedness plans are essential to minimize mortality and morbidity, have an effective response and to minimize the adverse impact of disasters.
The next item on the agenda was a detailed discussion of issues relevant to mental health and psychosocial aspects of disaster preparedness, concluding with recommendations as summarized in the next section of this document.

The Deputy Minister of Health, Dr Abdul Azeez Yoosuf, attended the closing ceremony in which the recommendations of the workshop were presented. In conclusion, he remarked that the Maldives had never faced a disaster of the magnitude of the tsunami. Although the government response may not have been perfect considering the limited local expertise available, substantial amount of physical and psychosocial support was provided to the community, many lessons were learnt and a disaster preparedness plan for mental health and psychosocial support was under preparation. The proceedings of the workshop will contribute to the development of this plan.
Impact evaluation in the Maldives

Section 1: Assessment based on information to be obtained from government departments

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

Assess WHO’s role for each question if appropriate.

<table>
<thead>
<tr>
<th>Activity to be assessed</th>
<th>Pre-tsunami</th>
<th>Post-tsunami</th>
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</table>
| What was the relative priority assigned to MHPS issues compared to other major programme areas? | Specific neuropsychiatric issues have been given priority by the Government of the Maldives in the past, but there was no overall plan:  
  ▪ Survey of prevalence of epilepsy and mental disorders in 1989 in 5 northern atolls.  
  ▪ A national registry that covers mental disorders is maintained at the Ministry of Gender, Family Development and Social Security. Patients once registered with this ministry are entitled to free medication.  
  ▪ There is one Home for People with Special Needs at Guraidhoo housing approximately 120 patients.  
  ▪ The Rapid Situation Assessment of drug abuse in the Maldives has shown that nearly 20% of drug users reported their primary reason for drug abuse was psychological problems.  
  ▪ A recent survey was carried out in 2004 by the Ministry. Based on this survey government gave priority to epilepsy. Training of community health workers and nurses has been conducted for epilepsy. | After the tsunami MHPS issues have received high priority from the government.  
  **Emergency Response**  
  ▪ The National Disaster Management Centre was established with a Psychosocial Unit in it.  
  ▪ The government launched a well-organized community-based campaign to provide psychosocial support to disaster-affected persons.  
  ▪ Emotional Support Brigades were established in each affected island. Through this outreach programme, all affected islands have been reached, and every affected person has been provided at least some emotional and psychological support.  
  **Building a community mental health system**  
  ▪ MoH requested a consultant to be sent by WHO. He spent three months and conducted workshops all over the country for health workers, nurses and physicians. These personnel will support community-based services. |
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<thead>
<tr>
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<tbody>
<tr>
<td>Community-based rehabilitation of the intellectually impaired has not been a government programme but an NGO (Care Society) does training and service delivery.</td>
<td></td>
<td><strong>Forum for Partners in Mental Health</strong>&lt;br&gt;This forum is a major initiative of the Government of the Maldives. It brought together all stakeholders working in the field of mental health. Two of the important recommendations of the forum were:&lt;br&gt;- A key agency be identified at the national level to coordinate the wide range of mental health related activities.&lt;br&gt;- Develop a national policy on psychosocial issues. <strong>Advisory Committee for MHPS issues</strong>&lt;br&gt;MoH has proposed the formation of a technical group to serve as an advisory body on the development of a mental health system in the country.</td>
</tr>
<tr>
<td>Learning and behavioural problems in children was identified as a priority area and WHO/SEARO was requested to develop technical material and send a consultant for training parents and teachers.</td>
<td></td>
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</tr>
</tbody>
</table>

