Module-4

National Disaster Management Training Module

Disaster Mental Health Services

March 2023

Jointly Developed by

National Disaster Management Authority
(NDMA)

National Institute of Mental Health and Neuro Sciences
(NIMHANS)

National Disaster Management Training

Module-4

Disaster Mental Health Services

Authors

Dr. D. Dinakaran
Dr. K. Sekar
Dr. Jayakumar C
Dr. Patrick Jude

NDMA, New Delhi
NIMHANS, Bengaluru

National Disaster Management Training Module-4
Psychosocial First Aid

Supported by
National Disaster Management Authority,
Government of India,
NDMA Bhawan,
A-1, Safdarjung Enclave,
New Delhi – 110029.

Published by
NIMHANS, Bengaluru
NDMA, New Delhi.

Layout & Printed by::
Futura Digital Colour Press
4/4, 3rd Main, Tata Silk Farm
Near Yediyur Lake
Bengaluru - 560 082, INDIA.
E-mail: futuradigital1@gmail.com

Edition First, March 2023

Copyright @ NIMHANS, NDMA

When citing this manual, the following citation should be used:
National Disaster Management Training Module-4, Disaster Mental Health Services.

2023 © National Disaster Management Authority (NDMA) and National Institute of Mental Health and Neuro Sciences All rights reserved. No part of this work may be reproduced in any form, by mimeograph or any other means, without permission in writing from the National Institute of Mental Health and Neuro Sciences and the National Disaster Management Authority.

www.nimhans.ac.in
www.ndma.gov.in

CONTENT

Chapter	Title	Page No
1	Introduction to disasters	1-5
2	Introduction to mental health and psychosocial support	6-10
3	Mental health impact of disasters	11-16
4	Vulnerable groups in disasters	17-21
5	Triaging and Psychosocial First Aid (PSFA)	22-26
6	Interview and assessment methods	27-29
7	Psychosocial management	30-34
8	Medical management	35-37
9	Primary Care Doctor (PCD) as an administrator	38-44
10	Facilitator’s guide	48-58
11	Workbook	59-80
12	Reference	81

FOREWORD

Primary healthcare forms the backbone of healthcare of all the countries. Easy accessibility to medical care, affordability, and availability of the health professionals in the community provide for the best possible healthcare management solution. Primary healthcare in India provides care for all the age groups in the community. During the aftermath of any disaster, mental well being of the community is disturbed worse than the physical well being. Everyone touched by disasters experience stress and fear during the immediate aftermath irrespective of their general physical well-being. Mental well-being is further worse in people impacted physically, economically or socially. Provision of mental health services at the community level during and after any disaster may reduce the mental health impact significantly.

Integration of mental health services at primary care is the long sought after goal and little success is achieved in its implementation. Primary Care Doctors (PCDs) have to be trained in different disasters, their impact on mental health, psychosocial preparedness, assessment, trianing, first aid, brief psychological interventions and specific medical management methods to provide basic mental health services. This module is devised to engage and educate PCDs in Disaster mental health services.

The training would capacitate PCDs on the implementation of Mental Health Services in disaster-affected communities. The uniqueness of this module is having both online and offline methodologies as the training aid.

Sh. Kamal Kishore
Member Secretary
Incharge

Sh. Krishna S. Vatsa
Member

Sh. Rajendra Singh
Member

Lt.Gen. Syed Ata Hasnain [Retd.]
Member

PREFACE

The National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru, is a premier institute of mental health and is a Center of Excellence in Psychosocial Support and Mental Health Services (PSSMHS), NIMHANS has been spearheading the care and services, capacity building, research and policy in the area of Disaster Management for over four decades. In these four decades of journey NIMHANS, collaborating with central, state, and local Governments and CBOs was able to reach the affected communities to mitigate the psychosocial trauma and promote mental health.

NIMHANS is also involved in developing policies, programmes and information materials, and in providing timely services in all the matters related to disaster across the country. As an institute of National Importance, NIMHANS is associated with the National Disaster Management Authority at various levels like framing policies and guidelines. The most significant outcome of this association was the release of NDMA guidelines on Psychosocial Support and Mental Health Services (PSSMHS) in the year 2010, culminating in declaring NIMHANS as a Center of Excellence in Psychosocial Care for Disasters. NIMHANS was also associated with various guidelines prepared by the NDMA. Subsequently NIMHANS has actively provided care and support for individuals and communities along with proposing preparedness programs for the country. The devastating Covid-19 Pandemic underscored the need for psychosocial care and has once again brought the crucial aspect of wellbeing to the forefront. NDMA has strived hard to mitigate the stress of the community during this outbreak and initiated an immediate outreach to provide Psychosocial First Aid through community based organizations, with technical support of NIMHANS.

The National Disaster Management Authority (NDMA), Government of India took a major initiative of addressing this crucial form of care by developing this module in collaboration with Department of Psychosocial Support in Disaster Management (DPSSDM), NIMHANS. This manual aims to facilitate in imparting standardized training in disaster mental health services. I congratulate NDMA and DPSSDM, NIMHANS for having undertaking this initiative. I am sure that this endeavor will go a long way in ensuring psychosocial support through medical practitioners at the community level.

Dr. Pratima Murthy
Director,
NIMHANS,
Bengaluru.

AUTHORS NOTE

In disaster context, traditionally the role of Primary Care Doctors (PCDs) was restricted to providing emergency medical services. However, PCDs have a comprehensive role to play at all the phases of disaster management cycle i.e., preparedness, response, and recovery. To be able to execute such roles, PCDs need to be oriented to disaster specific aspects and their roles as medical professionals especially in providing mental health services. Till date, there is no modules exclusively designed for the PCDs in disaster management available in India. Therefore, this module supported by National Disaster Management Authority (NDMA), New Delhi, is developed for the capacity building of PCDs in providing mental health services in disasters.

This stands as the 4th module developed for the larger project titled 'Development of Psychosocial Care and Preparedness Module and IEC Materials'. There are 3 parts in this module. Information module (part-1), facilitators guide (part-2), and workbook (part-3). Part-1 has 9 chapters covering different topics such as introduction to disaster, mental health and psychosocial support, mental health impact of disasters, working with vulnerable groups, triaging, psychosocial first aid (PSFA), assessment methods, psychosocial and medical management, and role of PCDs as an administrator. In the part-2, 13:30 hours training program aligning to part-1, consisting of 9 sessions is been given. The facilitators can train the PCDs referring to this facilitators guide. The workbook given in part-3 can be used as the resource material to do the exercises.

The target group of this module includes, medical practitioners with MBBS or above degree, working in Primary Health Centre (PHC), Community Health Centre (CHC), District Hospitals, District Mental Health Program (DMHP), medical colleges, private practitioners, medical camps and so on.

We would like to extend our sincere gratitude to National Disaster Management Authority (NDMA), New Delhi for the funding support, methodical inputs and periodical review meetings in developing this module. We sincerely thank Shri Sanjeeva Kumar, IAS, Former Member Secretary, Shri Kamal Kishore, Member Secretary, Lt. Gen. Syed Ata Hasnain (Retd) PVSM, UYSM, AVSM,SM,VSM & BAR, Shri Rajendra Singh, PTM, TM, Former Director General, Indian Coast Guard, Shri Krishna S. Vatsa, Member, Shri Alok, IAS, Additional Secretary, Ravinesh Kumar, former financial advisor, Col Kirti Pratap Singh Joint Secretary (Mitigation), Ms. Sreyasi Choudry, Shri Harsh Gupta, IAS Former Joint Advisor, Mitigation, Shri Biswarup Das, Joint Advisor (Mitigation) and Ms. Maithreyee Mukherjee, Senior Consultant, Psychosocial Care and Social Vulnerability Reduction for their constant support.

We are thankful to the Director, National Institute of Health and Neuro Sciences (NIMHANS), Bengaluru Dr. Pratima Murthy and Former Directors Dr G Gururaj and Dr B N Gangadhar for their constant guidance and administrative support. We would also like to extend heartful thanks to Dr. Vivek Bengal, Prof. and Head, Department of Psychosocial Support in Disaster Management (DPSSDM) for his continuous support and guidance. Special thanks to Dr. D. Dinakaran, Assistant Professor, DPSSDM for his valuable inputs in shaping this manual.

The insightful discussions from the consultation meeting with different stakeholders, SDMA, DDMA, NGO and experts greatly helped in planning the content of this module. We thank each and every member from SDMAs, DDMAs, first responders, and volunteers who took part in the consultation meeting.

Mr. Rins Thomas has done a meticulous job on simplifying the language for the better comprehension of the target population. Mr Govindaraju has contributed in developing the artwork. We thank them both for their time and effort.

We would like to acknowledge all the direct and indirect support received from all the team members of DPSSDM, NIMHANS, Bengaluru. We thank Ms Christella Sowmya for representing different illustration in this module. We would like to appreciate the support rendered by Dr. Balashanthi Nikketha, Dr. Rajamanikandan Savarimalai, Mr. Allen Daniel Christopher, Ms. Sandhya P D, Ms. Jane Maria, Mr. Kannan. M, Mr. Sathish and Ms. Sharmila.

LIST OF TABLES

Table No	Title	Page No
1.1	Types of disaster	2
4.1	Vulnerable groups, during different types of disasters	17
5.1	Psychosocial triage matrix	23
7.1	Do’s and don’ts of sleep hygiene techniques	33
8.1	General principles of medical management, different drugs, dosages, and their side effects	36

LIST OF FIGURES

Graph No	Title	Page No
1.1	Common disasters in India	3
3.1	Disasters and Mental illness - A domino effect	11
3.2	Stressful Reactions during Disasters	12
3.3	Normal and abnormal reactions post-disasters	13
4.1	Indicators of vulnerability	18
5.1	Psychosocial Triage	22
5.2	Key components of PSFA	24
7.1	Key Phases of Disaster Management	30
7.2	Key components of psychosocial management in disasters Community	30
7.3	Skills required to enhance psychosocial competency	33
8.1	Common and severe mental disorders	35
9.1	National disaster management structure	41

CHAPTER 1 INTRODUCTION TO DISASTERS

Disaster is an event or hazard that threatens the safety and lives of the people and is often unforeseen. It causes a severe ecological and psychosocial disruption that exceeds the coping ability of the affected people/community.

United Nations Office for Disaster Risk Reduction (UNDRR), defined disaster as "A serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human, material, economic and environmental losses and impacts".

The Disaster Management Act (DMA) (2005) states, disaster as "a catastrophe, mishap, calamity or grave occurrence in any area, arising from natural or manmade causes, or by accident or negligence which results in substantial loss of life or human suffering or damage to, and destruction of, property, or damage to, or degradation of, environment, and is of such a nature or magnitude as to be beyond the coping capacity of the community of the affected area".

TYPES OF DISASTERS

Disasters can be broadly classified as natural and human-made disasters. The severity of the impact, amount of damage and the nature of support required for the affected people indicate if the emergency is a disaster. For example, an earthquake that happens in a desert cannot be termed a disaster as it occurs in a place where people do not live.

Natural disaster: Occur as a result of natural physical phenomena either by rapid or slow onset of natural events (Table 1.1).

Human-induced disaster: Are events that occur as a result of human actions and settlements. For instance, pollution, environmental degradation, negligence, etc.

Table 1.1: Types of disaster		
Natural disasters		
Nature	**Cause**	**Type**
Geophysical disasters	Geological disturbance	Earthquake, Tsunami, Avalanche, Landslide, Volcano, Mass movement (dry), Rock-fall, Subsidence
Meteorological or Climatological disasters	Extreme weather	Storm, Heat/Cold Wave, Drought, Forest Fire, Land Fire, Wildfire, Tropical cyclone, Extra-tropical cyclone, Local storm, Climatological, Extreme temperature, Extreme winter condition
Hydrological disasters	Flooding or movement of water bodies	Flood, General flood, Storm surge/coastal flood, Mass movement (wet), Rock-fall, Landslide, Avalanche, Subsidence
Biological disasters	Microorganisms	Pandemic, Epidemic, Insect infestation, Viral infections, Disease, Bacterial infectious Disease, Parasitic infectious disease, Fungal infectious disease, Prion infectious disease, Insect infestation, Animal stampede
Human-made disasters		
Industrial accidents	Industrial or infrastructural damage or accidents	Chemical Spill, Explosion, Gas leak, Poisoning, Radiation
Communal accidents/Sabotage	Impatience of humans impacting the safety of other people or destruction of property	Riots, Terrorist Attacks, Bomb Blasts, Stampede
Accidents caused by human negligence	Accidents caused by human negligence	Air/Train/Road/Water accidents, Fire Accidents, Building collapse

COMMON DISASTERS IN INDIA

Disaster is not a new phenomenon. Disasters have been taking place worldwide constantly with "varied degrees of severity". Due to the geo-climatic conditions and socio-economic vulnerability India is highly prone to different types of disasters. India is said to be one of the ten worst disaster-prone countries in the world. 30 different types of disasters, including drought, floods, cyclones, landslides, soil erosions, earthquakes have affected Indian communities (NDMA, 2016).

Figure 1.1: common disasters in India

DISASTER MANAGEMENT CYCLE

Disaster management (DM) as defined in DMA, 2005 is "a continuous and integrated process of planning, organising, coordinating and implementing measures which are necessary or expedient" for the following:

Source: National Policy on Disaster Management, NDMA, 2009

1) Prevention of danger or threat of any disaster.

2) Mitigation or reduction of risk of any disaster or its severity or consequences.

3) Capacity-building.

4) Preparedness to deal with any disaster.

5) Prompt response to any threatening disaster situation or disaster.

6) Assessing the severity or magnitude of effects of any disaster.

7) Evacuation, rescue, and relief.

8) Rehabilitation and reconstruction.

Stages of Disaster Management Cycle

- **Response/ rescue:** This is initiated immediately after a calamity to ensure that everyone is safe. It involves providing temporary shelter, food, drinking water, other basic essentials, clearance of carcass (dead bodies), easing access to health care facilities, maintaining sanitation, power supplies, public information, and security. It has to be initiated within 72 hours from the impact.
- **Relief:** It aims at providing humanitarian help and recovery from the impact of disaster based on the psychosocial needs of the affected community. Along with other relief measures psychosocial support and mental health services will be provided at this stage. It has to be initiated between 72 hours to three months.
- **Rehabilitation:** It involves all measures aiming at increasing resilience, strengthening livelihood, quality of life and day-to-day activities. It focuses on enabling civic utilities, building infrastructure and restoration. From the mental health service point of view, it should aim at monitoring psychosocial complications, and facilitating mental health referrals and follow-ups. It runs between three months to two years.
- **Reconstruction/ rebuilding:** This stage goes on between two years to lifetime. It aims at creating sustainable and resilient communities that help to rebuild the individual coping abilities, family structures, livelihood, and environment. This stage is also linked with the pre-disaster phases (preparedness and mitigation) where the community is prepared to respond better to future emergencies.

- **Mitigation:** It is a process focusing on the elimination/reduction of disaster impact. This includes planning or modification of plans/policies, and developing measures to reduce disaster risk from local to national level.
- **Preparedness:** It is an ongoing activity where individuals, families and communities are helped to plan activities that they can do in response to a disaster and to minimise the impact of disaster. This ensures promptness, fosters adaptation, and builds resilience.

Remember

- Disasters overwhelm the coping capacity of the community.
- Disasters are broadly natural and human induced.
- Disaster management cycle encompasses mitigation, preparedness, response, and recovery phases.

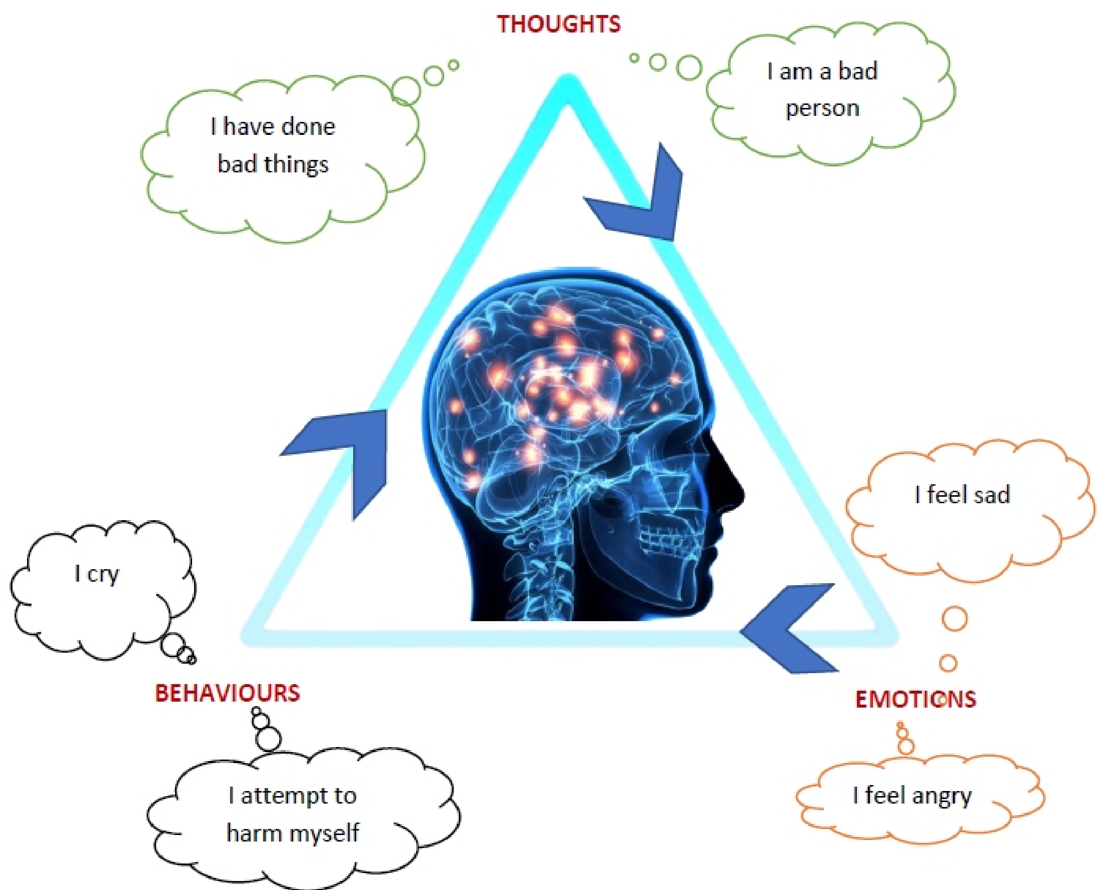
CHAPTER 2 INTRODUCTION TO MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Disaster-affected communities experience various physical and mental health problems. Unlike physical symptoms, mental health problems remain unnoticed most often. However, it is a well-established and scientifically proven fact that physical and mental health issues are interlinked. Further, World Health Organisation (WHO) defined health as “a state of physical, mental, and social wellbeing and not merely the absence of diseases or infirmity. Also, the extent to which the individual or group is able to realise aspirations and satisfy needs and to change or cope with environment”.

