NATIONAL PLAN OF ACTION FOR MENTAL HEALTH AND PSYCHOSOCIAL RELIEF OF EARTHQUAKE SURVIVORS- EMERGENCY PHASE

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INTRODUCTION

Importance of Mental Health and Psychosocial Care for the Survivors of Disasters:

On Saturday, October 8, 2005, a massive earthquake of 7.6 on Richter scale struck Azad Jammu and Kashmir and parts of the North Western Frontier Province of Pakistan. The estimates were of over 73,000 dead and more than 75000 severely injured. There were in excess of 2 million homeless and 4 million populations affected by the earthquake in one way or the other. This has been one of the biggest disasters in Pakistan for over 100 years.

It is well known that following any disaster, survivors experience a number of emotional reactions. This is the result of the bodily changes that occur as a response to going through the disaster as well as the psychological reaction to the losses experienced by the individuals.

The emotional reactions are mild during the initial period and affect almost all of the population. However about 20% experience sustained emotional reactions and these can become a serious handicap during the recovery and rehabilitation phases.(World Health Report, 2001).

The main approach in dealing with the psychosocial fallout of disasters is by meeting the emotional needs through strengthening the personal / family and community coping skills and by emphasizing the "normalcy" of the emotional reactions. This can be done through sharing of skills, sharing of thoughts and feelings, listening to each other, relaxation and use of spiritual beliefs and practices. The second approach is to integrate emotional support, and psychosocial care, in all health contacts, through training of the health workers and doctors. The third measure is to rebuild the psychiatric services for treatment of those with pre-existing mental illnesses and those with severe emotional reactions to the earthquake.

It was against this background of the recent earthquake and the recognition of the need for mental health/psychosocial care of the survivors, that the National Plan of action was developed to meet the needs of the survivors. There are two components to the Plan. The first part reviews and presents the broader framework for disaster mental health care and the second part presents an action plan. Indeed the plan was a dynamic and a flexible document and evolved in the light of the experiences gained. The Plan was able to accommodate the administrative as well as the socio-cultural variables.

PART I

Review of Literature and Mental Health Interventions in Disasters:

Although there are no reliable data on numbers of people with mental health and psychosocial problems in the earth quake affected districts, the following rule-of-thumb estimates give context to the likely size of the problem. These rates vary with setting (e.g. involving socio-cultural factors, current and previous disaster exposure) and assessment method and give a very rough indication what we can expect as the extent of morbidity

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and distress to be. We are likely to see 3 groups each requiring a different response:

1. People with Mild Psychological Distress that Resolves within a Few Days or Weeks:

A very rough estimate would be that perhaps 60-80% of the quake -affected population falls in this group. These people need psychological first aid.

2. People Either with Moderate or Severe Psychological Distress that that May Resolve with Time or with Mild Distress that is Chronic:

This group is estimated to be 20-40% of the earthquake effected population. This group covers the people that tend to be labelled with psychiatric diagnoses in many surveys involving psychiatric instruments that have not been validated for 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 post traumatic stress disorder) are on average about 10% in countries across the world. (World Mental Health Survey 2000). This rate is likely to rise - possibly to 20% - after exposure to severe trauma and resource loss. Over a number of years, through natural recovery, rates may go down and settle at a lower rate, possibly at 15% in severely affected areas. Thus, in short, as a result of disaster, the population rates of disorder are expected to go up about 5-10%. A misconception is that post traumatic stress disorder (PTSD) is the main or most important mental disorder resulting from disaster. PTSD is only one of a range of (frequently co-morbid) common mental disorders (mood and anxiety disorders), which tend to make up the mild and moderate mental disorders, and which become more prevalent after disaster. Consequently, we need to guard against over-emphasizing PTSD and 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 disorders: Severe mental disorder that tends to grossly disable daily functioning (psychosis, severe depression, severely disabling anxiety, severe substance abuse, etc.) is approximately 2-3% in general populations of countries across the world (World Mental Health Survey 2000). People with these disorders may experience, inability to undertake life-sustaining care (of self or of their children); incapacitating distress; or social unmanageability. The 2-3% rate may be expected to go-up by 1% after exposure to severe trauma and loss. Trauma and loss (a) may exacerbate previous mental illness (e.g., it may turn moderate depression into severe depression), and (b) may precipitate a severe form of trauma-induced common mental disorder in some people.