<p>| Does the country have a national mental health policy? If yes, how was it developed? | No                                                                                                                                                                                                          | Based on the recommendations of the Forum for Partners in Mental Health and the Advisory Committee, MoH has initiated the process to develop a mental health policy.                                                   |
| Does the country have a national mental health programme? If yes, how was it developed? | No                                                                                                                                                                                                          | All individual activities will be combined into a national mental health plan. A coordinator for mental health has been appointed in the MoH.                                                                 |
| What MHPS services are available at the PHC level and what is the basis of development of these services? | Training of health workers and nurses for identification and management of epilepsy had been done at two regional hospitals.                                                                             | General practitioners, nurses and health workers have been trained in a wide range of mental health issues in all the regions by the WHO consultant.                                                                 |</p>
<table>
<thead>
<tr>
<th>Activity to be assessed</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Is a regular budget allocated for providing MHPS services? Define the allocation.</td>
<td>No</td>
<td>Based on the recommendations of the mental health policy a regular budget may be allocated next year.</td>
</tr>
<tr>
<td>Are there established training programmes on MHPS issues for different cadres of health care providers?</td>
<td>None</td>
<td>▪ A video-based training programme for GPs, health workers and nurses is proposed. This will enable the government to train new staff with minimal expense. ▪ The Faculty of Health Sciences proposes to introduce teaching of essential mental health services in its curriculum for health workers and nurses.</td>
</tr>
<tr>
<td>Are common psychotropic medications (anti-psychotics, anxiolytics, anti-epileptics) regularly available at the regional, atoll and island level health care facilities? If yes, are they free?</td>
<td>There is no clear policy on availability of psychotropic medications at regional, atoll and island levels. Patients once registered with Ministry of Gender, Family Development and Social Services are entitled to free medications. Many psychotropic medications are available at private chemist shops.</td>
<td>The mental health policy, which will be drafted, will include a section on availability of psychotropic medications even at island health centres.</td>
</tr>
<tr>
<td>Is there a clear chain of command for decision-making and coordination of MHPS services?</td>
<td>Not before the tsunami.</td>
<td>To be clarified in the National Mental Health Programme which will be developed.</td>
</tr>
<tr>
<td>Does the government have a long-term plan for MHPS services?</td>
<td>None prior to tsunami.</td>
<td>There is active interest in developing all aspects of MHPS services in the long-term including legislation, policy, programmes and services.</td>
</tr>
<tr>
<td>Is there any mental health legislation in the country?</td>
<td>None prior to tsunami, but there is one section in the Health Act on mentally ill persons which needs substantial revision.</td>
<td>WHO consultant has reviewed the Health Act and has strongly recommended that the section on mental health be revised and separate mental health legislation created. This recommendation has been accepted in principle by the Attorney-General's Office.</td>
</tr>
</tbody>
</table>
**Conclusion:** The tsunami has been instrumental in motivating the Government of the Maldives to give high priority to MHPS services. Moreover, such services will be delivered in a coordinated manner in the long-term. The government should be complimented on the well-organized immediate response to the tsunami and development of clear plans for the long-term. For a small country such as the Maldives to consider modern mental health legislation reflects the farsightedness of the government.

**WHO’s role** in providing technical support for training of all levels of health care providers has been greatly appreciated. An official of MoH commented that this support will be sustainable in the long-term and assist the government in developing a comprehensive plan. A WHO consultant has been involved in the meeting of the Mental Health Forum and providing input to the formation of the Advisory Committee.
**Section 2:** Assessment based on information to be obtained from government departments

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

Assess WHO’s role for each question if appropriate.

<table>
<thead>
<tr>
<th>Item to be assessed</th>
<th>Response</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was a disaster preparedness plan of action for the health sector in place?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If yes, what was its MHPS component?</td>
<td>N.A.</td>
<td></td>
</tr>
<tr>
<td>If yes, was the plan implemented as designed? Please specify the experience with its implementation.</td>
<td>N.A.</td>
<td></td>
</tr>
<tr>
<td>If no, was a new plan of action for the health sector prepared after the tsunami?</td>
<td>A national disaster preparedness plan is under development.</td>
<td>Under development with the assistance of a WHO consultant.</td>
</tr>
<tr>
<td>Does the new plan have an MHPS component?</td>
<td>The new plan will have an MHPS component.</td>
<td>The disaster health plan will include a MHPS component. A national workshop for disaster preparedness on MHPS was held in September 2005. Recommendations were made for MHPS component. WHO/SEARO facilitated the workshop. The Deputy Health Minister of Maldives attended the workshop and provided input to the recommendations.</td>
</tr>
<tr>
<td>Was the new plan implemented as designed? Please specify the experience with its implementation.</td>
<td>N.A</td>
<td>There was no new plan, but MHPS activities were implemented in a well-coordinated manner.</td>
</tr>
</tbody>
</table>
Conclusion: The government assigned high priority to MHPS activities after the tsunami. Emergency response was appropriate and well implemented and long-term plans for mental health aspects of disaster preparedness have been initiated.