According to WHO Mental health is “a state of wellbeing in which the individual realises his/her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to the community”. Mental health deals broadly with thoughts, emotions, and behaviour of the individuals. Psychiatry, as a branch of evidence based medicinal science deals with the promotion of mental wellbeing, prevention, and management of mental illnesses. Psychiatry seeks to analyse the causes of illness, conduct research on the psychosocial factors behind wellness and illness and attempts to provide holistic care and support to the persons with mental illnesses.

Providing timely mental health intervention or psychosocial support services facilitate the early identification of the issues and speedy recovery of the affected people. In the context of disasters Psychosocial Support (PSS) refers to “comprehensive interventions aimed at addressing a wide range of psychosocial problems arising in the aftermath of a disaster”. In the past, distributing relief materials and physical reconstruction (body and environment) were given the priority during disasters. In the recent decades integration of PSS along with other relief services has got attention of the stakeholders.

THE DYNAMIC INTERACTION BETWEEN THOUGHTS, EMOTIONS AND BEHAVIOUR



Disturbances in thinking, mood and/or behaviour in an individual leads to mental illness. However, disturbances in these core domains does not predispose an individual to develop mental illness. When such disturbances affect the different areas of life (personal, social or occupational), it can be an indication of mental illness.

Most mental illnesses are conceptualised as a continuous degree from the 'normal' phenomenon. For example, following a sudden loss of job, everyone feels 'stressed' and 'sad'. However not everyone develops mental illness like 'Depression'. The degree of sadness varies from normalcy to distress to dysfunctional levels. Only among individuals in whom the dysfunction is significant, a diagnosis of 'depression' is determined. Similarly in disaster context emotional reactions such as fear, anger, grief, guilt, sadness etc, are normal. When it goes beyond a limit over a period of time causing dysfunction in the activities of daily life, it needs medical attention. Conceptualising illness as a continuum spectrum from normalcy, and understanding the illnesses as 'deviation in the degree of suffering' provide a basis for educating the general public. This even helps in reducing the stigma in the society towards mental illness.

PSYCHOSOCIAL DETERMINANTS OF MENTAL HEALTH IN DISASTER

Apart from the biological factors (genetics, infections, chemical imbalance in the brain etc.), psychosocial factors serve as the key determinants in maintaining health as well as developing diseases. Some of the important psychosocial determinants of mental health include:

Age: Children and elderly (extremities of age) are more vulnerable to disaster related impact, including the mental health impact. Individuals in this age group are dependent economically and socially on the other working age group and they are more prone to different types of abuses (psychical, sexual) and neglect. Lack of understanding about the situation, inability to control the events and cope with difficult situations make them more vulnerable.

"8 years old X witnessed his apartment catching fire, causalities and sudden chaos created around. From then he is extremely scared of fire, clingy, avoids going to school, and unable to sleep due to nightmares".

Gender: The traditional gender roles make women and other sexual minorities (including LGBTQIA+) face societal hierarchy related challenges, discrimination, and social inequality. For instance, unequal access to resources and relief assistance, increased vulnerability to abuse/exploitation (domestic violence, physical, emotional, sexual abuse etc), privacy issues in the relief centres, increased caregiving responsibilities etc.

"28 years old K lost her husband in a terror attack. Even after 8 months of his death, she is grieving to the same extent. Because of her constant low mood, crying spells, fatigue, and bodily complaints, she is not able to care for self, 2 years old daughter and her parent in-laws".

Caste, community, and religion: Social institutions like caste, community or religion influence the mental health of an individual. Sense of belongingness and togetherness, being in an identifiable group provide social support to the individual. On the other hand, social evils like., untouchability, discriminatory practices, religious hatred contribute to the ill health and poor access to the resources/services.

"A group of socio-economically oppressed community did not have their identification documents even prior to disaster. This affected them in having access to the relief services, post-disaster".

Environment: Growing in an environment with prevailing social problems such as; poor opportunities for education and gainful employment, violence, abuse/exploitation, etc determine the coping ability and resilience of an individual. These factors further make the people vulnerable to disaster.

"After losing his 15 years son on a mob attack, S alcohol consumption increased. He goes for work irregularly and not contributing to his family financially. This triggers frequent arguments between him and his wife. After every fight he hits her. However, she and people from neighbourhood is not taking active step to make him stope abusing her physically, as it is considered acceptable to hit wives".

Schooling and education: Unequal distribution of educational opportunities, inadequate learning experience, bullying/abuse experience, and overall educational attainment of the community play significant role in the psychosocial development of the individual. At the time of disasters, it influences the vulnerability and resilience of the people.

"After the COVID-19 restrictions, the online classes affected the children who are not having resources to attend classes, especially from rural communities and/or children from economically weaker sections"

Poverty and financial status: Poverty is a social evil that inadvertently leads to malnutrition, lack of resources, poor social support, discrimination, poor living condition etc., that affect the mental wellbeing of the people and make them even more susceptible to the impact of disasters.

"46 years old Somasekhar, lost all his crops due to stampede by elephants. Even after approaching community leaders, he did not get any help. Thinking of the debts and financial crisis in the family he attempted suicide"

Employment and job security: The resources in the community either help or hinder an individual in getting and maintaining a job. Having a secure employment enhances the social security of the people. It also moderates an individual's mental health.

"A group of migrant workers lost their job due to the COVID-19 pandemic. The unavailability of job, not being able meet the basic necessities of the family caused them significant distress, helplessness, hopelessness, worthlessness, and death wishes".

Accessibility to health resources: Equal distribution of health-related resources is a basic necessity. Primary health centres, sub centres and wellness centres across the nation play this essential role in the community. Wherever there is poor access to mental health care, the illness and suffering go unnoticed and the treatment gap becomes wider.

"After the flood, 54 years Anthony stopped his medicines for OCD. Now his symptoms have worsened, however he is not able to go for the follow-up as his family is preoccupied about their livelihood, aftermath of flood."

Stigma: Stigma is a social evil that leads to discrimination based on illness and excludes the individual from community participation. It is also identified as a crucial factor in increased treatment gap and poor treatment adherence.

"People hailing from an area where the Nipah was prevalent, were treated different by others in public spaces. This influenced the people when they had early signs of infection to maintain the secrecy, causing panic/anxious reactions".

Culture and indigenous practices: Indigenous knowledge form its base from the advanced understanding of a group of people on local environment. Beyond understanding, the indigenous practices are a way of life in the adaptation process or means of survival from the crisis. Such body of indigenous knowledge helps the community to reduce the risk, adapt and thrive from the impact of disasters.

'Change in weather, pattern of wave, behaviour of the weather, smell of the sea etc are the indication of environmental hazards like tsunami, flood etc., in many of the communities in India'

Along with the above-mentioned determinants, it is essential to understand the determinants that moderate the level of risk among disaster survivors. It includes:

1. Physical closeness (distance between the person and epicentre)
2. Emotional closeness (closeness of the person to the affected individual)
3. Individual vulnerabilities (pre-existing health conditions, frustration tolerance level, sense of optimism, socio-economic vulnerabilities)
4. Environmental vulnerabilities (number of members in the family, family coping, family functioning, health conditions in the family, family resources)
5. Instant and ongoing stress reactions (stress reactions and its intensity)
6. Individual coping patterns (positive or negative coping pattern).

These determine the risk for mental health complications among disaster survivors. Understanding mental health, mental ill health and psychosocial indicators of mental health, help Primary Care Doctors (PCDs) to integrate mental health services with routine medical care while working with disaster survivors.

Remember

- Mental health plays a crucial role in the overall wellbeing of the individuals
- Mental illnesses are conceptualised as a continuum from normalcy
- Social determinants are vital in determining resiliency and vulnerability

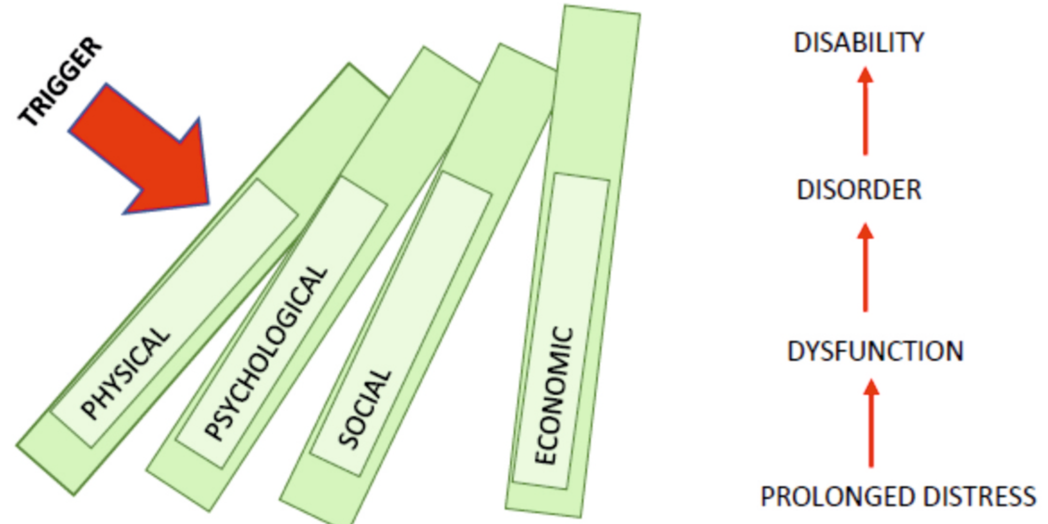
CHAPTER 3 MENTAL HEALTH IMPACT OF DISASTERS

Disaster creates short-term and long-term impact on the affected community due to various reasons such as- shock from the event, loss of lives and livelihood, property destruction, lack of shelter, loss of privacy, uncertainty about recovery, bereavement, and grief etc. The impact of disaster can be broadly classified into following domains;

- **Physical impact:** The damage caused to body/physical structures or worsening of pre-existing physical condition. Examples; wound, injury, fractures, skin allergies, pregnancy complications etc.
- **Psychological impact:** Denotes the, emotional or behavioural reactions in response to a disaster. Examples; shock, denial, fear, anger, anxiety, grief reactions, substance dependence etc.
- **Social impact:** Refers to the hardship created in the family or society. Examples; displacement, migration, increase in single parent families, increase in crime and delinquency etc.
- **Economic impact:** Indicates the financial, property and livelihood losses. Examples; unemployment/underemployment, debt traps, loss of property etc.

Impacts of disaster are interconnected. Generally, physical, and economic impacts get larger visibility in any disasters. The impact be it physical or economic, eventually lead to a psychological impact. However, psychological impact remains under recognized. Poor awareness on mental health is one of the main reasons for poor sensitivity to the psychosocial impact created by disasters. Hence, Primary Care Doctors (PCDs) need to be mindful of the biopsychosocial impact subsequent to any disaster.

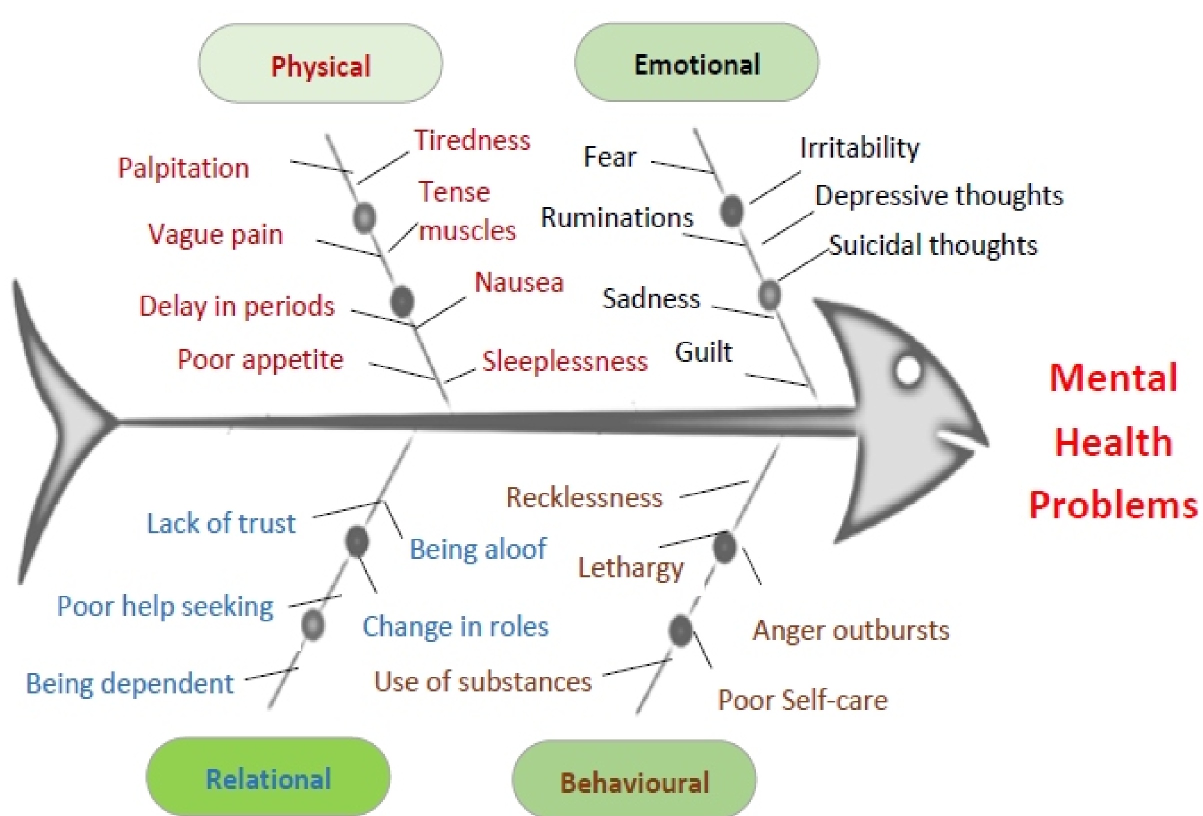
Figure 3.1: Disasters and Mental illness - A domino effect



STRESSFUL REACTIONS DURING DISASTERS

Stressful reactions are common in response to disaster. These reactions vary from person to person and disaster to disaster. However, it is important to note that these are the 'normal reactions during disaster'. Every individual experiencing stressful reactions need not develop mental health complications. Yet, everybody touched by the disaster benefit from psychosocial support (PSS) and do not require medicines or psychotherapy.

Figure 3.2: Stressful Reactions during Disasters



Normal and abnormal reactions post-disasters

Although disaster is a crisis situation, all the reactions to such crisis need not be abnormal. The PCDs should be able to distinguish between normal and abnormal reactions. This helps to provide focussed attention immediately and also to assess the need for referral to further specialised services as necessary.

The following tips help to distinguish such reactions;
Whether the;

- Fear, sadness, or other symptoms are persistent and prolonged
- Mental health issues are overwhelming the capacity of the individual
- Emotional problems are interfering with daily work
- Mental health issues affect the self-care or caring for others in the family
- Person is having thoughts of suicide
- Person is trying to harm self or others
- Person is being excessively angry, irritable, or violent
- Substance intoxication or withdrawal symptoms are prominent
- Individual is repeatedly seeking help
- Symptoms are not resolving even after primary care is provided
- Pre-existing mental health issues present
- Pre-existing disability present
- Extreme avoidance in participating in community activities
- Social support to an individual is poor

Figure 3.3: Normal and abnormal reactions post-disasters

Intrusion: Recurrent thoughts about the disaster (6 months)

Outcry: Immediate reaction involving fear, sadness, and rage

Working through: Accepting the disaster reality (after 6 months)

Denial: Refusal reaction to accept the disaster (one to two weeks)

Overwhelmed: Carried away by the immediate psychological reactions

NORMAL

Panic/Exhaustion: Panic or exhaustion secondary to elevated emotions

Extreme Avoidance: Adopting maladaptive coping strategies

ABNORMAL

Flooded states: Intrusive images and thoughts about the disaster

Psychosomatic responses: Body complaints (headache, stomach pain)

COMMON MENTAL HEALTH DISORDERS IN DISASTERS

The stress reactions aftermath of disasters subsides in first 1-2 weeks. If these stress reactions go beyond a month and exceeds the coping ability of the affected people, it poses threat to the mental health. The most common mental health disorders encountered by the disaster affected community immediately after a disaster includes- acute stress reactions/disorders, adjustment disorder, anxiety, depression, and sleep disorder. Depression, post-traumatic stress disorder (PTSD), and substance use disorders are the common long-term consequences of disasters. Almost 30-40% of individuals affected by disasters present with symptoms suggestive of anxiety and depression during the acute phase. The prevalence of mental health problems decreases around 10-15% by the end of 6 months after disasters.

Acute stress reactions/disorders

In response to exceptional physical and mental stress or traumatic experience caused by disaster affected individual may develop this transient disorder. Such traumatic experiences include serious threat to the safety of self or loved ones, and unexpected threatening change in the social position/network (e.g., disruption of the property and environment, multiple bereavement etc). Individual vulnerability (physical exhaustion or organic factors) and coping capacity add to the risk of developing this condition and also determine its severity. Immediately or after few minutes of getting exposed to an overwhelming stressor the person may experience shock, confusion, depression, anxiety, anger, despair, over activity, and withdrawal. None of these symptoms prevails for long. When the individual is separated from the stressful environment, the symptoms resolve rapidly within few hours. If the stress continues, the symptoms subside within 24-48 hours or at the most within 3 days.

Adjustment disorder

This disorder is the manifestation of a significant life change or consequences of a stressful life event, leading to subjective distress and emotional disturbance. Vulnerability factors serve as a major risk factor in determining the adjustment disorder. The symptoms include low mood, anxiety worry, helplessness to cope with the stressful situation and plan, and difficulty in performing daily routine. On rare instances individuals exhibit dramatic behaviour or anger outburst. Regressive behaviours such as bet-wetting, baby talk, or thumb sucking can be seen children. Following the stressful event or life change the onset occur within 1 month and the duration of symptoms does not usually exceed 6 months.

Anxiety disorders

Anxiety disorders are a spectrum of common mental disorders that include acute stress, generalised anxiety disorder, panic disorder, specific phobias, dissociative disorder, somatoform disorder, obsessive compulsive disorders, post-traumatic stress disorder etc. Common features of anxiety disorders include feeling restless, on the edge and tensed, worries about immediate future and long-term life prospects, inability to calm down or feel relaxed, headache, body aches, muscle tension, inability

to get sleep, being fidgety, biting nails, pulling hairs, excessive consumption of news, completely avoiding any news, availing medical care repeatedly and seeking reassurance.

