

An experience of provision of psychiatric services in the earthquake-affected area of Kashmir in India

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Developing psychiatric services for disaster-affected populations in a place with meagre resources is a challenge, especially if the place is remote and offers limited access, and the weather conditions are harsh. The earthquake in October 2005 posed just such a challenge (Makhdam & Javed, 2005). Massive damage was reported from Pakistan, as the epicentre was in Muzaffarabad, in Pakistani-controlled Kashmir. There was also extensive damage to life and property in some areas of Kashmir in India. The road and communication network had been completely destroyed in many of the affected areas.

Mental health resources in Indian Kashmir are few. According to one of the latest surveys by the government of India, the state of Jammu and Kashmir (J&K) had just four psychiatrists for a population of more than 10 million (Goel *et al.*, 2004), and even they were available only in the cities of Jammu and Srinagar. In light of this, a team of mental health professionals from the All India Institute of Medical Sciences, New Delhi, and the Postgraduate Institute of Medical Education and Research, Chandigarh, visited the area in November 2005 to assess the mental health needs and to provide the required interventions. The team was in the state for about 2 weeks. It consisted of three psychiatrists, two clinical psychologists and four psychiatric social workers.

The team reached Srinagar on 8 November 2005. Its objectives included assessing the mental health needs of the earthquake-affected population, and screening and providing treatment and psychosocial counselling for the people who were either simply distressed or diagnosed as having psychiatric problems. Since it was not possible for the team to stay in the area for a long time, it was decided to sensitise and train local doctors and paramedical professionals in the management of disaster-associated mental health problems.

Extent of the problem

Although the damage was worse in Pakistan-controlled Kashmir, in India the earthquake none the less badly affected two districts of the state of J&K, Kupwara

and Baramulla, with populations of 1 167 000 and 640 000, respectively. Each household in the state has an average of 6.5 family members (according to the 2001 census). The towns of Tangdar and Uri and surrounding areas bore the brunt of the tragedy. More than 50 villages were seriously damaged. Over 73 000 houses were damaged, of which 42 750 were completely destroyed. Some of the villages had all their houses damaged. In the earthquake, 1 195 civilians lost their lives and 4373 were injured. Nearly 150 security force personnel were also killed in the earthquake. (The number of casualties was reported to be nearly 100 000 in Pakistan.)

The problems were compounded by the after-shocks in the region. Being a difficult and remote terrain, it was difficult to reach many places. The Indian army and the government of J&K provided aid to most of the affected areas. The Department of Health of the government of J&K despatched medical relief teams immediately after the tragedy. Teams of doctors from the Indian army and the Directorate General of Health Services of the Government of India were sent to provide medical care for the affected people. The local police were also involved in the relief work.

Although the medical problems were managed by the general medical teams, there had not been much provision for the mental health needs of the population. We anticipated that the affected people would have mental health problems related to the tragedy. The team was also informed by the local doctors about acute stress reactions in the affected population during the first few days following the earthquake.

Clinical services

Considering the vastness of the area affected and the limited time available for the team, it was decided to send two small groups, of four or five members each, to Uri and Tangdar. Another group stayed in Srinagar and conducted a training programme for the medical officers and paramedical professionals in coordination with the Regional Institute of Health and Family Welfare, Dhobiwan (J&K).

The teams were stationed in the respective areas and visited the worst-affected villages, where clinics

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were conducted. The teams visited more than 30 villages in the area. They carried essential psychotropic medications with them. Advance notice of the visit was usually sent to the villages. A public address system was also used in the villages to inform people about the arrival of the team. The teams travelled for 4–5 hours every day. The army gave help with the logistics. The roads were very bad and some villages were near the line of control (the border between the two territories of Kashmir).

The team provided psychiatric assessment, medications, counselling and psychoeducation to people with psychiatric disorders or psychosocial problems. This included new-onset cases as well as persons having mental health problems before the earthquake.

The teams provided help to 450 people during their stay. Since many of the local health professionals were from the affected areas, they also experienced mental health problems. Interestingly, when the team was about to start the work, some of the health professionals in the area were sceptical of the purpose of the team, and said that they had not encountered any mental health problems. But when the team members started their work and interviewed affected people, some of the local health professionals also accepted themselves as having experienced psychological symptoms in the aftermath of the earthquake, and requested help.

Findings of the team

Common psychiatric problems detected during assessments included adjustment disorders, depression, generalised anxiety disorder, symptoms of post-traumatic stress disorder (PTSD), panic disorder and insomnia. In many cases, people had experienced stress-related symptoms immediately after the earthquake in the form of sleep disturbance, nightmares and anxiety, but these had settled down with support from other survivors and the rescue teams. The local population had shown tremendous strength in dealing with the trauma. This might be partly explained by the fact that the region has both frequently harsh weather conditions and difficult terrain, and this has fostered great resilience on the part of the local populace.

The patients were evaluated, counselled and provided with sufficient medication for 3–4 weeks. They were advised to visit the local government dispensaries for follow-up and further management. Patients seen at various places were informed that, in case of need, they could meet the team again at the Uri Health Centre on the last day of the contact programme.