A large number of countries, especially the developing countries like Afghanistan, Iraq, Iran, Sri Lanka, Turkey, have utilized the community based approach to meet the needs of the disaster and conflict affected populations (Ghosh, Mohhit and Srinivasa Murthy, 2004). The essential aspects are to organize the services at three levels, namely psychological first aid though community level personnel (volunteers, teachers, heath workers etc); integration of mental health care with general health services and support and supervision through psychiatric centres.

Situation Analysis:

For any emergency plan it is crucial to collect the 'vital statistics' on the site, setting, type, nature, impact, and consequences of the disaster in question. Other variables that have to be taken into account are the available resources in terms of trained manpower and

material, accessibility of the effected areas, health infrastructure that survives the disaster, will of the policy makers and relief agencies to include mental health care as a component of the health relief operations.

The plan that is presented in this paper is based on the experience of the authors with dealing with the earthquake of October 2005, in northern Pakistan and AJK.

This major Quake was followed by ongoing tremors that continued for many weeks, leading to intermittent blockade of roads and consequent obstruction of the relief efforts. The approaching winters and snowfalls in the affected areas were seen as a threat to the relief operations.

The quake was followed by a massive relief effort under the 12 point relief plan of the Prime Minister of Islamic Republic of Pakistan, the Federal Relief Commissioner, the Armed Forces of Pakistan, the Government of Azad Jammu and Kashmir, and the NWFP Government. The Federal Ministry of Health (MOH) committed to make the health relief effort an integral part of the over all relief effort. It was being assisted by a large number of national and international agencies alongside WHO and other UN agencies. There was a considerable input from the public and private sector organizations, non-governmental organizations and individual efforts from home and abroad.

With the affected areas dependent on a remittance economy, families surviving the quake were either stationed in relief camps in major towns and cities that could be approached through air or roads or else similar camps in Islamabad, Rawalpindi and other adjacent towns in NWFP and Punjab. Many families had left for the safe havens to distant towns like Lahore and Karachi and some who had the opportunity for abroad. A much smaller number continued to live in small hamlets away from the main roads and or in unapproachable valleys. All schools were closed, most were also damaged. Most Government buildings particularly the primary and health care settings had been badly damaged and were not functional. Even the tertiary care facilities of Army, were razed to ground. The teaching Hospital at Abbottabad was partially damaged with some of the wards operating in tents.

The most seriously injured had been shifted to tertiary care hospitals and make-shift field hospitals in Rawalpindi, Islamabad, Abbottabad, Peshawar, Wah, Lahore and many other smaller towns. Those with less severe injuries were being treated in emergency health outlets opened by the Government and as part of the national and international relief response.

The health care in the affected areas was mostly provided by the Field Hospitals set-up by the Ministry of Health, Armed Forces of Pakistan, Health Teams from various countries, small mobile hospitals set-up by NGOs and various organizations. Nearly all of these health facilities were set up as mobile and emergency hospitals in tents and were staffed by government employees and volunteers, from home and abroad, who were expected to leave sooner rather than later. The only health infrastructure that was likely to stay on ground for a longer period of time were the hospitals set up by MOH, Provincial Government, and about a dozen field hospitals set up by the Armed Forces. These facilities were mostly located at Muzaffarabad, Bagh, Rawalakot, Mansehra, Balakot, Battgram, Bhisham, Garhi Habibullah, Garhi Dupatta. Smaller health outlets and elements were also available in the Neelum and Jhelum Valleys.