Sleep disorders

Sleep in general is disturbed in people affected by disasters due to change in environment, unsafe surroundings, loss of privacy, fear, anxiety and depression etc. Sleep disturbances are usually characterised by difficulty falling asleep, waking up multiple times in the middle of the night, experiencing nightmares and getting up early than usually intended. Persistent sleep issues may lead to poor attention and concentration, poor immunity and can interfere with daily work. Daytime sleep may lead to industrial, work place and road accidents.

Depressive disorders

Depression is one of the common mental disorders during both the acute and chronic phases following disasters. Depression is characterised by pervasive low mood (feeling sad throughout days/weeks), losing interest in any activity including previously pleasurable ones, easily feeling tired, poor sleep and appetite, decreased interaction with people, crying spells, guilt, feeling hopeless about future, death wishes and suicidal thoughts/acts. However, during the acute phase, it is to be noted that many individuals may present with a mixture of both anxiety and depressive features. Generally, 2 weeks of symptoms manifestation is required for the diagnosis of depression. Shorter periods may be reasonable if symptoms are unusually severe and of rapid onset.

Substance use disorders

Alcohol and tobacco are the commonly used substances. Based on the availability, individuals may initiate the use of alcohol/tobacco as a coping mechanism to get relieved from the stress, tension and to get sleep. Individuals previously using the substances may increase their use. Because of the severe withdrawal symptoms (headaches, nausea, tremors, anxiety, hallucinations, and seizures etc), use of alternative forms and illicit liquor may occur where alcohol is unavailable. Characteristics of substance abuse are: craving/increased urge to use the substance, ignoring other pleasures for using substance, using the substance despite knowing the harm, tolerance, withdrawal symptoms, when they repeatedly fail to stop their habit, etc.

Post-traumatic stress disorder

This disorder manifests within 6 months of a traumatic event of exceptional severity. The typical symptoms include reliving the trauma from the intrusive memories (flashbacks), daytime imagery, or dreams, emotional detachment, numbing of feeling, unresponsiveness to surroundings, anhedonia, and avoidance of stimuli that might arouse recollection of the trauma are often present. Rarely, there may be dramatic, acute bursts of fear, panic or aggression, triggered by stimuli arousing a sudden recollection and/or re-enactment of the trauma or of the original reaction to it.

Remember

- Disaster impacts physical, mental, social, and economic wellbeing of the community.
- Most mental health reactions are normal reactions while facing abnormal situations.
- Disaster causes short-term and long-term mental health impact.

CHAPTER 4 VULNERABLE GROUPS IN DISASTERS

Disasters affect everyone in the community. However, the impact disaster differs based on the individual's vulnerability profile. Children, elderly, women, and gender minorities (LGBTQIA+), persons with pre-existing disability (including mental illnesses), homeless individuals, individuals in shelter homes and prisons, and frontline community workers are more prone to develop physical, mental and social stress related to disasters.

Table 4.1: Vulnerable groups, during different types of disasters

Factors	Vulnerable Groups
Age	Children and adolescents (unaccompanied children, orphans, child labourers and children in conflict with law)
	Elderly (older adults not cared for in families, older adults in elderly homes and elderly living alone)
Gender	Women (pregnant women, single women, widow and divorced women, destitute)
	LGBTQIA+ (lesbian, gay, bisexual, transgender, questioning, queer, intersex, pansexual, two-spirit (2S), androgynous and asexual)
Occupation	Farmers, fisherman, daily wagers, bonded labour, first responders/ front line workers, unorganized sectors, mine workers, commercial sex workers
Family	Single parents, families with younger children, families with large dependents, families with aged, and terminal/chronic illness
Ethnicity	Indigenous groups, cultural, linguistic and religious minorities, nomads
Status	Socio-economically disadvantaged, homeless/abandoned/destitute, slumdwellers, unemployed
Health	Long-term medical condition, addiction, immunocompromised state, persons with limited life span, persons in palliative care
Trauma	Intimate partner violence, previous experiences of trauma, violence in the family/community, victims of sexual/physical violence and abuse/exploitation, bereavement
Displacement	Immigrants, migrants, environmentally displaced, internally displaced, refugees
Disability	Low vision, locomotor disability, dwarfism, intellectual disability, mental illness, cerebral palsy, specific learning disability, autism spectrum disorders, speech and language impairment, hearing impairment, muscular dystrophy, multiple disability
	Others (thalassemia, haemophilia, sickle cell disease, chronic neurological disorders)
Others	Tourists, prisoners, homeless people, unorganised workers, retired people/elderly without caregivers

Vulnerability changes based on the pre-existing conditions, environment, political scenario, etc. For example, a drought or heavy rainfall in the field areas make farmers vulnerable; whereas, cyclone makes fisher folk and people living in the coastal areas vulnerable. It is essential that all the vulnerable groups need to be identified and equipped with skills and resources to anticipate, cope better, resist and recover from the impact of disasters. Though different factors contribute to vulnerability among individuals, the major vulnerable groups are: Children, Women, Elderly and Persons with Disabilities. It does not mean that other groups do not require attention. Vulnerable groups change based on the nature and intensity of the hazard, pre-existing risks, and prevailing socio-political conditions. It is hence essential to identify persons based on their vulnerability and plan measures to reach them promptly using assistive and easily accessible services. Type of vulnerable groups and the factors leading to it keeps changing. Therefore, care need to be taken to constantly update information on 'persons at risk' and plan programmes that enhance the psychosocial competencies of vulnerable groups.

Figure 4.1: Indicators of vulnerability

- Environmental - Geography, infrastructure, environment, density of population
- Health- Chronic health conditions, disability
- Communications- Media, public health education, warning arrangements
- Economy- Insurance,employment, production
- Psychology- Stress, personality, behaviour, acceptance
- Emergency management- Plans, capacity building, resources
- Organisational- Political systems, agencies, legislations
- Cultural/societal- Language, culture, norms

Principles of working with vulnerable groups

Vulnerable groups being physically, psychologically, or socially disadvantaged, need more attention, in the intervention process. As vulnerability refers to the compromised capacity of an individual to foresee, handle, resist to and recover from the impact of disaster, principles of working with vulnerable groups should focus on building resilience in them.

Principle of human rights promotion (promotion of equality, respect, dignity and autonomy)

2. Principle of non-discrimination (providing services without any discrimination)
3. Principle of accessibility (easy accessibility to information, resources, and services)
4. Principle of protection from violence and exploitation (promoting awareness on legal framework that protects vulnerable populations from any form of violence or exploitation and exercising the same)
5. Principle of priority of services (offering rescue, relief, and reconstruction services first to persons belonging to vulnerable population and then to the universal community)
6. Principle of preserving family unity (not separating vulnerable groups from their family or neighbourhood)
7. Principle of confidentiality (ensuring confidentiality to personal information of vulnerable groups and enabling anonymity while discussing about their issues and concerns)
8. Principle of inclusion (including in decision-making, planning, execution and evaluation)
9. Principle of acceptance (accepting individuals with his/her strengths and limitations)
10. Principle of resourcefulness (acknowledging the inherent strengths, knowledge and abilities of persons belonging to vulnerable groups)

Children

Specialised childcare is essential following disasters. Children from different age groups get impacted in different ways following trauma. It is important to be aware of such reactions. This will help in identifying the distress immediately and to facilitate focussed care. Children need a safe, nourishing, and nurturing environment and also need to socialise with friends of the same age group for a better development. It is essential to understand their basic need and plan effective deployment of the resources. Children may prefer writing, drawing, playing, clay modelling, singing or group activities as a mode of expression of their emotion. Engaging them through these activities serve as the initial step in psychosocial management.

A 7 years old boy was brought by mother with complaints that he is feeling fearful and not interacting with other children in the flood relief camp. He started sucking thumb again and bedwetting in the night. Other children tease him and he feels scared. Mother is also worried that he is not eating.

Women

Socially prevalent gender-based discrimination makes women more vulnerable to the after effects of disaster. Loss of lives and livelihood provide space for further exploitation. For instance, being removed from home and sheltered in a new place is likely to create insecurities. Worries regarding family members, personal hygiene, menstrual hygiene, privacy, safety related issues are all common following disasters. Lessons learnt from disasters suggest that women feel better when they are in a group with other women where they can discuss safety and other issues freely. Participating in group activities like prayers, religious services, helping in preparation of food and organisation of camp etc., noted to provide relief from stress.

A 35 years old widow, who recently lost her husband in the earthquake, currently living in a school camp has been brought by other survivors with complaints of poor interaction, poor eating, poor sleep and not participating in group activities.

Older adults

Pre-existing medical conditions, physical ailment, difficulty in mobility, dependence on others socially and economically make older individuals more vulnerable to the devastating physical and mental health effects of disasters. Their existing routine may be severely impacted and their needs may be neglected during the acute phase of rescue and recovery. By providing facts related to disasters, shelter, and safety, seeking advice or opinion, involving them in decision-making, enabling them to connect with their family and friends may lead to faster recovery.

A 65 years old man with many years of diabetes and hypertension on treatment, presents to you with complains of minor forgetfulness, poor concentration, poor sleep since recent cyclone. He is staying in an old age home that is away from his family and is worried about the effects of cyclone on his home and family members.

Persons with pre-existing disabilities (including mental illnesses)

Though there are legislations and administrative framework existing in the country for the welfare of persons with disabilities, they are a special group of people who needs much more attention. In view of their existing disabilities, dependence on society for functioning and prevalent social stigma against substance use, mental health, and disabilities in general, the differential impact of disasters on such special population is devastating. It is important for the community team to be aware of the special group during the acute phase of rescue to provide specific psychosocial interventions relevant to this group.

A 33 years old woman diagnosed with inztellectual disability was brought by her brother. He said that she is talking to herself, not maintaining self-hygiene, experienced difficulty to manage her during menstrual cycle, not eating properly. She was behaviourally stable before the recent earthquake.

Frontline community workers (Caring for carers)

During the initial rescue phase, most frontline workers participate with a sense for social welfare at heart and a need for coordinated care. However, it is important to be aware that, similar to general population, frontline and healthcare workers are also prone to be affected by the overwhelming nature of disasters. Guilt, moral injury, depression, physical and mental exhaustion are all common among frontline workers. It is important to work as a team and is essential to take care of each other during the rescue and recovery process.

Maintaining a logbook of work done, frequent sharing of experiences with the teammates, appreciating and recognising the efforts of others and supporting each other during crisis is absolutely vital.

A middle-aged lady Anganwadi worker, participating currently in flood relief is complaining of not able to work to the fullest of her potential. She was feeling tired and exhausted, was not able to sleep, feeling guilty that she is not able to help others, feels bad when her superior official scolds her for not working enough.

Impact of Disasters on Frontline and Health Care Workers

Physical impact	Psychological impact	Social impact
• Physical Injury • Wounds • Respiratory and Gastrointestinal infections • Gastritis • Headache • Body aches • Exacerbation of preexisting	• Mental injury (guilt) • Burnout • Depression • Anxiety • Sleep disturbances • Substance use • Poor concentration • Suicidal thoughts	• Stigma • Separation from family • Worries regarding family and friends • Job loss • Hostile conditions • Difficulty adjusting to new role • Increase in workload • Reduction in payment • Delay in pay • Irregular pay

The PCDs should be aware of the needs of these special populations. Knowledge on the needs would help PCDs to devise and monitor strategies for special groups. Care should be taken to prioritise reach of psychosocial and medical care services to these vulnerable groups before reaching the general population. In all the stages of disaster management, caring for vulnerable groups should be ensured.

Remember

- Disasters differentially impact vulnerable groups more
- It is important to be aware of the various reactions in this special group
- Focussed interventions attending to the needs of these special groups may benefit them immensely

CHAPTER 5 TRIAGING AND PSYCHOSOCIAL FIRST AID (PSFA)

Triaging refers to the grading of distress severity or damage to match with the existing resources. Triaging is the immediate and critical first step of assessment during the immediate aftermath of disasters. Triage paves way for efficient allocation of mental health resources during acute crisis. Identification of distress, rapidly assessing the severity of distress, grading and coding individuals based on the level of the distress and matching or referring them to the appropriate care are the key components of psychosocial triaging.

Figure 5.1 Psychosocial Triage

Step 1: Code Green in Medical Triage

No

Step 2: Follows simple commands

Reassign to medical triage

Yes

No

Step 3: Pre-existing medical conditions

Does the person require mental health follow-up based on the current medical condition?

Yes

No

Step 4: Assess risk level using psychosocial triage matrix and assign to specific services

Earlier diagnosis of Mental Illness

Yes

Referral to Mental Health Service within 24 hours

High risk

Medium risk

PSFA/PSS within a week or month

Low risk

PSFA + Continue long-term (month to year) mental health surveillance

(Adapted from Brannen et al., 2013)

Table 5.1: Psychosocial triage matrix			
Indicators	Low Risk	Moderate Risk	High Risk
Physical closeness	Greater distance from the epicentre (disaster affected site)	Closer to the epicentre but not in the epicentre	Present in the epicentre
Expressive closeness	Does not know the survivor/s	Knows/friend to the survivor /s	Closely related or best friend of the survivor/s
Individual vulnerabilities	1. No history of chronic physical or mental illness 2. Able to regulate emotions 3. Connected with social ties 4. No significant life events in the past 5. Not a person in the vulnerable group (children, women, PwD, migrant, farmer third gender, etc.) 6. Optimistic	1. Not certain about pre-existing physical/ mental illness 2. Certain problems with emotional regulation 3. Partial social withdrawal 4. Past life events present but not very significant 5. Partially fitting in to a vulnerable group 6. Partial Pessimism	1. History of chronic physical or mental illness 2. Poor emotional self-regulation 3. Active social withdrawal 4. Presence of significant life events in the past 5. Absolutely fitting into a vulnerable group 6. Extreme Pessimism
Environmental vulnerabilities	1. Living with all family members 2. Adequate parent-child relationship 3. Adequate family functioning 4. Absence of significant traumatic stress among parents 5. No history of mental illness in the family 6. Adequate family or community resources 7. Not a victim of stigma or discrimination	1. Living with some family members 2. Tenuous parent-child relationship 3. Inconsistent family functioning 4. Presence of minimal traumatic stress among parents 5. Not sure about mental illness in the family 6. Erratic family or community resources 7. Partial victim of stigma or discrimination	1. Not living with family members 2. Strained parent-child relationship 3. Poor family functioning 4. Presence of significant traumatic parental stress 5. History of mental illness in the family 6. Inadequate family or community resources 7. Dire victim of stigma or discrimination
Instant reactions during the disaster	Appeared relaxed during the impact	Expressed mild to moderate distress	Expressed acute distress
Ongoing reactions	Expressed few common crisis reactions	Expressed many common crisis reactions	Florid manifestation indicating mental health treatment (self-harm or causing harm to others, hyper vigilance, depression, acute dissociation, psychotic features, elated mood, etc.)
Coping	Active or adaptive coping (Able to deal with the impact effectively)	Uncertain coping (Unaware of how to deal with the impact)	Avoidant or Maladaptive coping (Harming self/ others, use of substances)

Source: Richter & Flowers 2008

Psychosocial First Aid (PSFA)

After establishing the triage, Psychosocial First Aid (PSFA) is the first step of intervention that can be provided for most of the affected people with low risk. Similar to medical first aid following trauma and injury, PSFA refers to the important, basic, psychosocial support provided to individuals following trauma and disasters. The provision of non-intrusive, primary, practical care and support during acute crisis is PSFA. It also provides the basis for needs assessment of the community and importantly serves in preventing people from facing further harm.

Figure 5.2: Key components of PSFA

Strategies of PSFA

World Health Organization (WHO) has given following four first aid strategies to guide the care providers to deliver their service effectively.

PREPARE

- Understand people and situation specific to a disaster
- Understand the biopsychosocial factors that make people vulnerable to a disaster
- Locate the survivors in the disaster area
- Identify resources within the community

- Immediate emotional reactions
- Physical health issues
- Psychosocial needs and concerns
- Availability of support within the family
- Availability of local/community resources
- Strengths of the survivors, their family and the community

- Listen to their needs and concerns
- Acknowledge their strengths
- Normalize the feelings and thoughts
- Give reassurance
- Ensure their safety
- Provide basic needs

- Connect survivors to their primary caregivers or loved ones
- Connect them to a safe place for shelter and fulfil their basic needs
- Connect them to a care facility based on their bio-psycho-social concerns (persons with mental illness to respective district mental health programs; unaccompanied child with the child protection agency; and hearing aid for persons with hearing impairment).

Interventions in PSFA

All the PSFA interventions are aimed at promoting safety of the individuals, treating with respect and dignity, promoting a sense of calmness, improving the social support and providing hope. PSFA is the beginning of the association of rescue team with the community. The objective is to restore the social and behavioural functioning of the community following disasters. There is no rigid framework provided for intervening immediately after crisis. Following techniques are can be seen as a flexible framework or guide while approaching a community to provide PSFA.

Assess the urgent needs (food, medical, safety, immediate emotional reactions, etc.).

Safeguard from further damage (shifting the affected people to the safe places ,medical services, etc.).

Provide help for survival (financial support, basic facilities, etc.).

Listen and console (understand the problem and provide assistance accordingly).

Impart knowledge on how to deal with the problems effectively (seeking help, looking for resources/ strengths).

Link to different sources of support (educational, health, community, religious institutions, etc.).

Teach about normal and abnormal reactions.

a) Sense of safety

Immediately aftermath of any disaster the affected community experiences wide range of physical, psychological, and social impact. It is essential to attend to the basic and safety needs of the community immediately to provide an overall sense of safety. Immediate support helps in changing the view of the survivors from "this is a dangerous and unsafe world" to "may be yesterday it was… it may not be always". Here, sense of safety is not in absolute terms but relating to the previous impact created by the event. The role of media in providing the accurate facts also plays an important role ensuring the sense of safety.

b) Calmness

Emotions overwhelm immediately after disasters and may interfere with coping and restoration of biological and social functions. Initial emotions are normal and most individuals return to their baseline soon. Those who are unable to manage may develop psychological problems. Games, breathing exercise, grounding, muscle relaxation, yoga and mindfulness help in reducing the hyper-emotional state and induce calmness. Calming helps individuals to move from "I am going crazy" to "this is a normal reaction to a crisis situation".

c) Sense of self and collective efficacy

Following traumatic events, individuals appear to feel a loss of sense control or powerless. This extends to the community as well following major disasters. Such events further lead to a generalisation of beliefs like "nothing will change… nothing can be done". The loss of control may lead to further emotional and behavioural dysregulation and poor coping. Interventions focussed on re-establishing the sense of self-efficacy like recollecting resources, individual and group focussed activities may help the community to swim together and recover faster saying, "this too shall pass… we shall overcome".

d) Connectedness

Social connections get disturbed during disasters where people might feel, "I have no one to support me". Families, relatives, friends, and societies come together following a traumatic event in the locality. Social support and connectedness provide the basis of collective recovery and aids in individual recovery as well. It enables a spirit of oneness and cohesion where people feel, "I have someone to rely upon… there is some form of help". Linking with loved ones, known individuals, providing information about missing persons, breaking bad news and providing support, etc are essential in bringing the community together. Regulation of social rituals and reconnecting with the school, college, work place improves emotional recovery.

e) Hope

Hopelessness is common post disaster. Mass casualty shatters all the hope in the community. Negative emotional state associated with such events further hinders recovery. Individuals feel pessimistic about future and say, "there is no hope in life at all". Spirituality, religious beliefs, support, and relief provided by external resources like governmental and non-governmental organisations, other communities are the key elements in reconstruction of the hope in affected community. It instils hope and optimism among individuals where they might feel, "I can rebuild myself…. there are better tomorrows".

