

Evolving Trends in Disaster Mental Health Research

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Expertise/Experience currently available in India

NATIONAL LEVEL:

- **NIMHANS-20 years- Dr.Nagaraja, Dr. Sekhar-Bhopal, Orissa, Gujarat,Tsunami & others**
- **IHBAS- 10 years-Multidisciplinary Teams for service delivery & research- Yamuna Pushta, Gujarat Earthquake, Gujarat Riots, Tsunami in Tamilnadu, Kashmir
(Drs.DKGupta,UKSinha,Jahanara,Anilkumar)**
- **ICMR - Consistent interest 20 years-
Dr. Bela Shah, Dr. Ravinder**

Expertise/Experience currently available in India

STATE/LOCAL LEVELS:

- **Bhopal- Dr. Bhiman, Dr. Sahu, Dr.Rajni**
- **Pune (Latur)- Dr. Mohan Agashe & others**
- **Orissa- Dr. GC Kar, Dr.Swain**
- **Kashmir- Dr. Mustaq Margoob**
- **Gujarat- Drs. Bakre, Ajay Chauhan, Samani, Tilwani**
- **Tamilnadu- Dr. Nambi**
- **Mumbai- TISS(Drs.Kety Gandevia, Surinder Jaiswal)
Dr.Harish Shetty**
- **Military Psychiatrists at many different stations**

Progression of Indian Experience

- **Bhopal- Emotional First Aid, Training of Health Workers, Descriptive Epidemiology**
- **Orissa Cyclone- Service Delivery, Epidemiology**
- **Latur- Epidemiology: Descriptive & some aspects of Analytical Epidemiology**
- **Yamuna Pushta, Delhi- Epidemiology, Community Perceptions**
- **Gujarat- all of the above, QRM, Care for the carers**
- **Tsunami- all of the above, QRM, attempt to integrate**
- **INCREASINGLY, COMBINING PROVISION OF SERVICES WITH GENERATING RESEARCH DATA**
- **MOVING FROM CLINICAL TO PUBLIC HEALTH MODELS**
- **FROM PSYCHIATRY TO NORMALCY PARADIGM**

“Public Health” Perspectives

- **Clinical Medicine/Psychiatry** : “One on One” Paradigm, The Best for One “Patient”, Clinical Judgment, mainly about treatment;
(Unit of Study: Individual; Settings: Hospital/Clinic)
- **Community Medicine/Community Health**: Carrying the services to the community, includes more preventive & promotive elements of health;
(Unit of Study: Individual; Settings: Community as important context)
- **Public Health**: Paradigm of “populations”(“ for the millions”), beyond clinical care & treatment; to service needs of populations & their effectiveness, covering all possible aspects which impinge ;
(Unit of Study: Individual & Groups & Communities; Settings: Any/All)

Public Health originated from the field of communicable diseases, but is not limited to sanitation & hygiene or merely prevention of diarrhoea & dysentery!!!! Nor is it only to do with policy & deskwork!!!!

Public Mental Health Perspectives for Disaster Situations

- **Response/Consequences/Effects:**
Psychiatric Disorders/PTSD/psychological distress
Mental health needs/ psychosocial &
supporting counseling needs
Role of psychological & psychosocial
issues in relief & rehab activities
- **Preparedness (of psychological nature/of communities)**
Does it prevent/reduce psychiatric morbidity? Or distress?
Does it prevent/reduce physical morbidity?
Does it help in organizing relief/rehab activities?
Does it help in the overall recovery of populations?

RECENT REVIEW REPORT

**“WHO-ICMR National Workshop on
Disaster Management with Special
Reference to Mental Health”**

December, 2003 IHBAS, Delhi

**Nimesh G. Desai, Bela Shah, Dhanesh K.
Gupta, RA Singh, Anil Kumar, Ravinder
Singh**

WHAT DO WE KNOW?

- **Psychological distress and/or ill health in majority in initial few weeks**
- **Moderate increase in psychiatric disorders, first 1 or 2 years.**
- **Psychiatric morbidity reduces over 5 years, continues in small number**
- **Predictors: relief work, social support, age**
- **Psychological support generally provided by informal/semiformal mechanisms**

WHAT DO WE KNOW?