The national workshop (facilitated by WHO) made a significant contribution to the planning process. The Maldives is the first country to conduct a national level workshop in which different ministries, UN agencies, NGOs and affected community members participated. Every person and agency had the opportunity to present its views in an open and cordial manner. Significant conclusions emerged which will be of great help to the country in long-term planning for MHPS services.
Section 3: Assessment based on information obtained from multiple sources and review of documents

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

Assess WHO’s role for each question if appropriate.

<table>
<thead>
<tr>
<th>Item to be assessed</th>
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<th>Comments</th>
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</thead>
</table>
| Role of community-based health care providers for MHPS services                     | ▪ Training programmes for counsellors (two-day session in Malé).  
▪ Training programmes for Emotional Support Brigade in each island (one training session in each affected island).  
▪ Training programme for all levels of health staff (health workers, nurses, GPs; 8 workshops covering all regions). | Training programme facilitated by many agencies (American Red Cross, UNICEF, UNFPA etc.).  
WHO consultant conducted training of all health staff.                                                                                                                                                  |
| 1. How many training programmes were conducted and for which categories of health workers? | 70 counsellors from within the Maldives were trained for psychosocial support. All trainees were local Maldivians, many were previously trained counsellors working in different agencies, everyone was requested to volunteer for the relief efforts.  
CLWs/nurses from all regions were trained in the identification and care of common mental health problems.  
GPs from all regions have been trained to provide basic mental health services. | Using local staff who speak the language and are familiar with the culture is a very important prerequisite for effective psychosocial relief efforts.                                                          |
| 2. How many health care providers were trained and how were they identified?         |                                                                                                                                                                                                           |                                                                                                                                                                                                         |
Conclusion: The psychological first aid provided by CLWs during the emergency phase was exceptionally good. Every person in every affected island was reached. Back-up mental health services have now been created in all regional, atoll and island health centres. The community level work and clinical services are closely linked.
### Section 4: Assessment based on information obtained from technical focal points

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

Assess WHO’s role for each question if appropriate.

<table>
<thead>
<tr>
<th>Item to be assessed</th>
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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial assessment qualitative/quantitative</td>
<td>Multiple assessments were carried out by different agencies (UNICEF, Care Society, IFRC, Save the Children, Ministry of Planning, Ministry of Gender, Family Development and Social Services). Ministry of Planning as part of the Tsunami Impact Assessment (Psychosocial and Reproductive Health module) has conducted a survey – results pending.</td>
<td>Essentially each agency was trying to assess the field situation in terms of its own mandate. The surveys used different methods in sample selection and study design (quantitative and qualitative measures). People working with the relief efforts point out that these surveys often duplicated information. Also, the lack of normative data made interpretation of the findings difficult. Data analysis for the Ministry of Planning survey is complicated and special expertise will be needed. WHO has offered to help.</td>
</tr>
</tbody>
</table>
| GHQ scores/other instruments used               | Initial mean score: ____  
Date: _____ NA                                                                 | Initial not used. But now being implemented by an NGO in some affected islands. WHO has provided support for data analysis. |
|                                                | IlInd mean score: ____  
Date: _____ NA                                                                 | \                            |
|                                                | IlIrd mean score: ____  
Date: _____ NA                                                                 | \                            |
| Was it validated                               | GHQ12 was validated for use in the Maldives with WHO support.            | \                            |
| Experience with its use                        | Remains to be seen.                                                     | \                            |
Additional Comments:
Not having quantitative community-based data on the magnitude of psychosocial distress and mental health needs limits assessment of the impact of psychosocial relief efforts.

Conclusion:
- A clear plan should be in place to determine which instruments for assessment of psychosocial distress will be used, when and by whom.
- Validated quantitative questionnaires for needs assessment and mental health status of the affected population should be readily available to all partners.
- Technical support needed for data analysis and interpretation should be identified.
Section 5: Assessment based on information obtained from community leaders

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

Assess WHO’s role for each question if appropriate.