Training programme

The training-cum-sensitisation programme lasted 1 day, divided into two sessions. It was conducted for the doctors and paramedical professionals separately at the Regional Institute of Health and Family Welfare, Srinagar, 14–19 November 2005. A total of 160

doctors and 216 paramedical professionals attended. Handouts were distributed to all those present. The participants were very happy with the programme and had felt the need for such training for a long time. Although it was a very short interaction, it was expected that, with this sensitisation, it would be possible for the health professionals to provide satisfactory follow-up treatment for the mental health problems of the earthquake-affected population. It would also help them to deal with similar issues in their clinical practice, and to identify and refer such people for help.

Discussion

In the present case, it was not possible to carry out an epidemiological survey of the population, as the team had gone primarily to provide services. Generally, about 10–12% of any normal population is expected to suffer from some form of mental disorder. But in areas affected by a disaster on the scale of this earthquake, more than 50% of the population would be expected to experience mental health problems (Van Ommeren *et al*, 2005). The 12-month prevalence of severe mental disorders (e.g. psychosis, severe depression, severe anxiety disorders) has been estimated at 3–4% in a disaster-affected population, from a baseline of 2–3%. Mental disorders of mild to moderate severity (including PTSD) have been projected to have an annual prevalence of about 20% in the year after a disaster, as opposed to a baseline prevalence of about 10%. About 30–50% of the affected population would be expected to suffer from moderate-to-severe psychological distress that does not meet criteria for a mental disorder, and which may resolve over time or become mild but chronic. Another 20–40% of the affected population will suffer from mild psychological distress which resolves over time. Such figures ought to apply to the affected people of Kashmir.

In recent years PTSD has often received too much publicity in the aftermath of disasters and has sometimes consequently attracted disproportionate resources. PTSD is only one of various mental disorders seen following disasters, along with depression and anxiety disorders, although it occurs specifically in such populations (de Jong *et al*, 2003). In non-Western cultures, PTSD has been associated with low levels of help-seeking, which is an indirect indication that it is not a pressing concern of many survivors of trauma (Jones *et al*, 2003; Silove *et al*, 2004).

In the assessments conducted by our teams, we did not find significant numbers of cases of PTSD, but it was too early for the full syndrome of PTSD to appear, since the team was assessing the patients 5–6 weeks after the disaster. However, a number of patients had complained of nightmares, intrusive thoughts and hyperarousal. The area had also been facing after-shocks and there were earthquakes of milder intensity in late November and mid-December.

The World Health Organization (WHO) (2003) recommends that everyone with mental health problems induced by trauma and loss, ranging from pre-existing severe mental disorder to non-pathological psychological distress, should have access to basic mental healthcare from general health services and community mental health services. The WHO has advised countries to make social and basic psychological interventions available to the whole population in the community through a variety of sectors, including the health sector. These interventions may also provide some support to those people with mental disorders who do not seek help within the health sector. Such intervention could include restarting schooling, organising child-friendly spaces, family reunification programmes and economic development initiatives (Van Ommeren *et al*, 2005).

In the limited time available, the main objective of our team was to give as much help as possible to the affected population. This was achieved by providing clinical services at various peripheral settings. Training programmes for the doctors and the paramedical professionals were conducted to prepare them to provide help to the affected population.

It was not possible to collaborate with the local mental health professionals during the team's visit, as the area had also been affected by terrorism and the team was advised to be back to their bases by 6 p.m.

Future plan

It would be good to reassess the situation after 6–9 months and to identify the mental health needs of the population at that time, to inform service provision. It would be advisable to include the local mental health professionals in planning such work.

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THEMATIC PAPER – NATURAL DISASTERS AND THEIR AFTERMATH

Ten months on: qualitative assessment of psychosocial issues in northern Sri Lanka following the tsunami

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The tsunami which affected South Asia on 26 December 2004 caused over 41 000 deaths in Sri Lanka, representing 0.2% of the total population, and displaced over 880 000 people from their homes and livelihoods (World Health Organization, 2004). Kilinochchi, Jaffna and Mullativu districts in the Northern Province of Sri Lanka were affected by the tsunami and, as of April 2005, in the whole province, 6200 people had lost their lives, 961 were still missing, 19618 were still housed in welfare centres and 45548 were housed with relatives and friends (Government of Sri Lanka, 2005).

The Northern Province of Sri Lanka is populated predominantly by Tamils and has experienced many years of civil war. There is currently a ceasefire, but because of the war many people in the north had experienced trauma and displacement before the tsunami. Although government mental health services in the province are chronically underfunded, over the years these have been supplemented by the development of local non-governmental organisations (NGOs) with expertise in community psychosocial interventions aimed at targeting the effects of war, particularly its post-traumatic effects. On 29 December

Dr Danvers' association with Shanthiham is through Voluntary Service Overseas, 317 Putney Bridge Road, London SW15 2PN, UK