- **Specialists mental health services required only for small proportion, but also over long term**
- **Special need for at risk population, PTSD lower than expected**
- **Positive mental health promoting activities by communities and relief agencies**
- **Recognition of psychological issues by relief workers and agencies, but difficulty in “psychiatry” or “mental health services”**
- **Normative paradigm better accepted**

What do we not know?

- **Course of syndromes like PTSD and predictors**
- **Impact of preventive counseling**
- **Influence of media**
- **Relationship between severity of impact and mental health morbidity**
- **Effectiveness of training of personnel**
- **Strategies and mechanisms for integration at different levels**

CONCLUSIONS

- **SERVICE DELIVERY: CONSIDERABLE EXPERIENCE ABOUT EFFECTS/RESPONSE/CARE; TO BE EXPANDED & FURTHER DISSEMINATED (COMMUNITY RESOURCES, RESOURCEFULNESS & STRENGTHS WITH INCREASING PROFESSIONAL INPUTS)**
- **RESEARCH: ADEQUATE, POSSIBLE ON SPECIFIC ISSUES (OF INTERNATIONAL LEVEL, WITH LEADERSHIP POTENTIAL FOR INDIA)**
- **POLICY: MICRO AND MACRO STRATEGIES FOR INTEGRATION REQUIRED (LIMITED, MIXED SUCCESS TILL NOW: CHALLENGE & OPPORTUNITY, INDEED A DUTY)**

CROSS-CULTURAL ASPECTS OF DISASTER & MENTAL HEALTH

1. **Reactions To, And Consequences Of The Disaster**
 - Individualism vs Collectivism
 - Acute Stress Reactions - ?somatic symps.
 - PTSD – different rate, profile & recovery.
 - Resilience of individuals & communities.
2. **Mental Health Service Needs**
 - Availability & Accessibility.
 - Recognition – by Community / Relief Workers.
 - Adequacy of Human Resources.
3. **Response Patterns**
 - Preparedness & readiness for disasters.
 - Official vs Spontaneous.
 - Level of organization of the response
 - According to Social Identity Groups.

Myths & Facts

- Myth: Thanda matlab Coca Cola
(Cold Drink = Coca Cola)
- Fact : There are many other equally good or more important cold drinks
- Myth: MH Aspects of Disaster= PTSD
- Fact : There are many other important, relevant aspects including some very positive ones

Research Issues

- **Time of Assessment- often too early**
- **Clinical v/s questionnaire based diagnosis**
- **Instruments for screening & diagnosis**
- **Really lower prevalence rates????**

Possible Reasons for Lower Prevalence of PTSD in some cultures/developing countries

- (1) Individual Resilience- psychobiological**
- (2) Family & Community Support Systems-**
 - (A) in the background**
 - (B) in disaster situations**
- (3) Strengths of Cultural/Religious/Spiritual nature-
oriental defence mechanisms eg. 'fatalism'**
- (4) Previous Experiences with disasters/
difficulties**

Integration?

- **Why?** –
 - Inadequate specialist manpower (human resources)
 - More effective & better accepted by people
- **Where?**
 - In Health Care models
 - In social welfare models (psychosocial care)
 - In General Relief & Rehab Models
- **How?**
 - Dissemination & Dialogue about information
 - Devolving the expertise
 - Development of Integrated models

Barriers

- **In Mental Health Field & Professionals**

Fear of loss of identity, territoriality

Need for vertical programmes & “credit”,

Lack of appropriate response,

- **In General Health Field & Professionals**

Ignorance of the experience/expertise,

Denial of the need,

Perceptions of complexity,

Extreme Positions of Nihilism or Positivism

Facilitators

- **In Mental Health Field & Professionals**

Perception of need & benefit, Learning from
Experience-positive & negative,

Evolving paradigms-from psychiatry to mental
health & from abnormality to normative

- **In General Health Field & Professionals**

Increased acceptance of mental health needs,
feedback from community,

THANK YOU

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