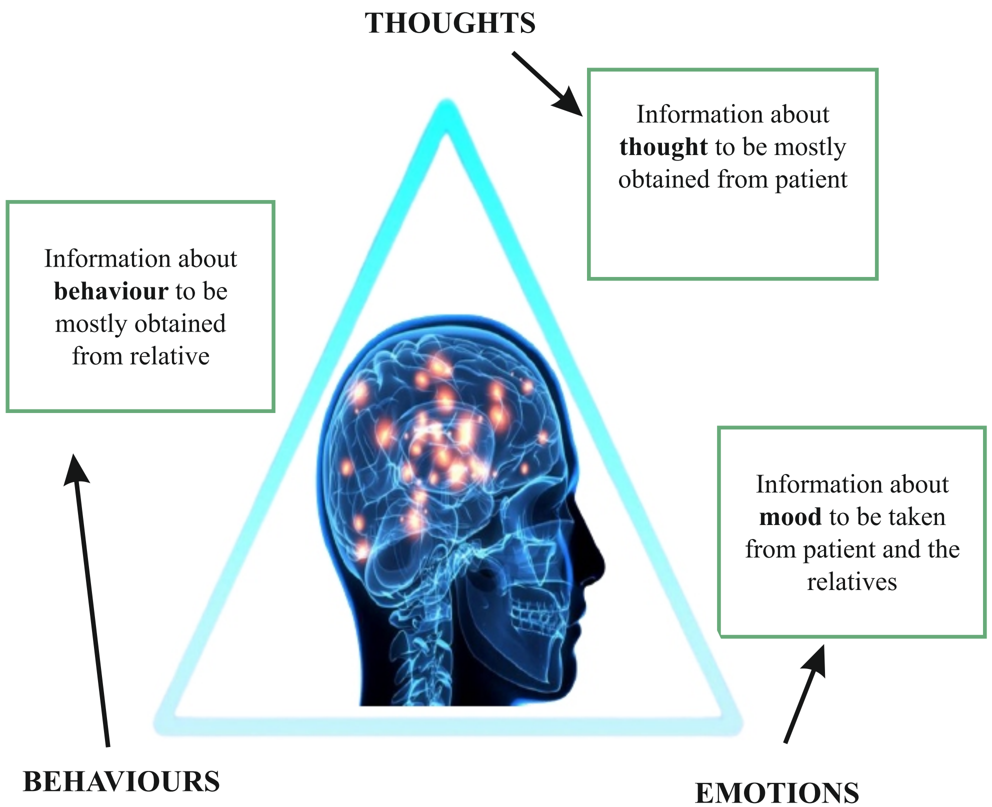
Remember

- Psychosocial triaging is similar to medical triaging
- PSFA works on the basic strategies of 'Prepare', 'Look', 'Listen' and 'Link'
- PSFA can be provided at individual and community level

CHAPTER 6 INTERVIEW AND ASSESSMENT METHODS

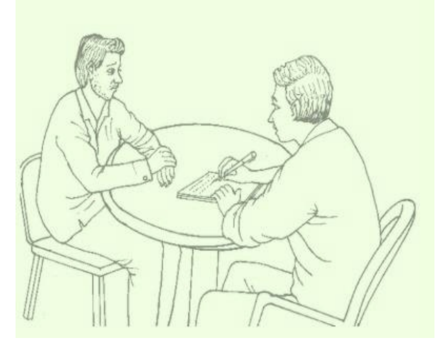
Just like medical interview, in disaster context interview begins with assessing the sociodemographic factors, chief complaint`s, history of presenting illness, past, family, and personal history. However, there needs to be special attention provided to collect enough information from different reliable sources as feasible. Basic enquiry in psychiatry encompasses the enquiry about various difficulties in the thought, mood, and behaviour of an individual. This chapter, focuses on conducting basic psychiatric interview, skills necessary to connect better with an individual in distress, focus on psychosocial vulnerability or risk factors and simple but structured assessment tools to measure anxiety and depression.

SOURCES OF INFORMATION IN PSYCHIATRIC INTERVIEW



Principles of Psychiatric Interviewing

'Therapeutic relationship' is essential for appropriate assessment, adequate clinical care, and long-term management. The following principles and techniques help in establishing strong therapeutic relationship.



Empathy

Empathy is one of the basic and crucial psychosocial care techniques that help in building rapport and trust with the disaster survivors. Here the care provider understands the subjective experience of the survivor and communicates it the survivor. E.g., 'I understand it must be very difficult for you to witness the pain and suffering', 'I can't imagine being in that situation', 'I know you have tried your best to support your family', etc.

Expression of empathy can be practiced by these four basic elements;

- Viewing from the other person's perspective
- Understanding their feelings and emotions
- Non-judgmental acceptance
- Communicating that the care provider has understood the other person's situation

Unconditional positive regard

This involves showing complete support and acceptance of the person irrespective of what the person does or says. This is about rising above one's own likes and dislikes and providing unconditional warmth and support. This helps the person to develop trust and express feelings and thoughts without any inhibitions.

Confidentiality

Confidentiality refers to the state of knowledge being held in confidence. Except in certain medico-legal circumstances (observed threat to self or others), the confidentiality is to be strictly maintained.

Given below are some techniques that can be used while interviewing:

Asking open ended question: It is always advisable to avoid closed ended questions which would yield only 'yes' or 'no' response. For instance, asking 'how are you feeling?', allows people to talk more, than asking 'are you sad?', similarly asking 'tell me about your problem?' leads to free-flowing response than limiting the question to 'Is there a problem'.

Clarification: When the care provider is not clear about what is been said by the affected person or unclear about the symptoms, issues, or concerns, instead of jumping into the conclusion it is better to clarify.

Ex: Symptom - "I panic a lot"

Can you explain what you mean while saying "I panic"?

Can you give examples of what happens when you are in the panicky state?

Verbal and non-verbal communication: When the views, thoughts and emotions are expressed in the form of sound or words, it is called as verbal communication. Most often it takes in the form of face-to-face communication. In the process of interacting with the survivors of disasters making verbal gestures like, 'mmm., yes., okay.,' etc, help in providing reassurance.

In non-verbal communication transmission of messages or signals take place through visual/bodily cues such as eye contact, facial expressions, gestures, posture, leaning forward, nodding head, and maintaining silence etc.

Reflective listening: In this type of listening the interviewer pays keen attention to the content and the emotions of the affected person. In this the interviewer also expresses his/her understanding to the client. 'Summarizing' and 'Paraphrasing' help in expressing the understanding.

Client: Whenever I go to bed, I cannot sleep, I get visions of house being flooded and fearful. I feel so exhausted with all these.

Doctor: So… It sounds like when you go to bed, you cannot sleep, you get images of your house being flooded and you feel fearful and tired (Reflective listening)

Doctor: I get that you are feeling sleepless, tired, and fearful with visions of your house being flooded (Summarizing)

Doctor: It seems to be that you have images of house being flooded when you go to bed and that makes you fearful and sleepless (Paraphrasing)

Remember

- Assessment of mental health symptoms is same as physical issues.
- Host of psychosocial factors make an individual vulnerable to the after effects of disaster.
- Specific principles and techniques may be applied while interacting with individuals for better care.

CHAPTER 7 PSYCHOSOCIAL MANAGEMENT

Provision of Psychosocial First Aid (PSFA) is the basic minimum a community worker can provide during the acute crisis following any disaster. PSFA should be made available universally for everyone touched by a traumatic event and to the community as a whole. However, the role of the Primary Care Doctor (PCD) does not stop at providing PSFA alone. Primary care conceptually involves health promotion, illness prevention, care and management of diseases/disorders. PCDs could play a crucial role in psychosocial preparedness, care, recovery, and rehabilitation of the affected community.

Figure 7.1: Key Phases of Disaster Management

Pre – Disaster	During Disaster	Post Disaster
To reduce the potential for human, material or environmental losses To minimize hazard and vulnerability when disaster strikes	Relief, response and immediate recovery To minimize the difficulties and physical and mental pain due to disaster	To rehabilitate the people with restoration needs To achieve recovery post disaster To reduce the vulnerability To foster adaptation

Key components of psychosocial management in disasters

Primary care plays a crucial role in all the phases of disaster management. The following Figure (7.2) summarises the different components of comprehensive psychosocial management from prevention to rehabilitation. The items highlighted (in capital letters) are within the domain of PCDs.

Figure 7.2: Key components of psychosocial management in disaster

Prevention
Efforts to avoid the occurrence of disasters (SOCIAL EFFORT)

Mitigation
Efforts to eliminate/ reduce the impact of disasters (COMMUNITY RESILIENCE)

Preparedness
Actions taken to reduce impact and improve response (CAPACITY BUILDING)

Response
Immediate acute crisis management (PSFA)

Recovery
Psychosocial needs assessment and care (BRIEF INTERVENTIONS + MEDICINES)

Rehabilitation
Specialised care needed for few individuals (REFERRAL/ SPECIALIST CARE)

Community Resilience

Community resilience refers to the ability to utilise existing resources or build new resources in anticipation to face, withstand and recover from any adversity. PCDs play a vital role in improving the community's resources to prepare better and recover from disasters. Some of the key elements and strategies to strengthen community resilience includes;

- Mapping of internal and external resources
- Strengthening the health infrastructure
- Coordinating with local government or non-governmental organisations in advocacy and decision-making
- Learning from the public about indigenous methods of disaster preparedness
- Preparing and providing Information, Education and Communication (IEC) to general public about possible disasters in the locality
- Identify gaps and accelerate systems to minimise vulnerabilities and risks
- Enable equality of services and make sure the services reach all individuals in the community
- Capacitate individuals on adaptive coping behaviours
- Ensure sustainability of services

INDICATORS OF COMMUNITY RESILIENCE

(Source: Chandra et al., 2011)

Capacity building

A key psychosocial preparedness element is capacity building. The community should be equipped and prepared enough to face and recover from the disasters. Capacity building broadly refers to development of financial, technological, institutional, and human resource development in the community. A PCD can play a pivotal role in the development of human resources through training and skill building in disaster management. This also involves supervision and research in the area of disasters and mental health. Such capacity building exercise should be based on the strengths and limitations of the resources available, existing indigenous knowledge, and common disasters specific needs in the affected community.

Psychosocial competencies

Psychosocial competencies are skills that communities should inculcate to nourish better adaptation and to foster resilience in disaster prone communities. It is essential to capacitate individuals with psychosocial competencies that help individuals to cope effectively with the daily stressors. Psychosocial competency empowers individuals, and enable prompt and rational reactions in response to disasters. The skills that disaster prone communities need to develop during the life course to enhance the psychosocial competencies are mentioned below:

Figure 7.3: Skills required to enhance psychosocial competency

Emotional Skills	Self-awareness; Empathy; Adaptability; Coping; Resilience
Cognitive Skills	Problem solving; Decision making; Critical thinking; Creative thinking
Social & Civic Skills	Interpersonal Relationship Skills; Effective communication; Cross cultural sensitivity; Social responsibility
Leadership Skills	Planning; Organising; Collaborating; Influencing; Conflict resolution
Information Skills	Information literacy; Media literacy; Information Communication literacy

BRIEF PSYCHOLOGICAL INTERVENTIONS

Sleep hygiene techniques

Sleep is often disturbed following traumatic events. It is essential to be aware of certain techniques that improve the overall quality of sleep. The following table summarizes the brief advice related to sleep hygiene.

Table 7.1: Do's and don'ts of sleep hygiene techniques

Do's	Don'ts
• Routine sleep-wake hours	• Erratic sleep hours
• Prefer single stretch of sleep at night	• Day time naps
• Empty bladder before going to bed	• Heavy meals before bedtime
• A glass of warm milk before bedtime	• Take stimulating drinks (coffee)
• A brief walk before going to bed	• Exhausting exercises before bed
• Use bed only for sleeping	• Eat and watch TV in Bed
• Read a book just before sleep	• Play intense mobile games
• Listen to calming music just before retiring	• Watch movies and TV series
• Ensure bed room is quiet and dark	• Add artificial lights
• If not sleepy, get out of the bed	• Keep rolling till you fall asleep
• Go to bed later when you feel sleepy	• Try harder to get sleep

Breathing exercise

Place your hand on your lower abdomen and feel the gentle rise and fall of your belly as you breathe.

Breathe in slowly---Pause for a count of three---Breathe out slowly---Pause for a count of three.

Continue the above steps for one minute, pausing for a count of three after each inhalation and exhalation.

Jacobson's Progressive Muscular Relaxation (JPMR)

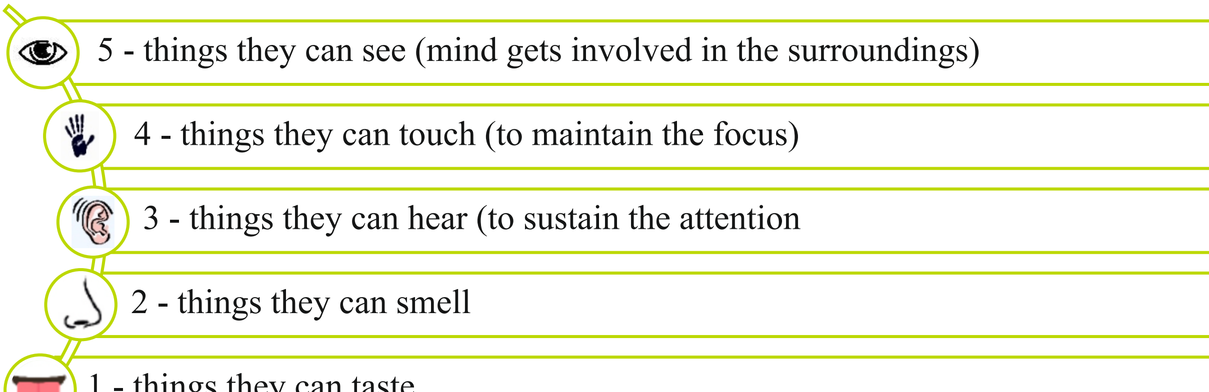
Progressively tightening and loosening muscles in the multiple parts of the body starting from toe to head. It is proven that stress/muscle tension gets accumulated in multiple parts of the body and manifest as pain. Systematic tightening and loosening of body muscles helps in releasing pent up emotions. It is important to notice the difference in tension of the group of muscles and how they feel when relaxed. The individual may breathe in while tightening and gently release the tightening muscles while breathing out.

Grounding techniques

Grounding techniques help to reduce intense distress and anxiety and help to refocus away from distressing memories/worries. Grounding techniques entertains the sensations of touch, smell, hear, see and taste to 'ground' the racing mind away from intense feelings, worries and memories.

The 5-4-3-2-1 technique

One of the grounding techniques that stimulates all five sensory organs. When a person feels panicky or feels like going crazy – request them to focus on their environment.



All these divert the person's restless mind and make them focus on the task at hand and thereby reduces their stress and panic.

*Sensory organs may be interchanged and need not be in the same order

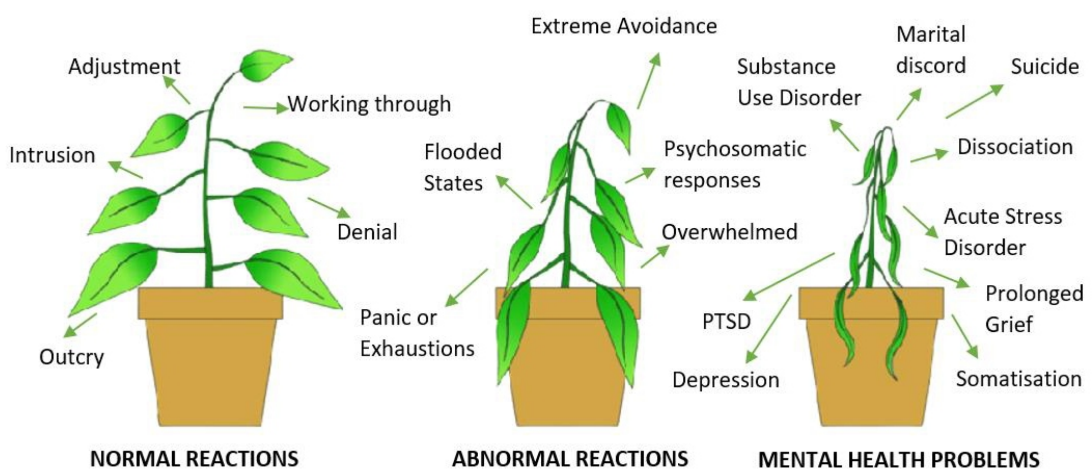
Remember

- Psychosocial care involves all aspects of disaster management.
- Community resilience is a key element in faster recovery.
- Brief relaxation techniques may help individuals cope better.

CHAPTER 8 MEDICAL MANAGEMENT

Most of the psychosocial concerns and mental health reactions following disasters are 'normal reactions to a crisis situation'. Often such reactions can be managed by providing Psychosocial First Aid (PSFA). Many acute phase mental health reactions are transitory in nature due to the overwhelming impact of the disasters. Only a handful of individuals may require medical management and further specialist referral.