There were no dedicated mental health facilities in the affected areas. The initial dispatch of drugs to the areas did not include psycho-tropics or anti-epileptics. The only tertiary care psychiatric facilities in the vicinity were available at Ayub Medical Complex, and Combined Military Hospital Abbottabad, and teaching psychiatry units at

PIMS, Islamabad, Institute of Psychiatry at Rawalpindi General Hospital, and Military Hospital Rawalpindi, all in the 100 km radius of the affected areas. The tertiary care psychiatric facilities were also available at Peshawar and Lahore, particularly for the families moved to these cities as well as the sick and wounded evacuated to hospitals.

During the emergency phase, there was a gross shortage of trained manpower in the field of mental health, in the affected areas. There were less than two-dozen psychiatrists in all the above facilities put together, and the number of qualified psychologists was even less. The psychiatric social workers were almost non-existent. A major resource in the field of mental health were the junior/trainee psychiatrists, female psychologists with Masters in Psychology, volunteer social workers mostly in the NGO sector and students of psychology, and medical students in the various institutions in major cities. However most of these resources could only be used at the tertiary care facilities.

Keeping the above in mind, it was felt that a potential resource that would ensure long term sustainability and community acceptability would be the use of primary health care personnel, community organizations and social institutions, preferably of local origin or those that employed the inhabitants.

For many months, the social life and societal institutions in affected areas did not return to normalcy. The Armed Forces and the local politicians and some elements of provincial governments organized the day to day life. The retired army and civil personnel who had come back to the area from abroad and from major cities participated in the relief operations. The law and order situation in some places remained unpredictable. The quake-victims continued to complain of shortage of tents, warm clothing, cash-flow, relief compensation and the demands flew higher as the winters and the festival of Eid-ul-Fitr approached (within couple of weeks).

It was in this backdrop that the following objectives for the mental health and psychosocial relief were drawn:

Objectives:

- Public mental heath education about the emotional impact of earthquake and treatability of mental disorders.
- Ensure availability of psychological first aid by trained manpower at all health service delivery points (including patients admitted with injuries locally and those in tertiary care facilities) and in the community.
- Incorporate psychosocial care and rational use of psycho-tropics in the medical and surgical treatment plans at all tiers along with integration of mental health care at all health care levels.
- Early detection, intervention, referral and follow-up of acute trauma related psychosocial consequences and psychiatric disorders in the affected population.
- Restoration and provision of psychiatric services.
- Provision of psychosocial support for the relief workers, professionals, paraprofessionals and, volunteers involved in the relief effort to ensure that they are able to maintain their own health.
- Mobilisation of community social support and social organizations as partners in all activities of mental health care.

Principles of Mental Health Relief:

- Integrated approach: To incorporate the provision of mental health care with the general medical and surgical care and the relief operations in place.
- Catchments Area (district) based approach: To form Mental Health Relief Cells in all relevant tertiary care psychiatric facilities, each responsible

for a defined catchments area, in terms of delivery of care, training, initiation and maintenance of referral links.

- Continuity of care: The mental-healthcare of disaster victims demands a continuity of care and bonding with carers on a long term basis. The one-off exposure of a victim to a mental health professional from a distant city will be discouraged. It is important to have continuity of care in mind from the very beginning all the way through to the longer term care. This approach ensures continuity in assessment, and treatment goals.
- Long haul approach: This is to ensure that all committed to the relief plan will do so for an extended period and will not "cut–out" without warning. The commitment will go beyond training and initial availability for support but will in the long haul extend to rehabilitation of the mental health services in the affected areas.
- Peer support initiatives: The mobilization of the community will start at the very beginning to eventually take over the role of the relief workers in all spheres but particularly so in mental health delivery. This will be taken over by the community and the social institutions in the affected areas. This approach aims at ending dependency on external support systems and empowering the communities in the long term.