<table>
<thead>
<tr>
<th>Item to be assessed</th>
<th>Response</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are displaced families now back home? How soon after the disaster did they return?</td>
<td>Immediately after the disaster the affected people lived in houses of people who were not affected. Temporary shelters were constructed by the government within one month and they shifted to these shelters.</td>
<td>One of the main concerns voiced by IDPs is to get a permanent shelter/home.</td>
</tr>
<tr>
<td>Have families returned to their normal way life? How soon did this happen?</td>
<td>In the most affected islands people have not yet fully returned to normal life as they are still living in temporary shelters. Houses are being built for them. Women started doing their daily household chores as soon as they were given their own place to live.</td>
<td></td>
</tr>
<tr>
<td>Have people returned to their occupations? How soon did this happen?</td>
<td>Farm land has been given to people of the affected islands in their new island of residence. Some were employed by fisherman from the community of non-affected islands. Some have their own boats which had not been damaged, so they started fishing soon.</td>
<td>Most people want to resume their means of livelihood. However, some people appear to be happy just receiving aid for as long as possible.</td>
</tr>
<tr>
<td>Have children returned to school? How soon did this happen?</td>
<td>Most children returned to school on the first day of school in the new island they had been shifted to.</td>
<td>This is a particularly vulnerable group which still has signs of psychosocial distress. Resuming normal school activities and helping the entire family settle down will greatly help the children.</td>
</tr>
<tr>
<td>Item to be assessed</td>
<td>Response</td>
<td>Comments</td>
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</tr>
<tr>
<td>Did the community get psychosocial support?</td>
<td>Psychosocial support was provided very soon after the disaster when the Emotional Support Brigades were established in each island.</td>
<td>Almost immediately after the disaster the Psychosocial Unit was established by the government. This unit recruited 70 counsellors who were trained by the American Red Cross in psychological first aid and immediately went to each affected island. This outreach programme is highly commendable. WHO consultant has trained health workers and nurses based in government health facilities in providing mental health and psychosocial support to affected communities.</td>
</tr>
<tr>
<td>When</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What type</td>
<td>Psychological first aid, counselling and assistance in returning to normal way of life.</td>
<td></td>
</tr>
<tr>
<td>By whom</td>
<td>By members of the Emotional Support Brigade.</td>
<td>WHO consultant has trained health workers and nurses based in government health facilities in providing mental health and psychosocial support to affected communities.</td>
</tr>
<tr>
<td>How often</td>
<td>As often as needed since the Emotional Support Brigade was from within the local community and always present.</td>
<td></td>
</tr>
<tr>
<td>Was the community satisfied with the psychosocial support provided?</td>
<td>The community members were satisfied, but most expressed the desire to return to a permanent house as soon as possible.</td>
<td></td>
</tr>
<tr>
<td>Did the community get mental health support?</td>
<td>Soon after the tsunami.</td>
<td>Based on information provided by the atoll hospital doctor, some patients did come to him with anxiety and depressive symptoms.</td>
</tr>
<tr>
<td>When</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What type</td>
<td>Prescriptions were provided by atoll hospital doctors but medicines had to be purchased from the private chemist shop.</td>
<td></td>
</tr>
<tr>
<td>By whom</td>
<td>By GPs in the island health centre.</td>
<td>Immediately after the tsunami GPs posted at the island health centres, many of whom have minimal exposure to mental health, were treating patients with all kinds of mental health problems. After the tsunami, all GPs have received training by a WHO consultant on treatment of common mental disorders and should be better prepared to handle the needs of patients.</td>
</tr>
</tbody>
</table>
### Conclusion:
The community outreach programme through which psychosocial support was provided to every person is highly commendable. Also, this psychosocial support was provided by local Maldivians who were appropriately trained. The initial limitation was lack of awareness of mental health issues among GPs and non-availability of psychotropic medications. GP training has now been completed, but because of the high turnover, new GPs will again need training. A proposal has been made to prepare video-based training for new GPs. If accepted, this will provide the training at minimal cost. Availability of psychotropic medications in the long-term remains to be considered by the government. Providing appropriate information to the community was a plus point of the programme.

<table>
<thead>
<tr>
<th>Item to be assessed</th>
<th>Response</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often</td>
<td>Patients in need usually went to see the doctor once.</td>
<td></td>
</tr>
<tr>
<td>Is the community satisfied with the mental health support provided?</td>
<td>Most patients were not fully satisfied as no psychotropic medications are available in the health centre.</td>
<td></td>
</tr>
<tr>
<td>Were adequate amount of psychotropic medication available in the clinic?</td>
<td>Psychotropic medications are not routinely available at island health facilities.</td>
<td>The government is now aware of this issue, and availability of psychotropic medications will be included in the mental health plan being developed.</td>
</tr>
<tr>
<td>Did the community get adequate and appropriate information from the media?</td>
<td>Reliable, timely and frequent information was provided by senior government officials on television and radio. Most people greatly appreciated this information as it reassured them.</td>
<td>Many people have pointed to the need for reliable information to be made available in times of emergencies, specifically what services are available and where these services can be obtained.</td>
</tr>
</tbody>
</table>
Recommendations for mental health and psychosocial aspects of disaster preparedness (based on the national workshop in the Maldives)

(1) A national disaster preparedness plan should be developed. Mental health and psychosocial aspects of a disaster should be included in the plan.