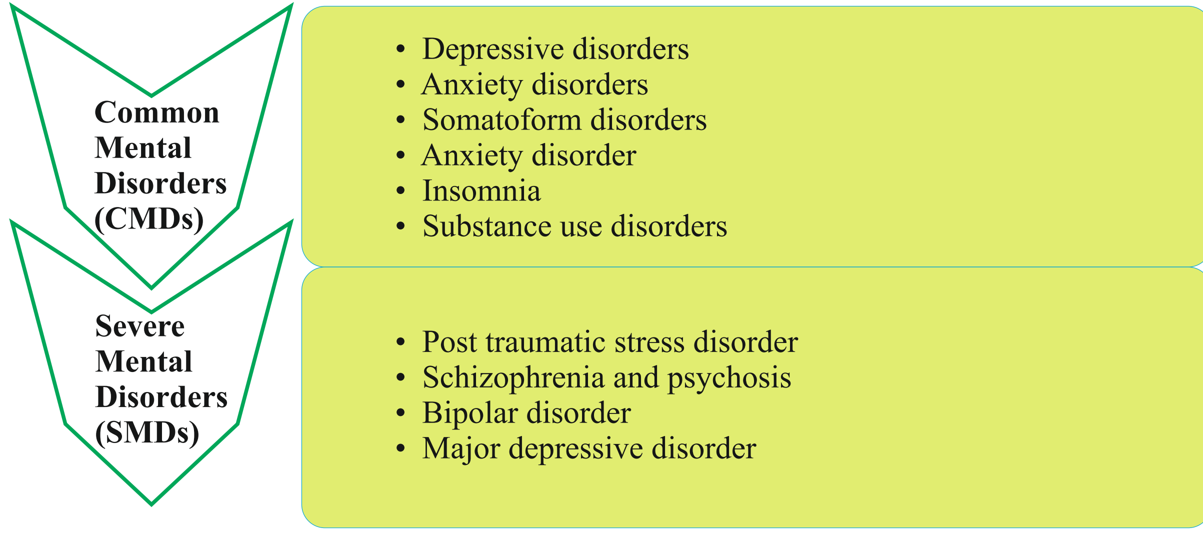
NORMAL AND ABNORMAL REACTIONS DURING DISASTERS



Common mental disorders (CMDs)

Some of the common mental disorders may become severe based on the impact and functioning of the affected individuals. The following figure summarizes the common and severe mental disorders.

Figure 8.1: Common and severe mental disorders



With respect to medical management, most common mental disorders can be managed at the primary level with psychosocial support, brief psychological interventions for relaxation and medicines (only when needed). CMDs respond very well to the first-line antidepressant and anti-anxiety medications. Selective Serotonin Reuptake Inhibitors (SSRIs) are the preferred first-line of medicines. Safety and tolerability profile are evaluated immensely and is suitable for prescription across age group (preferably after age-12).

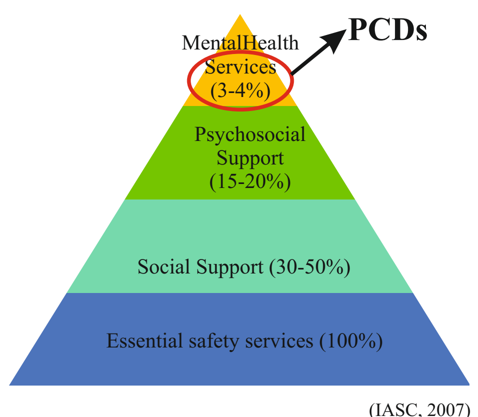
Table 8.1: General principles of medical management, different drugs, dosages and their side effects

Drug (Class)	Starting dose	Maximum dose	Common side effects	Remarks
Fluoxetine (SSRI)	20mg	20-40mg	Gastritis (to be taken after food) Sleep disturbances (to be taken in the morning)	Potent inducer of CYP450 liver enzyme
Escitalopram (SSRI)	10mg	20mg	Gastritis and nausea Electrolyte disturbances in the elderly	Less Liver enzyme interactions
Sertraline (SSRI)	25mg	150mg	Gastritis and nausea Electrolyte disturbances in the elderly	Safe after cardiac or cerebral events
Amitriptyline (TCA)	10mg	150-225mg	Sedation, nausea, gastritis, dry mouth, blurred vision, constipation (anticholinergic)	Useful in somatoform pain disorders
Imipramine (TCA)	25mg	150-225mg	Sedation, nausea, gastritis, dry mouth, blurred vision, constipation (anticholinergic)	At 25-50mg in the night useful in enuresis
Diazepam (Benzodiazepines)	5mg	10-15mg	Dizziness. daytime sedation interfering with work, slow excretion.	Caution to avoid driving, industrial work
Clonazepam (Benzodiazepines)	0.25mg	1mg	Dizziness, unsteadiness and daytime sedation	Mouth dissolving form for acute effects
Lorazepam (Benzodiazepines)	1mg	4mg	Tiredness. poor absorption. short acting agent	Safe in liver derangements

General principles of psychotropic prescription

1. Start low dose and increase gradually
2. Avoid polypharmacy
3. Try drugs sequentially – onset of action may be delayed (2 weeks)
4. Explain the effects and side effects clearly
5. Provide prescriptions only for few days (maximum 2 weeks)
6. Review regularly for side effects
7. Refill prescriptions as needed
8. Drugs belonging to SSRI class may interact with liver enzymes – note co-prescribed drugs
9. Caution about sedation while using Benzodiazepines and Tricyclic antidepressants (TCA)
10. In elderly, electrolyte imbalance may be noted with SSRIs

Need for referral



At the primary care level, most common mental health reactions and disorders can be managed. However, it is also important to observing and identify specific conditions that need specialist care. After referral, it is also essential to follow up the patients whom the PCD has referred for further mental health management.

When to refer?

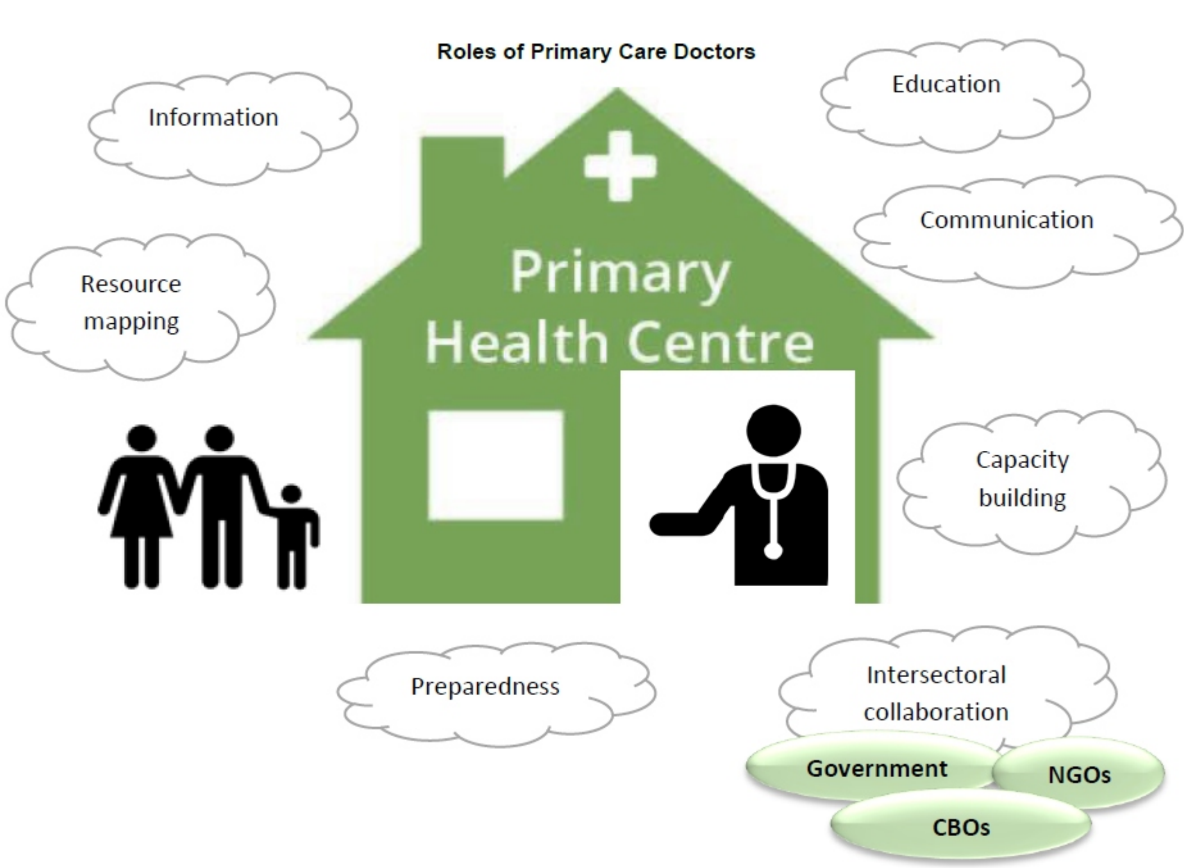
- When the symptoms are persisting despite first line management
- When there is immediate harm to self (suicide)
- When there is immediate harm to others/property (violence)
- When there is gross self-neglect
- When substance intoxication or withdrawal is problematic
- When the side effects of psychotropics are distressing
- When the person has multiple co-morbidities
- When the person has severe mental disorder
- When there are new symptoms while treating CMDs
- When the person insists for specialised care

Remember

- Psychosocial management may be preferred first line.
- Safe and efficacious first line drugs are available.
- It is essential to understand referral process and follow up.

CHAPTER 9 PRIMARY CARE DOCTOR (PCD) AS AN ADMINISTRATOR

Primary Care Doctor (PCD) plays a critical role in disaster management. Their role is not restricted to provision of psychosocial care and medical management of common mental health reactions and disorders. It encompasses the vital support provided by the PCDs in each phase of disaster management cycle. This involves Information, Education, Communication (IEC) activities, resources mapping, capacity building, inter-disciplinary coordination between different government, non-governmental and community-based organizations (CBOs), capacity building, active assessment of common disasters in the region, indigenous disaster management measures, provision psychosocial support and management, research, and advocacy.



Role of PCDs in different phases of Disaster Management cycle

Preparedness — BUILDING RESILIENT COMMUNITIES

- Identification of hazards
- Information, Education and Communication (IEC) development
- Creating awareness to the public about different disasters
- General health promotion
- School wellness programs
- Life skills education program
- Promotion of psychosocial competencies among community members
- Mapping of vulnerable groups
- Preparedness initiatives among vulnerable groups
- Assessment of the community resilience level
- Learning the indigenous practices of managing disasters
- Capacity building – human and other resources

Mitigation — DISASTER RISK REDUCTION

- Coordinating with different stakeholders to reduce the risk
- Conducting Hazard Risk Vulnerability (HRV) analysis
- Identifying the vulnerable region and sub-population
- Coordinating the mitigating measures
- Promoting immunization practices
- Resource mapping activities
- Creating a log of available resources

Response — REDUCING FATALITIES

- Immediate action
- Involving the community resources
- Coordinating with other rescue agencies
- Psychosocial triaging
- Psychosocial First Aid (PSFA)
- Medical first aid
- Management of wound, infirmity and other illness
- Prevention of new water and food-borne illnesses

Recovery — TOWARDS THE ROAD TO RECOVERY

- Assessment of coping pattern in the community
- Assessment of resources utilized
- Preparing reports to reflect the community health status
- Psychosocial management of acute events
- Medical management of common physical and mental disorders
- Caring of the carers (frontline and healthcare workers)
- Referral and follow up
- Taking up research initiatives

Rehabilitation — ENABLING RESTORATION AND RECONSTRUCTION

- Participation in community rebuilding
- Ensuring adequate relief measures
- Coordinate with other departments for further care
- Data collection, analysis and preparation of research report
- Further specialised assessment and management
- Inform policy makers from the existing data about future plan
- Ensure public-private participation in rehabilitation measures
- Inform the disaster management authority for integration of new data

Functions of PCDs

Provision of quality care

Continuing care amidst emergencies

Community engagement and empowerment

Communication, c ollaboration & c oordination

Working with individuals, families, and care providers

Improving infrastructure and identifying innovative working strategies

Legislations, Policies, Plans and Programmes

It is important for the Primary Care Doctors (PCDs) to be aware of the system with respect to disasters and mental health management. Wherever applicable, PCDs need to survey the available framework further with respect to their district, block, or panchayat union. Such knowledge help PCDs in better preparedness to face the disasters and mental health crisis that is common following any disaster. A few important legislative and administrative framework existing in the country related to disaster management and mental health are given below:

DISASTER MANAGEMENT RELATED

- Disaster Management Act, 2005
- National Policy on Disaster Management, 2009
- National Disaster Management Guidelines, Medical Preparedness and Mass Casuality Management, 2007
- National Guidelines on Psychosocial Support and Mental
- Health Services during Disasters, 2009
- National DIsaster Management Plan, 2019
- State Disaster Management Plans
- District DIsaster Management Plans

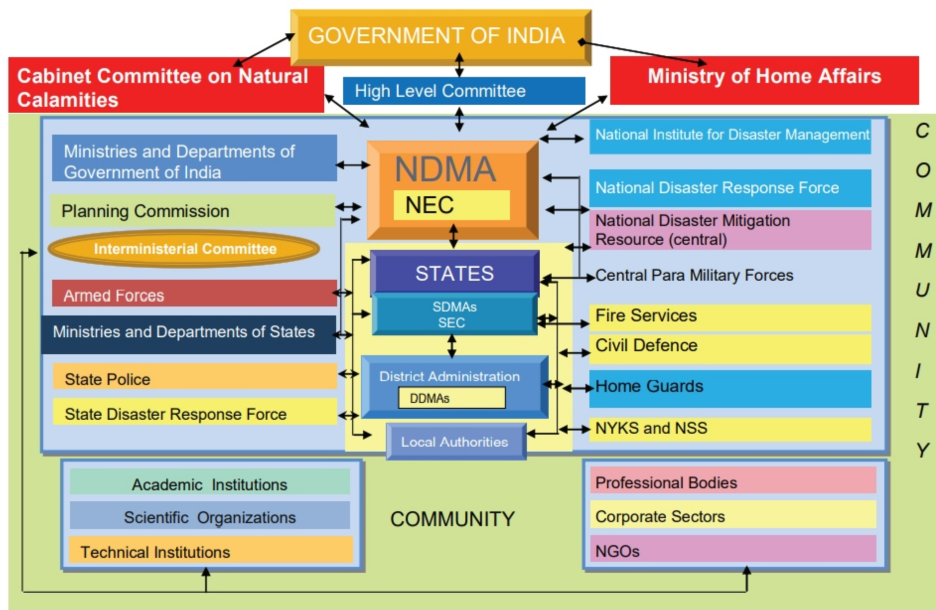
MENTAL HEALTH RELATED

- Mental Health Care Act, 2017
- Rights of Persons with Disabilities Act, 2016
- National Mental Health Policy, 2014
- National Mental Health Programme
- District Mental Health Programme

Disaster Management Act, 2005 (DMA-2005)

This act was enacted by the parliament in 2005. It provides institutional framework and monitoring measures for the implementation of disaster management in terms of prevention, mitigation and prompt response to disaster situations.

Figure 9.1: National disaster management structure



(Source: Disaster Management in India, 2011)

National Disaster Management Guidelines, Medical Preparedness and Mass Causality Management, 2007

This guideline has been designed to provide directions to the central ministries, departments, and state authorities for the preparation of their detailed 'medical preparedness' plans. In order to strengthen the capacities of the hospital and health care workers, more emphasis is given on the need for creation of an institutional mechanism is stressed. The roles and responsibilities in providing medical and psychosocial services of different stakeholders, including medical professionals as first responders is given in this guideline.

National Policy on Disaster Management, (NPDM) 2009

NPDM envisions to build a safe and disaster resilient India by developing a holistic, proactive, multi-disaster oriented and technology driven strategy through a culture of prevention, mitigation, preparedness and response. This policy adopts community-based disaster management approach and also targets capacity building at for all the stakeholders, blending past initiatives and best practices in the planning and multisectoral coordination.

National guidelines on Psychosocial Support and Mental Health Services (PSSMHS) during disasters, 2009

This guideline aims at rebuilding lives of disaster affected communities in the response, relief and rehabilitation aspects during kinds of disasters. The provision of PSSMHS will be combined with the spectrum of care including general health programmes, National Mental Health Programme (NMHP), District Mental Health Programme (DMHP) and district health plan. This guideline also focuses on the capacity building, training, service delivery, research, documentation, monitoring and evaluation at the national, state, district, and community levels as a part of implementation of PSSMHS activities.

National Disaster Management Plan (NDMP), 2019

NDMP provides a framework and direction to the government agencies to manage disaster at all phases of disaster management cycle mandates in accordance with the provisions of the DM Act 2005 and the NPDM 2009. It intends to implement disaster management plan in a flexible and scalable manner and also to eliminate the ambiguity of responsibilities for the stakeholders involved.

DM act, 2005 mandates each State government to prepare their ***State Disaster Management Plans (SDMP)*** based on the specific needs and situation of the state. SDMP shall also assist the Central Government and central agencies in various aspects of DM. Similarly, each district is mandate to have their own District Disaster Management Plans (DDMP).

Mental Health Care Act, 2017 (MHCA-2017)

Union government passed this Act in April, 2017 and the act came into force from May, 2018. This act provides universal basic mental healthcare and services for persons with mental illnesses (PwMI) and promotes rights-based approach while treating PwMI.

MHCA mandates the government to set up mental health institutions across the nation for the people living in a remote locality to avail mental health services. Mental health establishments and professionals working in public, private sectors or NGOs need to register themselves under this act. State and central government are mandated to maintain an online registry of the all the professionals providing care in a particular region. As discussed in chapter 3, disaster significantly impacts the mental health of affected community. This act guides on the dos and don'ts for the PCDs while dealing with disaster survivors.

Rights of Persons with Disabilities Act (RPWD), 2016

RPWD act defines disability as a dynamic and evolving concept. As per this act, the government has to take the responsibilities of the persons with disabilities by taking appropriate measures to safeguard their rights. From the initial 7 types of disability as given under Persons with Disability act (PwD), 1995, under RPWD it is been increased to 21 types of disabilities (physical, intellectual, and mental health related disabilities; disability caused by chronic neurological conditions & blood disorder: multiple disabilities) and the central govt has the power to add more type disabilities based on the needs of the people. This act also provides, provision of guardianship for the PwD. District court or the designated authority should carry out the responsibilities of granting the support for PwDs.

National Mental Health Policy, 2014

This is an inclusive policy which follows an integrated, participatory, rights and evidence based comprehensive approach including both medical and non-medical aspects of mental health. The major goals of this policy include; to reduce distress, disability, exclusion morbidity and premature mortality associated with mental health problems across life span of the person; to enhance understanding of the mental health in the country; and to strengthen the leadership in the mental health sector at the national, state and district levels.