Strategies:

a. Setting up of a national multi-disciplinary, inter-agency, multi-sectoral, coordinating and steering group including mental health, public health and social services professionals under the umbrella of Federal Relief Commission responsible for:
   - Liaising with the services, media, international agencies and community organizations.
   - Providing the direction and coordination to the multifarious activities to be initiated in the sphere of psychosocial and mental health relief.
   - Logistics including ensuring provision of basic psychosocial interventions and essential psychotropic drugs to the facilities caring for the survivors (governmental, non-governmental, private sector and international).

b. Setup a core group comprising of mental health and social services professionals that operates at the tertiary care facilities / base hospitals and is responsible for:
   - Developing training and resource material for doctors, paramedics, social/ voluntary workers and community members.
   - Ensuring ongoing on the job supervision of trained staff.
   - Organising and conducting training workshops for the above mentioned groups.
   - Providing long term supervision, monitoring, and referral support to the relief teams and health facilities in the designated catchment areas, till the time this function is taken up by the local health facilities.
   - Mobilise resources (financial, transport, and administrative for the mental health relief teams dispatched to affected areas).
   - Maintain records of the constitution, work, and services provided through the mental

health relief teams operating in the affected areas.

c. Establish Mental Health Relief Units (MHRU) at each affected district. Every MHRU should have a junior psychiatrist.
d. Develop a corps of mental health relief groups comprising of social / voluntary workers, mental health professionals, doctors and paramedics, to operate in the affected areas, as mental health relief teams.

- The mental health relief teams should be working not only in field health facilities but should also be available at the existing PHC and secondary care facilities and entities outside the health sectors (schools, community centres, mosques (if culturally acceptable etc).
- They should engage the community institutions at this stage so that long/ medium term activities can be smoothly integrated.

Organisation of Mental Health Relief Framework:

The programme aims at setting up a coordinated mental health relief effort that merges with the broader relief plan in general. The organization of the mental health relief effort is as follows:

Mental Health Relief Cell (within the Federal Relief Commission setting and Houses the Steering Group)

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Mental Health Relief Centres (at the Tertiary Care Psychiatric Facilities housing the Members of the Core Group)

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Mental Health Relief Units (District Level)

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Mental Health Relief Teams

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Community Institutions

Modes of Intervention:

- Community Based Psychosocial Supports: The key strategy in the mental health relief plan is to use the community institutions, cultural models of grief work, and mobilization of peer support. The essential message to the community is the "normalcy" of the emotional reactions to the disaster and the capacity of individuals for recovery.
- Mental Health Literacy: The main mode of promoting mental health literacy is to utilize the media as well as informal community networks to counter the stigma attached with psychological reactions and convey the essential normalcy of the experiences of the affected population. This mode can also be utilized to share information on relief activities as well as on mental health outlets, early signs of psychiatric morbidity, mental health interventions and answering simple psychosocial concerns through television, FM radios operating locally, local print media, handouts etc.
- Psychosocial Interventions through Social Institutions: Effective psychosocial interventions will be put into place through the mental health teams who will operate by mobilizing emotional support through schools, mosques, and various other community institutions
- Integration of Mental Health with Primary Health Care: Majority of the survivors with emotional reactions will be cared for at the level of the

primary health care as it is there that they present and the numbers are so large that the mental health teams cannot cater alone. The effectiveness of operating through the primary health care personnel with the support and supervision of the mental health teams to deal with minor psychiatric morbidity and emotional reactions has already been widely accepted.

- Provision of basic mental health care for common psychiatric disorders: Common psychiatric disorders seen in the population will be the duty of the mental health teams supported by the mental health units and centres. This tier of mental health care will also provide the referral link between the mentally ill and the secondary and tertiary mental health centres. During their stay in the field they will also provide supervisory support to the mentally ill, for any minor changes or drug reactions..
- Rebuilding of mental health services: The 4 million population of the disaster affected areas had very limited access to formal mental health services before the disaster occurred on October 8, 2005. It is imperative that formal mental health services are organized in the affected areas as part of the recovery and rehabilitation phases. This can translate an adversity into an advantage.