Observation

- Mental health and psychosocial programmes should be integrated into disaster preparedness and contingency plans.
- Training workshops and periodic drills to implement the disaster preparedness plan should be considered.
- All stakeholders and resources for mental health and psychosocial support should be identified and listed.
(2) One ministry should be designated the lead ministry for mental health and psychosocial aspects in any future disaster. Suggested ministry is the Ministry of Health.

Observation

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

(3) Coordination mechanisms and responsibilities between ministries at the ministerial level with a clear chain of command and responsibility for mental health and psychosocial aspects should be in place.

Observation

- The lead ministry should be responsible for developing a plan and determining coordination mechanisms and responsibilities in consultation with other relevant stakeholders at a senior level with a clear chain of command and responsibility for mental health and psychosocial emergency response.

(4) Technical material (such as training material for community level workers, survey instruments to be used, guidelines for NGOs, guidelines for the media etc.) should be validated for use in countries and be readily available.

Observation

- Availability and dissemination of the following guidelines or manuals on clinical/psychological interventions should be ensured:
  - for mental health professionals.
  - for general health staff (doctors, nurses, community level health workers, etc.).
  - for human resources outside the formal health sector (e.g. teachers, religious leaders, volunteers).
- Information documents for the media and general public on mental health/psychosocial problems, coping, sources for social support, and available care should be widely available.
- Plans on specific problems like organization of family tracing and reunification, preventing child abuse, gender-based violence during and after disaster should be available.
Guidelines for care of children who are a particularly vulnerable group should be available.

Widows and the elderly may experience disproportionate stress due to loss of support systems, and their care should be given attention.

Availability of ethical guidelines for post-disaster research should be ensured.

(5) A plan for assessment of psychosocial distress in the community should be in place.

Observation

- A clear plan should be in place to determine which instruments will be used, when and by whom in case of future disasters.
- Instruments to be used in assessment must be culturally appropriate and locally validated.
- Qualitative information on mental health and psychosocial aspects, resources and ways of coping should be collected on a regular basis and linked to quantitative assessments.
- Validated quantitative questionnaires for needs assessment and mental health status of the affected population should be readily available to all partners.
- Rapid assessments (if done) should be interpreted carefully within the social and cultural context of the event.

(6) The roles and responsibilities of community level workers in times of disasters should be clearly defined.

Observation

- Manuals and guidelines for training CLWs should be translated and adapted to the local culture. As far as possible, one set of manuals dealing with overall psychosocial support activities should be prepared. To this each agency can add a section of specific interest to them such as children’s programmes, women’s programmes etc.
- The lead ministry should be responsible for coordinating activities such as framing of standard curriculum for their training, deployment, supervision and monitoring.
- Support by mental health professionals for persons identified by CLWs needing specialized care should be available.
- Organizational policies should be developed for the prevention and management of stress in all relief workers including CLWs.
- The role of external international organizations, particularly INGOs, should be carefully considered and their activities monitored.

(7) Communication equipment should be installed/upgraded regularly.

**Observation**
- Modern communication equipment should be installed/upgraded regularly.
- Use of modern technologies such as e-mail, web-cam, wireless and satellite communication at regional, atoll and island levels should be made available.
- Similar communication problems as observed in the Maldives, can arise in mountainous or remote areas in other countries.

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

**Observation**
- Reliable public information should be provided by senior officials. This can help to reassure the public and avoid rumours.

(9) Efforts in empowering the community to launch the first response to a disaster and developing community resilience, coping skills and promoting community relationships and harmony should be encouraged.

**Observation**
- The experience of the Maldives island-level response and the warm reception by the host community points to the need for developing community resilience, coping skills and promoting community relationships and harmony.
- Considering the fact that in most disasters, the community itself must respond in the most crucial first 6 to 12 hours, community resilience and preparedness is crucial.
A well-developed community mental health system is the best form of disaster preparedness. This can serve the needs of the community now and can be readily mobilized during a disaster.