National Mental Health Programme (NMHP)

NMHP was launched in 1982 by govt of India. Main objectives of this program is to ensure the availability and accessibility of minimum mental healthcare for all, especially vulnerable and underprivileged groups; to encourage the application of mental health knowledge in general healthcare and social development; and to promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

District Mental Health Programme (DMHP)

Under the National Mental Health Programme (NMHP-1982), decentralization was sought and the DMHP was initiated in 1996. The programme envisions the provision of basic mental healthcare in the community level. DMHP team includes psychiatrist, psychologist, social worker, mental health nurse, and office staff. It is mandated to allocate 10 beds dedicated for psychiatry inpatient services at the district level, 4 satellite outreach camps in PHCs/CHCs every month by the DMHP team.

The components of outreach programmes include school life skill education, college counselling services, work place stress management and suicide prevention strategies.

Understanding this institutional framework and disaster management measures can help PCDs to carry out their roles effectively by coordinating with different ministries and line departments involved as given in the provisions of these legislations, policies, and programs.

Remember

- PCDs have a crucial role to play in all types of disasters.
- Medical management has to be combined with psychosocial care.
- PCDs need to play different roles in different phases of disaster.
- Disaster Management Act 2005 and Mental Healthcare Act 2017 are the principal legislations in their respective fields

Level-4: Certificate Course on Disaster Mental Health Services (DMHS)

The DMHS module can be provided as a certificate course. This level would focus on capacitating Medical Officers in DMHP and private practitioners on mental health services for disaster affected communities. The training will be a three months virtual certification programme. The participants will be provided DMHS manual and workbook. The participants would be trained on mental health complications subsequent to disasters, medical and psychosocial management. On completion of the course curriculum of 12 online sessions of two hours each and 17 resource material provided and completion of assignments, case studies and other requirements they will be provided a Certificate from NIMHANS and endorsed by NDMA/SDMA.

National Disaster Management Training Module - 4

Facilitators Guide

Disaster Mental Health Services

March 2023

Jointly Developed by

National Disaster Management Authority (NDMA)

National Institute of Mental Health and Neuro Sciences (NIMHANS)

CONTENT

Chapter	Title	Page No
	Section-1	
1	Introduction to disasters	50
2	Introduction to mental health and psychosocial support	51
3	Mental health impact of disasters	52
4	Vulnerable groups in disasters	53
5	Triaging and Psychosocial First Aid (PSFA)	54
6	Interview and assessment methods	55
7	Psychosocial management	56
8	Medical management	57
9	Primary Care Doctor (PCD) as an administrator	58

PROGRAMME SCHEDULE

No	Name of Session	Methodology	Duration
1	Introduction to disasters	Brain storming	120 mins
2	Introduction to mental health and psychosocial support	Sharing of experience	180 mins
3	Mental health impact of disasters	Brain storming and group discussion	150 mins
4	Vulnerable groups in disasters	Free listing, group activity and discussion	240 mins
5	Triaging and Psychosocial First Aid (PSFA)	Role play and group discussion	150 mins
6	Interview and assessment methods	Case discussion and activity	180 mins
7	Psychosocial management	Presentation	150 mins
8	Medical management	Case discussion and activity	150 mins
9	Primary Care Doctor (PCD) as an administrator	Presentation and discussion	120 mins

FACILITATORS GUIDE

Session 1: Introduction to disasters.

Aim: To orient the participants on disasters.

Methodology: Brain storming.

Duration: 120 minutes.

Process: Facilitator will give an introduction to disaster and explains the various types of disaster. The activity given will be conducted. Followed by the activity, facilitator discusses the disaster management cycle and concludes the session.

Outcome of the session: Participants will understand the concept of disaster.

Activity 1

Description of the activity: Mapping of Disasters in India

Aim: To trace the common disasters occurring in India

Duration: 120 minutes

Materials Required: Indian Map, Markers or Pens

An Indian Map will be shown to the participants. The participants will be asked to take turn and say one disaster they know occurred in a particular state, so the facilitator mark it with an asterisk '*'. Duplication of work will not be allowed. The facilitator keeps giving the clues to help the participants.

FACILITATORS GUIDE

Session 2: Introduction to mental health and psychosocial support.

Aim: To enhance participants understanding on psychosocial aspects of mental health.

Methodology: Sharing of experience.

Duration: 180 minutes.

Process: Facilitator will give a brief introduction to health, mental health, psychosocial support (PSS) and dynamic interaction between thoughts, emotions & behaviour. Discussion on psychosocial determinants of mental health with case examples will be done. The session will be concluded with the following activity.

Outcome of the session: Participants will understand psychosocial aspects of mental health.

Activity 2

Description of the activity: Discussion

Aim: To discuss psychosocial determinants metal health

Duration: 180 minutes

Materials required: Nil

Facilitator will encourage the volunteers to share the cases they have dealt in their practice and point out the psychosocial determinants. Others can add on to the point based on their observation.

FACILITATORS GUIDE

Session 3: Mental health impact of disasters.

Aim: To help participants understand mental health impact of disasters.

Methodology: Brain storming and group discussion.

Duration: 150 minutes.

Process: Facilitator will give an introduction to impact of disaster on different area of life and the following activity will be conducted. After the activity the facilitator will discuss about the stressful reactions during disasters, normal and abnormal reactions post-disasters and common mental disorders in disasters.

Outcome of the session: Participants will understand mental health impact of disasters.

Activity 3

Description of the activity: Group discussion

Aim: To facilitate discussion on stressful reactions during disaster

Duration: 150 minutes

Materials required: Nil

Participants will be divided into 4 groups and instruction will be given to discuss on the stressful reactions during disaster preferably with case examples. Each group will be given specific areas to focus, i.e., physical, emotional, relational and behavioural reactions respectively. Once the discussion is done, each group will have to present their points to the large group. Facilitator will add on the left out points and connects the activity to normal and abnormal reactions post-disaster.

FACILITATORS GUIDE

Session 4: Vulnerable groups in disasters.

Aim: To help participants understand about vulnerable groups in disasters.

Methodology: Free listing, group activity and discussion.

Duration: 240 minutes.

Process: Facilitator discusses about the factors leading to vulnerability on specific group, indicators of vulnerability, and principles of working with vulnerable groups. The session will be concluded with the activity 4 given below.

Outcome of the session: Participants will understand the need to give special attention on vulnerable population.

Activity 4

Description of the activity: Group discussion

Aim: To discuss the impact of disaster on vulnerable population

Duration: 240 minutes

Materials required: Case vignettes

The focus of this activity will be to identify and discuss the difficulties faced by women, children, elderly, persons with pre-existing disabilities (including mental illness) and frontline workers. Participants will be divided into 6 groups and given case vignettes pertaining to a particular vulnerable group. Based on the case vignette each group will have to make a list of impact on the said groups. While one group is presenting, other group members will be encouraged to add on their observation.

FACILITATORS GUIDE

Session Name: Triaging and Psychosocial First Aid (PSFA).

Aim: To help participants understand about psychosocial triaging and PSFA.

Methodology: Role play and group discussion.

Duration: 150 minutes.

Process: Facilitator will begin the session by discussing about the psychosocial triage using figure 5.1 and table 5.1 given in chapter 5. Once the participants get familiarised about psychosocial triaging, the facilitator continues discussing about the PSFA and its key components, strategies, and interventions. An activity given below will be conducted and the session will be concluded.

Outcome of the session: Participants will be able to establish psychosocial triage and provide PSFA.

Activity 5

Description of the activity: Role play and discussion

Aim: To discuss on 'psychosocial triaging' and 'psychosocial first aid'

Duration: 150 minutes

Materials required: Case vignette

2 volunteers will be called for to play the role of a PCD and a care recipient. Case scenario will be given, based on which the PCD has to plan psychosocial triage. The observation of the remaining participants will be welcomed. After getting consensus about the triage from all the participants, the facilitator will ask the volunteers to do the role reversal and provide PSFA. Second round of open floor discussion will be done the session will be concluded.

Case vignette: Mrs. C is 45 years old mother of 3 children, who had lost her husband in a recent earthquake. Currently she is staying in a shelter home with poor sanitation and hygiene facilities. She is found tearful most of the time and is not participating in any of the group activities conducted by other women. She does not allow her children to go out either. She eats very less and has poor sleep.

FACILITATORS GUIDE

Session 6: Interview and assessment methods.

Aim: To enhance participants understanding on interview and assessment methods in disaster context.

Methodology: Case discussion and activity.

Duration: 180 minutes.

Process: Facilitator will discuss about the significance of interview, connecting it to the sources of information in psychiatric interview and principles of psychiatric interview which can be adopted as assessment methods. Activity 6 given below will be conducted and the session will be concluded.

Outcome of the session: Participants will understand the nature of interview and assessment with disaster affected population.

Activity 6

Description of the activity: Open group discussion

Aim: To generate the discussion on psychiatric interview skills and assessment tools

Duration: 180 minutes

Materials required: Case vignettes, white board and marker

Case vignettes will be displayed on by one and the participants will be encouraged to tell their view on the interview and assessment approach that can be applied. They can further justify their observations giving the examples from their practice experience. As participants tell the points the facilitator notes it down on a white board. Once the discussion for all the cases is done, based on the points noted, the facilitator concludes the session.

1. Mr. A, is a 45-year-old farmer, with history of depression in the past. Following flood in his village, in the last 3 weeks he was feeling sad most of the time and crying in isolation. He is not sleeping well and is not interacting well with others because of financial troubles He was recently found buying pesticide bottle and wished to end his life.

2. Ms. B, a 35-year-old transgender lady who earlier worked in garment factory, recently lost her job. She resides alone in a village but away from family owing to family discord. Following a cyclone, she lost her hut and is currently staying in a school shelter home. She complains of intense fear about recurrence of cyclone, thunder and lightning, gets intrusive images of the storm. She started consuming more tobacco to relieve her stress, and says at times that she experiences fast heartbeat, shaking hands, sweating and fears she may die immediately during such episodes

FACILITATORS GUIDE

Session 7: Psychosocial management.

Aim: To impart knowledge on psychosocial management in disasters to the participants.

Methodology: Presentation.

Duration: 150 minutes.

Process: Facilitator discusses about the key phases of disaster management, key components of psychosocial management, community resilience and its indicators, psychosocial competencies and skills required to enhance it and brief psychological interventions. An activity given below will be conducted and the session will be concluded.

Outcome of the session: Participants will be able to provide psychosocial management in disasters.

Activity 7

Description of the activity: Case discussion and presentation

Aim: To facilitate discussion for comprehensive psychosocial management in disasters

Duration: 150 minutes

Materials required: Case vignettes

Participants will be divided into 4 groups. All the groups will be given with a case and they will be instructed to identify the condition and come up with psychosocial management plan. Once all the groups complete discussion, representative from each group will have to present their plan to the entire set of participants.

1. **Case vignette – 1:** A 35 years old software engineer's, colleagues recently died due to viral illness. After that he gets sudden episodes of intense fear thinking even, he has got the infection and would die. During the episode his heartbeat increases, hands start trembling, and sweating. COVID-19 lockdown made him lose his job. This further added on worries regarding his loans, EMIs, and reduced employment opportunities. Being the only breadwinner in the family, he has the responsibility to take care of his old parents.

2. **Case vignette – 2:** A 40 years old home maker, who is the mother of 2 children, complaints of poor sleep in the last 3-4 weeks. Because of the crop loss due to the heavy rain fall, her husband is started overusing alcohol and not helping the family financially. She has recently started working as a helper at a nearby hotel. Whenever she goes to bed, she keeps thinking about the loans, debts and school fees for children, house rent and other daily expenses.

FACILITATORS GUIDE

Session 8: Medical management.

Aim: To help participants understand about medical management in disasters.

Methodology: Case discussion and activity.

Duration: 150 minutes.

Process: In this session, the participants will be briefed about the normal and abnormal reactions during disasters, common mental disorders, general principles of medical management, different drugs, dosages and their side effects, general principles of psychotropic prescription and need for further referral. The session will be concluded with the activity given below.

Outcome of the session: Participants will get oriented about the medical management in disasters.

Activity 8

Description of the activity: Case discussion

Aim: To discuss the medical management of common mental disorders following disasters.

Duration: 150 minutes

Materials required: Case vignettes

The cases will be displayed and the participants will be asked to identify the diagnosis, and plan the medical and psychosocial management. Volunteers will be called to discuss their plans and others will be encouraged to add on their alternative plans.

- A 35 years old man, fisherman complains of persistent sadness, crying spells, worries regarding unemployment and financial distress due to red alert for cyclone in his area. He has sleep disturbance, loss of interest to interact with others, and death wishes.
- • A 40 years old lady, home maker, complains of worries, headache, sleeplessness, episodes of breathlessness, chest pain, dizziness, fear of death, fear of going crazy, and sweating. She started demonstrating these symptoms after the gas leak incident from a plastic industry in her community where many people had health adversities.

FACILITATORS GUIDE

Session 9: Primary Care Doctor (PCD) as an administrator.

Aim: To help participants understand the role of primary care doctor as an administrator.

Methodology: Presentation and discussion.

Duration: 120 minutes.

Process: The session will begin with the activity given below. Followed by the activity the facilitator discusses about the role of PCDs in different phases of disaster management cycle and also different legislations, policies, plans and programmes related to disaster and mental health.

Outcome of the session: Participants will understand their roles in disaster and also get an overview of the existing plans and programs that are applicable in their practice.

Activity 9

Aim: To discuss the roles of Primary Care Doctor (PCD) as an administrator

Duration: 120 minutes

Materials required: Chart sheets and markers

Session Description: Group discussion

The participants will be divided into small groups to discuss and come up with the roles expected of a PCD during different phases of the disaster management cycle. Each group will be asked to present their activity to the large group and the facilitator will stimulate the discussion.

National Disaster Management Training Module - 4

Workbook

Disaster Mental Health Services

March 2023

Jointly Developed by

National Disaster Management Authority (NDMA)

National Institute of Mental Health and Neuro Sciences (NIMHANS)

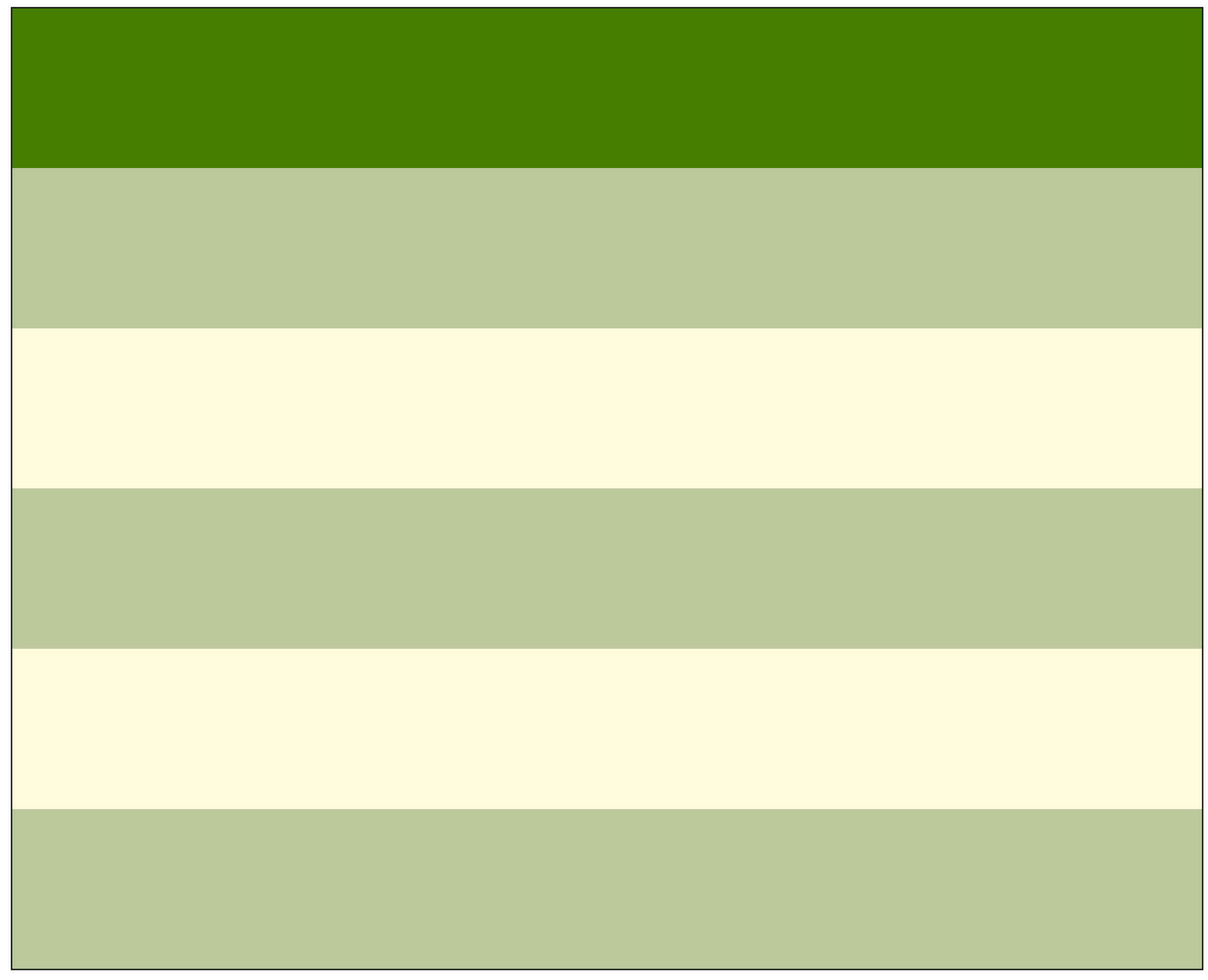
CONTENT

Chapter	Title	Page No
	Section-1	
1	Introduction to disasters	57-58
2	Introduction to mental health and psychosocial support	59
3	Mental health impact of disasters	60-62
4	Vulnerable groups in disasters	63-64
5	Triaging and Psychosocial First Aid (PSFA)	65-67
6	Interview and assessment methods	68-69
7	Psychosocial management	70-71
8	Medical management	72-74
9	Primary Care Doctor (PCD) as an administrator	75-76