Administrative Support to the Programme:

The National Plan for mental health relief requires an administrative structure and funds for the implementation of the same. The plan and its implementation must have full administrative and policy support of Ministry of Health, UN, local and international funding agencies, the Federal and provincial relief bodies.

Voluntary and International Organizations:

In the overall disaster relief, recovery and rehabilitation process the international and national voluntary organizations have an important role to play at all levels of care. The approaches of the National Plan are developed in consultation with and are to be shared with the voluntary organizations. The plan envisages the role of the Mental Health Relief Cell as well as the centre to provide ongoing support to these organizations, in terms of technical guidance, training of personnel and evaluation of the activities.

Monitoring and Evaluation:

Monitoring and evaluation of the mental health care programme will be an important component of the plan. Structured and standard records should be prepared for collection of information by all of the centres providing clinical services, through their respective mental health units and mental health relief teams. Periodic population based need assessment surveys ought to be part of the ongoing evaluation. In addition there will be selected evaluation of the impact of the interventions on the individuals, families and communities. The standard format of input, process and outcome indicators needs to be incorporated as an essential part of the plan, from the very beginning of its implementation.

Research:

A catastrophe offers opportunities to both understand the mental health impact of the disaster as well as the effectiveness of the various interventions. A systematic collection of relevant data and clinical information would go a long way to develop and modify the future national plans. The research activities however need to be timed with intense sensitivity to the fact that the affected population is focused on services and provision of relief goods primarily and a research tool administered in isolation may be viewed negatively as well as considered

superfluous. The research priorities however must focus on psychosocial needs, patterns of normal psychological reactions to adversity, changes in psychiatric morbidity, psychosocial correlates of injury and disease, homelessness, loss, and trauma. The research must also draw upon the experience and the psychosocial reactions of the carers and relief workers. The effectiveness, relevance and impact of various interventions used in the emergency phase need to be researched as well.

It is important to focus not merely on morbidity, but also to collect data on factors influencing human resilience, positive mental health in the wake of disaster, and post traumatic stress growth. The influence of anthropological and social factors on psychosocial responses also needs to be researched.

It is crucial to protect against licentious research activities in the garb of research. The steering committee must develop a policy to examine, monitor, control and peruse all research activities, and never to let the emergent nature of the situation influence or compromise the quality of the scientific methodology or ignore the relevant ethical requirements.

Summary table on psychosocial/mental health assistance to earthquake-affected populations.

Description	Before disaster: 12-month prevalence rates	After disaster: 12-month prevalence rates (projected)	Type of aid recommended	Sector/agency expertise
Severe disorder (e.g., psychosis, severe depression, severely disabling form of anxiety disorder, etc)	2-3%	3-4%	Make mental health care available through general health services and in community mental health services	Health sector (with WHO assistance)
Mild or moderate mental disorder (e.g., mild and moderate forms of depression and anxiety disorders, including of PTSD)	10%	20% (which over the years reduces to 15% through natural recovery without intervention)	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	1) Health sector 2) A variety of sectors
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	No estimate	30-50% (which over the years will reduce to an unknown extent through natural recovery without intervention)	Make social interventions and basic psychological support interventions available in the community	A variety of sectors
Mild psychological distress, which resolves over time	No estimate	60-80% (which will over the years increase as people with severe problems recover)	No specific aid needed	No specific aid needed

Note: WHO projections and recommendations: These rates vary with setting (e.g. socio-cultural factors, previous and current disaster exposure) and assessment method but give a very rough indication what WHO expects the extent of morbidity and distress to be.

PART II

The Action Plan:

The following is the action plan in the context of the known understanding about

mental health care for the disaster survivors and the local situation in Pakistan.