Observation

- A quick and appropriate response to a disaster depends on an existing policy structure and system.
- The best form of disaster preparedness in mental health and psychosocial needs is to have a strong community mental health system in place to which additions in terms of personnel, skills and resources can be mobilized rapidly should the need arise.
- All aspects of mental health and psychosocial services should be developed in the long-term including:
  - Development of mental health legislation.
  - Development of mental health policy.
  - Development of community mental health services.
  - Enhancing the administrative structure for mental health in the country.
Lessons learnt from Thailand for mental health and psychosocial aspects of disaster preparedness

Thailand’s excellent response to the tsunami is based on a well-developed data and information collection system which obtains data from every village and an established health care delivery system which can easily be mobilized and scaled up to meet any disaster. The health care delivery system is supported by five additional support networks which supplement the system. These include:

- Health volunteers are located within the community in each village. Besides providing basic services to the community, they provide valuable information from the community, which gradually feeds into the central data monitoring system.

- Health workers based in the Community Health Centre supplement the work of village health volunteers in the community. They also reach each and every village.

- Teachers and education system can be rapidly mobilized to supplement any health or public health programme. There is a well-developed School Advisory Programme functioning in all schools which provides an opportunity for children to seek help and for teachers to identify children who may be in need of psychosocial support.

- Buddhist monks and religion play an important role in Thai society. Temple land is used for many social activities of benefit to the community. Monks play an important role in providing solace to grieved persons. There is already a precedence of monks running a community mental health programme where there is no stigma towards patients and where there is a very high level of compliance with treatment.

- Mass media maintains a social responsibility, for example, when the needs of the community changed after a few days of the disaster, the mass media relayed this information to the outside world, based on which relief supplies were reoriented.

Since managing disasters is clearly multisectoral, all willing partners should join to plan together for future disaster preparedness. The Thai experience is the finest demonstration of an organized response of the health sector in meeting the needs of the affected communities.
The tsunami of 26 December 2004 affected six countries of the South-East Asia Region simultaneously. The number of people affected in terms of death, injured, missing or displaced was overwhelming. As the apex international agency for public health, WHO, along with many partner agencies, responded to the disaster which was the worst in recent history. To support governments, WHO launched coordinated activities at all three levels including headquarters, the regional office and country offices.

Following the tragedy, WHO was requested by Member Countries to support ministries of health in affected countries to restore health services. Mental health and psychosocial support were among the top priorities. Each and every person in the disaster struck areas was, to some extent, psychologically affected. In terms of numbers, therefore, the magnitude of the problem of psychological trauma in the disaster-affected population could be said to be as large as the size of the population.
It was recognized that any neglect of psychosocial support could impair efforts at physical rehabilitation. Providing psychosocial support to communities affected by the tsunami was a key component of WHO’s short, medium and long-term strategy. Such support was crucial, but to be effective, the support had to be appropriate and culturally sensitive. It was also important not to ‘medicalise’ the problem, that is, to prescribe a pill when sympathetic listening and kind words of support would suffice.
The immediate need after the tsunami was to reach out to all those who had been affected. Appropriately trained community level workers who understood the local culture were used effectively to provide psychosocial support. In this context, the role of INGOs has raised some questions, particularly the issue of coordination among these agencies.

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

The tsunami brought into focus many issues related to mental health which have been pending for a long time, such as the lack of appropriate mental health policy. A nationally accepted mental health policy sets the guidelines for mental health programmes. Indonesia and the Maldives have initiated the process of developing a mental health policy. A new mental health policy has already been accepted by the Cabinet in Sri Lanka.

The experience of dealing with the tsunami brought out the fact that disaster preparedness plans to meet the mental health and psychosocial needs of the community were extremely limited. Every country, affected or unaffected by the tsunami, should prepare a detailed plan to meet any situation which may arise in future disasters. Mental health and psychosocial relief efforts should be an integral part of disaster preparedness plans. The best form of disaster preparedness is to have a strong community mental health system in place which can be rapidly scaled up to meet the needs of the community in case of disasters.
This document has been produced through collaborative efforts between focal points in WHO offices of tsunami-affected countries and Department of Noncommunicable Diseases and Mental Health, WHO Regional Office for South-East Asia.

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Mental Health and Psychosocial Relief Efforts after the Tsunami in South-East Asia