CHAPTER 1: INTRODUCTION TO DISASTERS

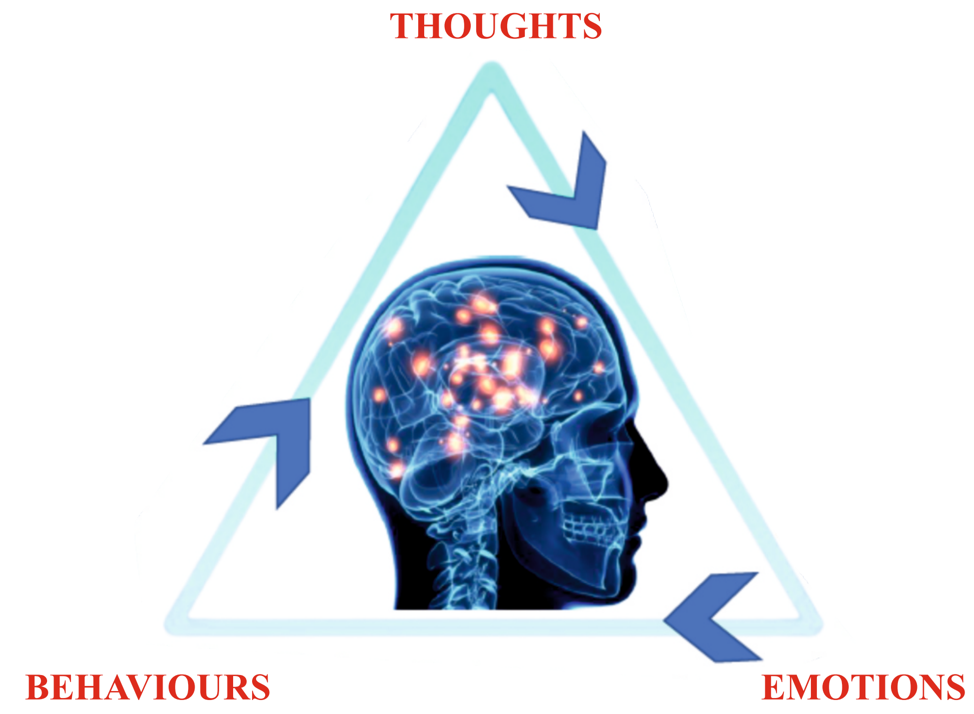
Types of disaster		
Natural disasters		
Nature	**Cause**	**Type**
Geophysical disasters		
Meteorological or Climatological disasters		
Hydrological disasters		
Biological disasters		
Human-made disasters		
Industrial accidents		
Communal accidents/Sabotage		
Accidents caused by human negligence		

Stages of disaster management cycle



CHAPTER 2:
INTRODUCTION TO MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

The dynamic interaction between thoughts, emotions and behaviour

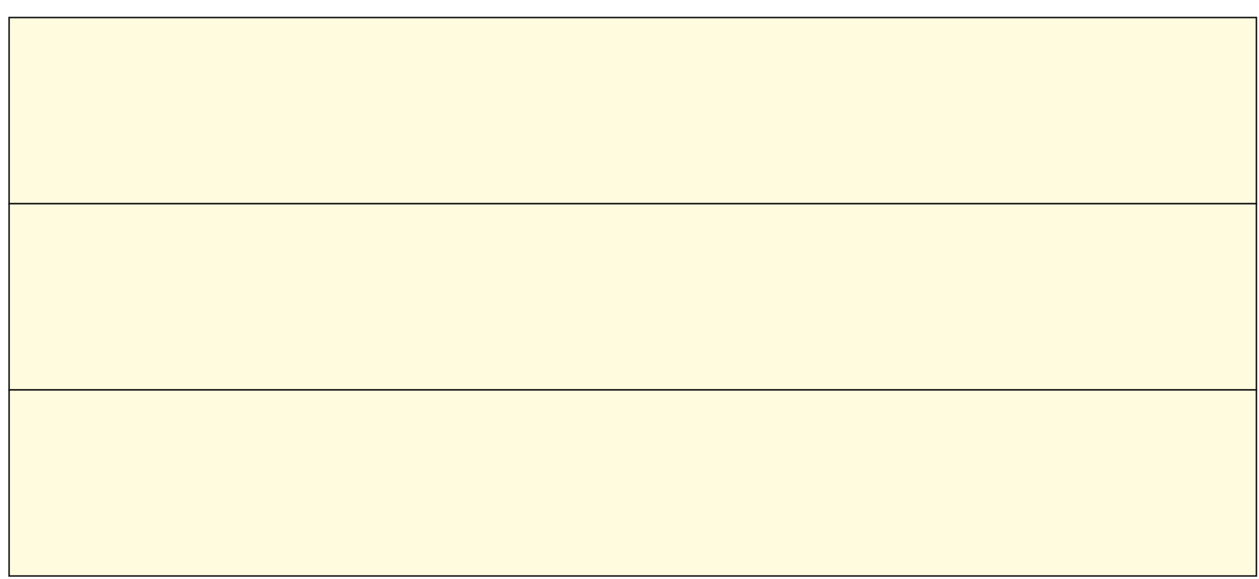


Psychosocial determinants of mental health in disaster

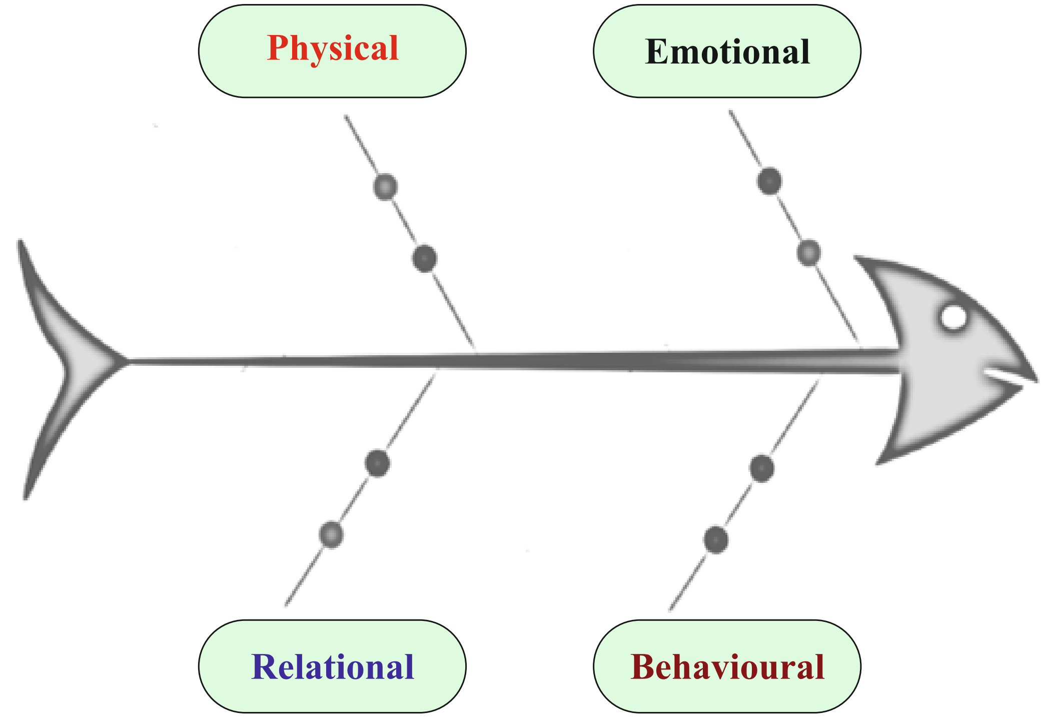
1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

CHAPTER 3: MENTAL HEALTH IMPACT OF DISASTERS

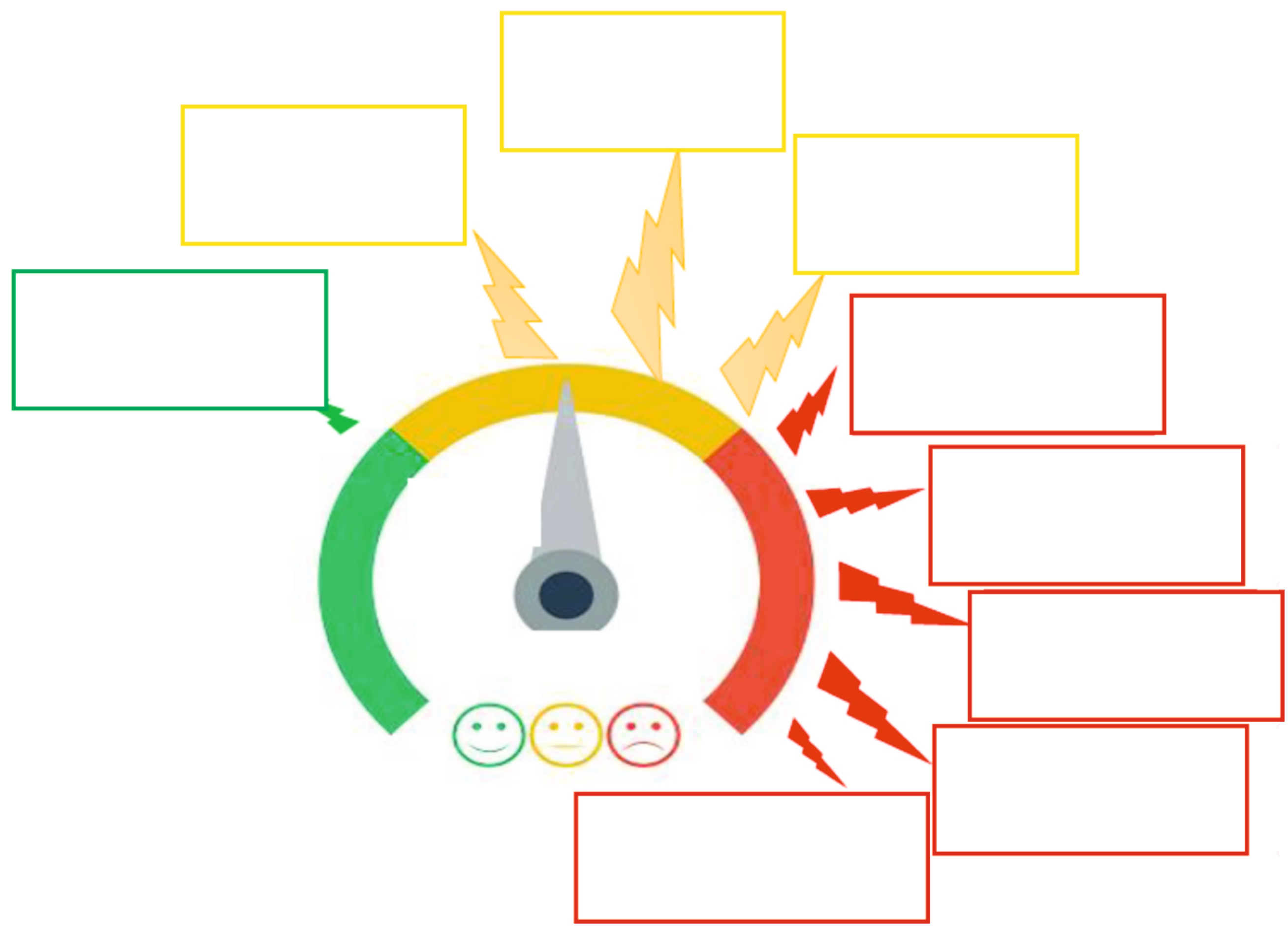
The impact of disaster can be broadly classified:



Stressful reactions during disasters



Normal and abnormal reactions post-disasters



Common mental health disorders in disasters

CHAPTER 4: VULNERABLE GROUPS IN DISASTERS

Vulnerable groups, during different types of disasters

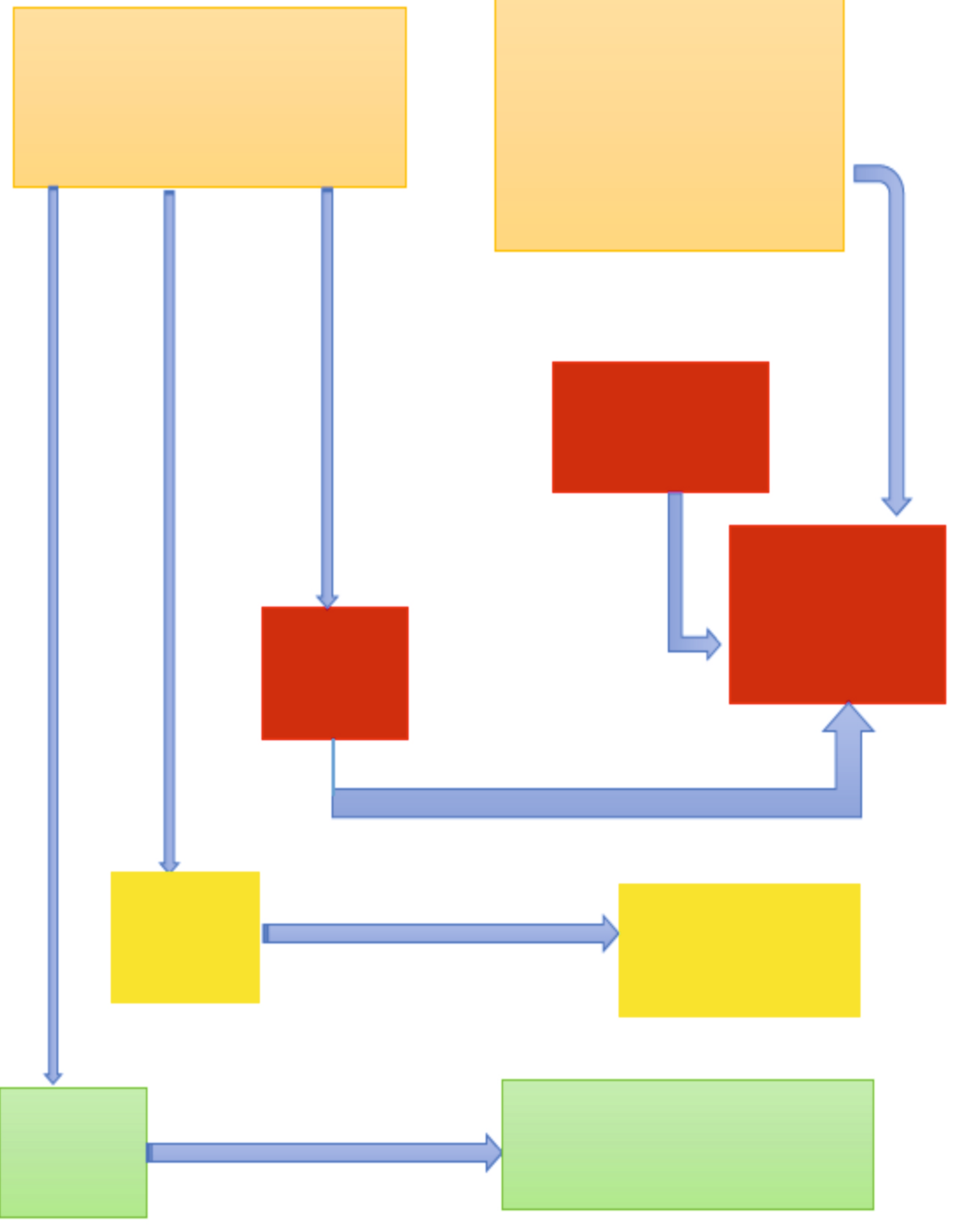
Age	
Gender	
Occupation	
Family	
Ethnicity	
Status	
Health	
Trauma	
Displacement	
Disability	
Others	

Impact of disasters on frontline and health care workers

Physical impact	Psychological impact	Social impact

CHAPTER 5: TRIAGING AND PSYCHOSOCIAL FIRST AID (PSFA)

Psychosocial triage



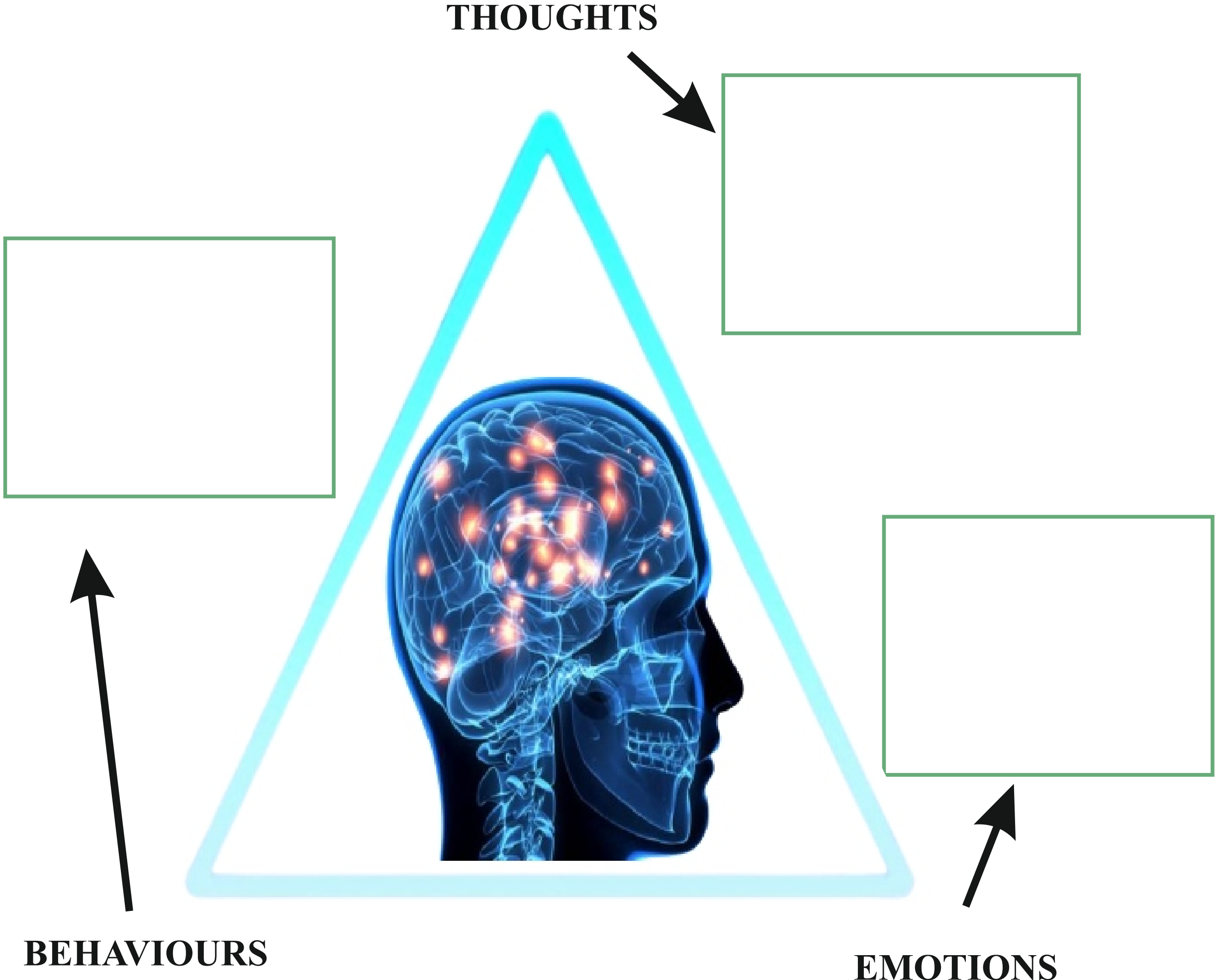
Psychosocial triage matrix

Indicators	Low Risk	Moderate Risk	High Risk
Physical closeness			
Expressive closeness			
Individual vulnerabilities			
Environmental vulnerabilities			
Instant reactions during the disaster			
Ongoing reactions			
Coping			