- Establishment of the Mental Health Relief Cell for the Mental Health Intervention and Rehabilitation (MHIRC)
- Constitution of the Steering Group and mobilization of stake-holders
- Compilation of commitment to resources, responsibilities and allocation of duties
- Formation of Mental Health Relief Centres (MHRCs), Mental Health Relief Units (MHRUs) and Mental Health Relief Teams (MHRTs).
- Development of uniform training manuals and print material for the provision of basic training in counselling and emotional support, and early detection and acute treatment of trauma-related psychiatric morbidity to the members of the mental health relief teams as well as the general medical care teams, operating at the primary care level. Training manuals for relief workers and educated members of the community's healthy survivors of the earthquake must also be developed.
- Training Workshops for the health care teams, psychologists and social workers in priority areas such as psychological care, counselling, informational care of the aggrieved, the homeless, the orphans and the destitute, as well as early detection and first line interventions in patients with acute stress reactions, post traumatic stress disorder, as well as other equally important clinical entities, such as anxiety, depression, phobias, somatisation, and dissociation.
- Provision of essential psychotropic drugs at the grass root health facilities as well as base hospitals required for use in patients requiring biological treatment. Conscious effort must be made to guard against the misuse of benzodiazepines and prevent dependence.
- Deployment of Mental Health Relief Teams in the affected places based on the catchments area distribution.
- Provision of psychosocial care to the injured, the sick, and their attendants.
- Development and maintenance of effective referral links for the severely affected psychiatric patients between the grass root health facilities and MHRCs at base hospitals and the tertiary care psychiatric facilities.
- Development and distribution of health education material in print.
- Dissemination of information on the facilities available at the grass root as well at the MHRCs through media
- Launch of the Mental Health Literacy initiatives in print and in media for the victims and general public
- Provision of psychological support to the relief workers and the health professionals against burn-out and psychiatric effects of working with disaster victims
- Mobilization of a workforce of psychologists, social workers, volunteers, medical students who receive training workshops at the nominated Centres and their prompt placement and replacement in Mental Health Relief Teams as well as in tertiary care MHRCs. They will only operate after adequate training on the provision of psychosocial support and counselling for the victims at the grass root, sick and wounded quake-victims, as well as their attendants at the various health outlets.
- Organize training of psychiatrists, psychologists and grief workers in the

field of Trauma Psychology in collaboration and association with national and international experts in this field.

TIME LINE

In the First Six Weeks:

- Setting up of the Mental Health Relief Cell as a subsidiary of federally or a centrally operative relief body. This fact must be advertised and made known through the electronic and print media alongside the information regarding the role and functioning of the Cell. This will help converge the resource flow and help coordinate the mental health relief pattern in a synchronized and an organized fashion.
- Meeting of mental health professionals and all stake-holders under the auspices of the MHRC to discuss and start the implementation of the mental health relief plan within a week
- Setting up of MHRCs at tertiary care facilities.
- Commencement of training of health professionals and relief workers.
- Training Workshops by MHRCs in early detection and counselling of trauma victims for the volunteers, psychologists, and social workers.
- Provision of psychotropic drugs particularly Imipramine, Diazepam, Haloperidol and Fluoxetine at all health outlets
- Deployment of Mental Health Relief Teams
- Establishment of effective bilateral referral and follow up links
- Provision of psychosocial relief and support to the carers and relief workers.
- Linking up and mobilization of support with community resources such as students, teachers, pesh-imams (prayer-leaders in mosques).
- Mobilise support from opinion makers, media (electronic, print), politicians and policy makers to make mental health a priority at par with physical health care and relief effort.
- Organise compilation of data collected at the various tiers of mental health care and review the resource allocation according to changing needs in the field.
- Organise feedback sessions from the community, members of the mental health relief teams and fellow health professionals at the health outlets.
- Link up with international experts to seek expert advice, guidance and support through e-mails, videoconferencing and short yet focused visits.

After six weeks the meeting of the Steering Group may be reconvened to evaluate the initiative and review strategies and the commitment of the stakeholders. The evaluation will heavily draw upon the experiences of the MHRCs, MHR teams and the influence of ground realities on the plan. A medium and the long term strategy could then be developed on the lessons learnt.

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