Psychosocial first aid strategies

CHAPTER 6: INTERVIEW AND ASSESSMENT METHODS

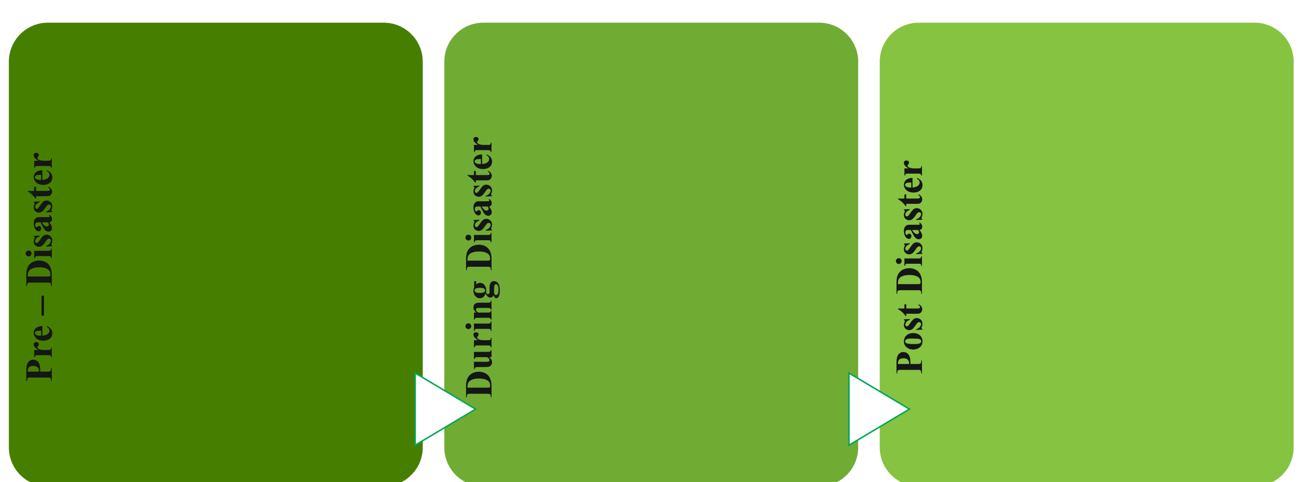
Sources of information in psychiatric interview



Principles of psychiatric interviewing

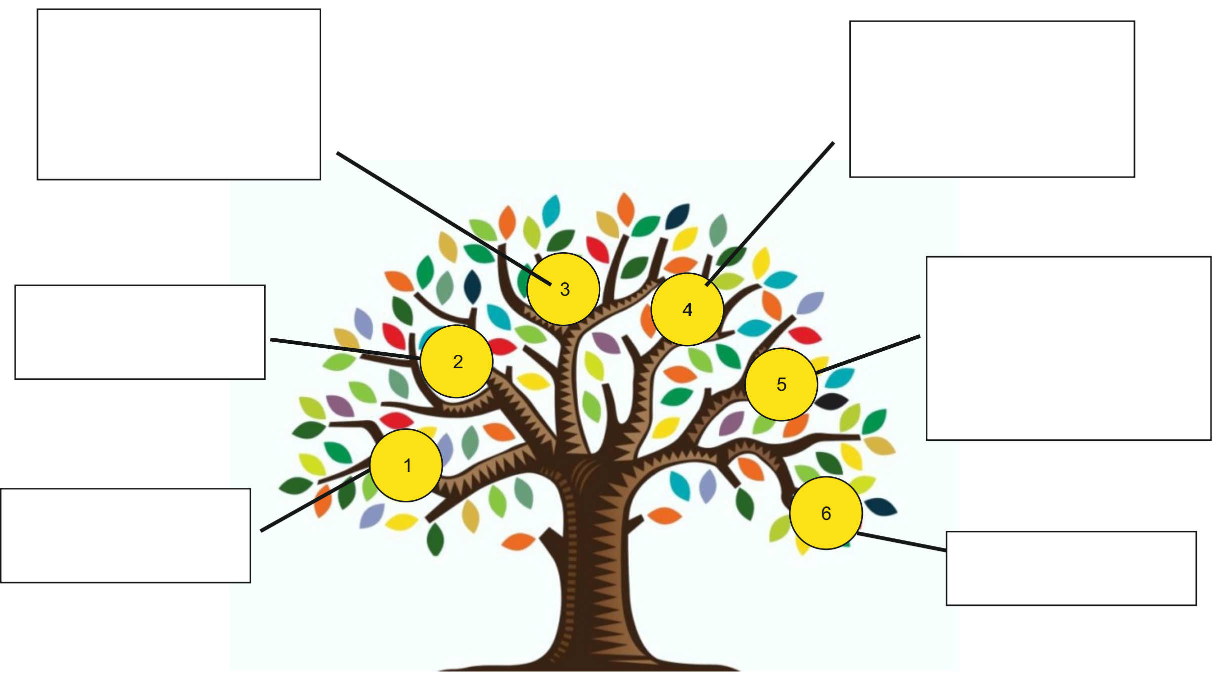
CHAPTER 7: PSYCHOSOCIAL MANAGEMENT

Key Phases of Disaster Management



Key components of psychosocial management in disasters

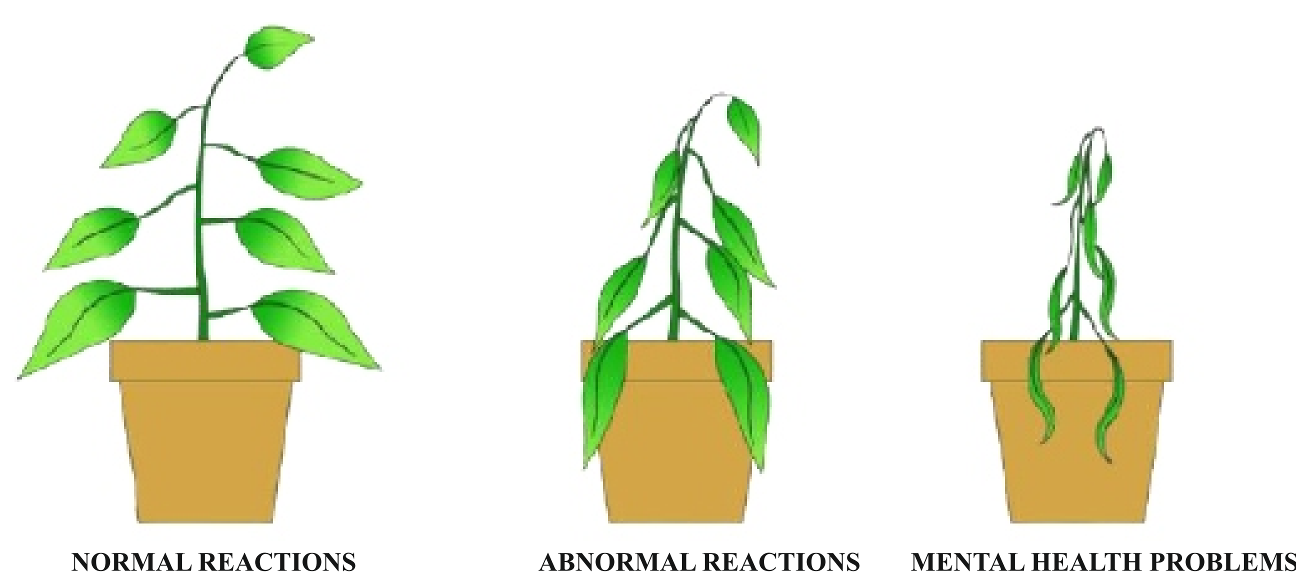
Indicators of community resilience



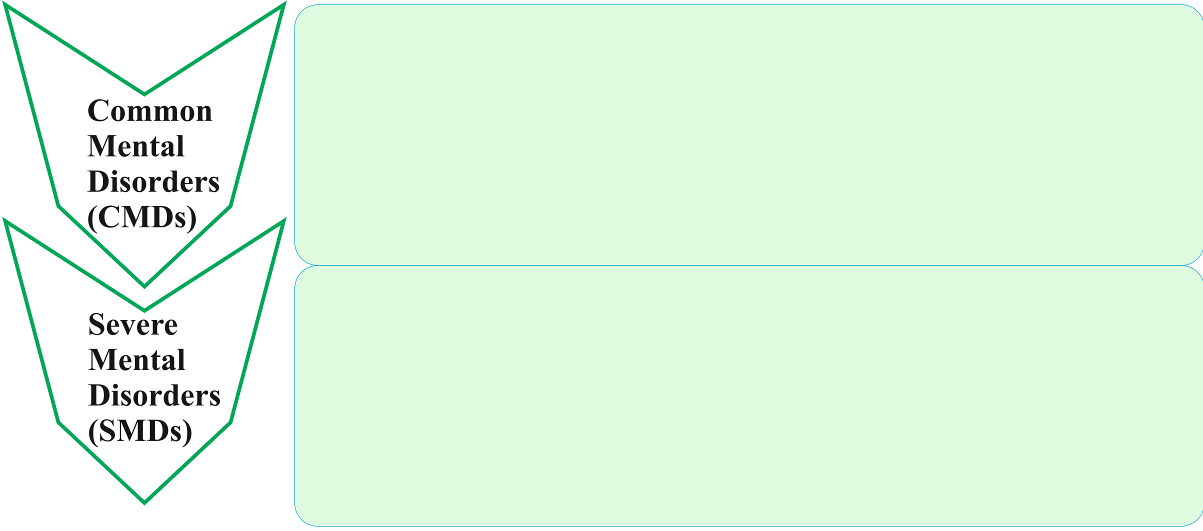
Skills required to enhance psychosocial competency

CHAPTER 7: MEDICAL MANAGEMENT

Normal and abnormal reactions during disasters



Common and severe mental disorders



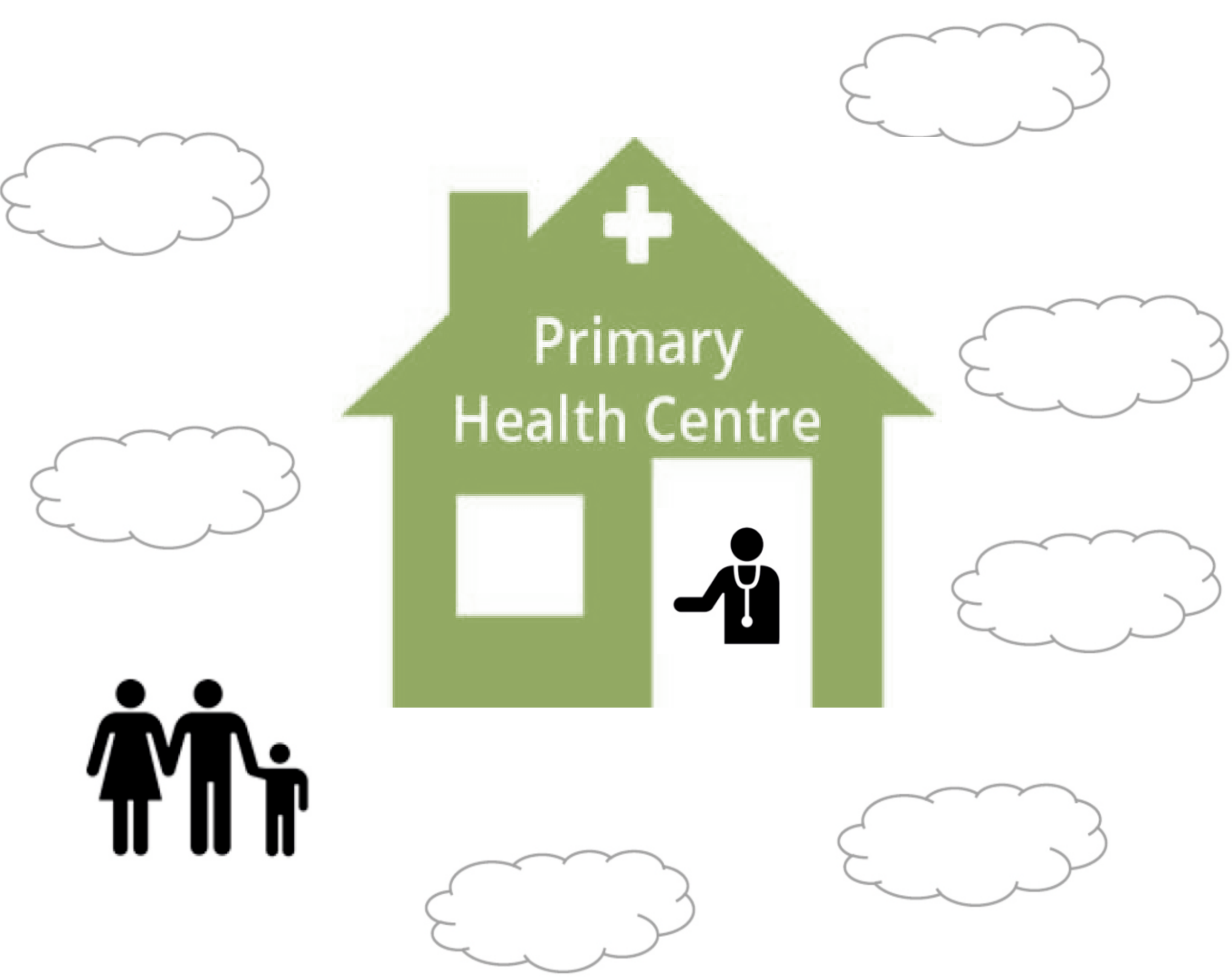
General principles of medical management, different drugs, dosages and their side effects				
Drug (Class)	**Starting dose**	**Maximum dose**	**Common side effects**	**Remarks**
Fluoxetine (SSRI)				
Escitalopram (SSRI)				
Sertraline (SSRI)				
Amitriptyline (TCA)				
Imipramine (TCA)				
Diazepam (Benzodiazepines)				
Clonazepam (Benzodiazepines)				
Lorazepam (Benzodiazepines)				

General principles of psychotropic prescription

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

CHAPTER 9:
PRIMARY CARE DOCTOR (PCD) AS AN ADMINISTRATOR

Roles of primary care doctors



Role of PCDs in different phases of disaster management cycle

PREPAREDNESS	
MITIGATION	
RESPONSE	
RECOVERY	
REHABILITATION	

A few important legislative and administrative framework in India

DISASTER MANAGEMENT RELATED	
MENTAL HEALTH RELATED	

Reference

1 Brannen, D. E., Barcus, R., McDonnell, M. A., Price, A., Alsept, C., & Caudill, K. (2013). Mental health triage tools for medically cleared disaster survivors: an evaluation by MRC volunteers and public health workers. Disaster medicine and public health preparedness, 7(1), 20–28. https://doi.org/10.1001/dmp.2012.49

2 Chandra, A., Acosta, J., Howard, S., Uscher-Pines, L., Williams, M., Yeung, D., ... & Meredith, L. S. (2011). Building community resilience to disasters: A way forward to enhance national health security. Rand health quarterly, 1(1).

3 IASC Reference Groups MHPSS. IASC Guidance on Operational Considerations for Multisectoral Mental Health and Psychosocial Support Programmes during the COVID-19 Pandemic; IASC: Geneva, Switzerland, 2020; Available online: https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-guidance-operational-considerations-multisectoral-mental-health-and-psychosocial-support (accessed on 6 May 2022)(In Multiple Languages).

4 National Disaster Management Guidelines: Psycho-Social Support and Mental Health Services in Disasters, 2009. A publication of the National Disaster Management Authority, Government of India. ISBN 978-93-80440-00-2, December 2009, New Delhi.

5 NDMA. (2009). Retrieved from National Disaster Management Policy: https://ndma.gov.in/sites/default/files/PDF/national-dm-policy2009.pdf

6. NDMA. (2021). Annual Report. New Delhi: National Disaster Management Authority.

7. Roxane Richter, E. M. T., & Flowers, T. (2008). Gendered dimensions of disaster care: critical distinctions in female psychosocial needs, triage, pain assessment, and care. American journal of disaster medicine, 3(1), 31-37.

8. World Health Organization. (2011). Psychological first aid: Guide for field workers. World Health Organization.

Project Advisory Committee (PAC)

1. **Shri. Krishana S Vatsa,** Member, National Disaster Management Authority, and PAC Chairman, New Delhi.
2. **Dr. Nimesh Desai,** Director, Institute of Human Behavior and Allied Sciences (IHBAS), Delhi.
3. **Dr. Jacqueline Joseph,** Professor, Centre for Disaster Management, Jamsetji Tata Institute of Social Sciences, Mumbai.
4. **Ms. Sindhuja Khajuria,** UNICEF, Communication Consultant, New Delhi.
5. **Dr. Atreyi Ganguli,** National Professional Officer, Mental Health and Substance Abuse, WHO, India.
6. **Dr. Saurabh Dalal,** National Professional Officer, Emergency Risk and Crisis Management, WHO, India.
7. **Shri. Maître Mukerji,** Senior Consultant, National Disaster Management Authority, New Delhi.

Project Team

Dr. D. Dinakaran, Assistant Professor of Psychiatry, Department of Psychosocial Support in Disaster Management, National Institute of Mental Health and Neuro Sciences, Bangalore.

Dr. K. Sekar, Former Prof. and Head, Department of Psychosocial Support in Disaster Management, National Institute of Mental Health and Neuro Sciences, Bangalore.

Dr. Jayakumar C, Associate Professor, Principal Investigator, Department of Psychosocial Support in Disaster Management, National Institute of Mental Health and Neuro Sciences, Bangalore.

Dr. Patrick Jude, Project Coordinator, Department of Psychosocial Support in Disaster Management, National Institute of Mental Health and Neuro Sciences, Bangalore.

Dr. Veena Sree, Project Coordinator, Department of Psychosocial Support in Disaster Management, National Institute of Mental Health and Neuro Sciences, Bangalore.

Mrs. Jayashree, Project Associate, Department of Psychosocial Support in Disaster Management, National Institute of Mental Health and Neuro Sciences, Bangalore.

Mrs. Aleena Mathai, Project Associate, Department of Psychosocial Support in Disaster Management, National Institute of Mental Health and Neuro Sciences, Bangalore.

Ms. Irien Joe, Project Associate, Department of Psychosocial Support in Disaster Management, National Institute of Mental Health and Neuro Sciences, Bangalore.