Psychosocial support to disaster victims is crucial. However, there can be no one "universal formula" for dealing with the needs of all Regions and for all types of disasters. Similarly, those delivering psychosocial support services need to be well versed with the culture and way of life of disaster affected victims.

Immediately after a disaster, the community itself usually provides the support system, including psychosocial support, e.g. the experience in the Bhuj earthquake disaster in Gujrat, showed that the community moved the women and children to large open fields, set up a community kitchen and began religious chanting which lasted all night. The men went about rescue efforts and tended to the injured as best as they could. All this happened long before any external aid could arrive.

Strategies should be developed to enhance a community’s inbuilt capability to develop psychosocial support in the immediate aftermath of the disaster. Many times, community members may downplay the importance of traditional methods such as, chanting, meditation and counseling from within the community by senior members.

Immediately after a disaster, families are in shock and are grieving for family members who have been killed or seriously injured. This phase takes time to heal and most people will recover in due course. There is very little role for any medical intervention (e.g. giving sedatives) to the grief-stricken people.

In the acute relief phase, it is advisable to conduct as few psychosocial interventions as critically needed, so there will be little interference with responses to vital needs such as food, shelter and control of communicable diseases.

The following guidelines should be useful in determining appropriate responses:

- To provide uncomplicated and accessible information on location of corpses.
- To discourage unceremonious disposal of corpses.
- To provide family tracing for unaccompanied minors, the elderly and other vulnerable people.
- To encourage members of field teams to actively participate in grieving.
- To encourage recreational activities for children.
- To widely disseminate uncomplicated, reassuring, empathic information on normal stress/trauma reaction to the community at large (religious leaders, teachers and other social leaders should be involved actively).
- In this phase, the crucial component is complete break down of service delivery to known cases of serious mental and neurologial disorders, such as, schizophrenia and epilepsy. Efforts should be made to ensure that these patients continue to receive and take their medication.

More specific mental health activities should be initiated during week three/four, once life-saving operations are already underway.

THE FOLLOWING SECTION TAKEN FROM THE SPHERE HANDBOOK 2004 MAY BE USEFUL: (http://www.sphereproject.org/handbook)
“Control of non-communicable diseases: mental and social aspects of health

Social and psychological indicators are discussed separately. The term ‘social intervention’ is used for those activities that primarily aim to have social effects. The term ‘psychological intervention’ is used for interventions that primarily aim to have a psychological (or psychiatric) effect. It is acknowledged that social interventions have secondary psychological effects and that psychological interventions have secondary social effects, as the term ‘psychosocial’ suggests.

People should have access to social and mental health services to reduce mental health morbidity, disability and social problems.

Key social intervention indicators (to be read in conjunction with the guidance notes)

During the acute disaster phase, the emphasis should be on social interventions.

- People have access to an ongoing, reliable flow of credible information on the disaster and associated relief efforts (see guidance note 1).
- Normal cultural and religious events are maintained or reestablished (including grieving rituals conducted by relevant spiritual and religious practitioners). People are able to conduct funeral ceremonies (see guidance note 2).
- As soon as resources permit, children and adolescents have access to formal or informal schooling and to normal recreational activities.
- Adults and adolescents are able to participate in concrete, purposeful, common interest activities, such as emergency relief activities.
- Isolated persons, such as separated or orphaned children, child combatants, widows and widowers, older people or others without their families, have access to activities that facilitate their inclusion in social networks.
- When necessary, a tracing service is established to reunite people and families.
- Where people are displaced, shelter is organized with the aim of keeping family members and communities together.
- The community is consulted regarding decisions on where to locate religious places, schools, water points and sanitation facilities. The design of settlements for displaced people includes recreational and cultural space.

Key psychological and psychiatric intervention indicators (to be read in conjunction with the guidance notes)

- Individuals experiencing acute mental distress after exposure to traumatic stressors have access to psychological first aid at health service facilities and in the community (see guidance note 3).
- Care for urgent psychiatric complaints is available through the primary health care system. Essential psychiatric medications, consistent with the essential drug list, are available at primary care facilities (see guidance note 4).
- Individuals with pre-existing psychiatric disorders continue to receive relevant treatment, and harmful, sudden discontinuation of medications is avoided. Basic needs of patients in custodial psychiatric hospitals are addressed.
- If the disaster becomes protracted, plans are initiated to provide a more comprehensive range of community-based psychological interventions for the post-disaster phase (see guidance note 5).

Guidance notes

1. **Information**: access to information is not only a human right but it also reduces unnecessary public anxiety and distress. Information should be provided on the nature and scale of the disaster and on efforts to establish physical safety for the population. Moreover, the population should be informed on the specific types of relief activities being undertaken by the government, local authorities and aid organizations, and their location. Information should be disseminated according to principles of risk communication i.e. it should be uncomplicated (understandable to local 12-year-olds) and empathic (showing understanding of the situation of the disaster survivor).

2. **Burials**: families should have the option to see the body of a loved one to say goodbye, when culturally appropriate. Unceremonious disposal of bodies of the deceased should be avoided.

3. **Psychological first aid**: whether among the general population or among aid workers, acute distress following exposure to traumatic stressors is best managed following the principles of psychological first aid. This entails basic, non-intrusive pragmatic care with a focus on listening but not forcing talk; assessing needs and ensuring that basic needs are met; encouraging but not forcing
company from significant others; and protecting from further harm. This type of first aid can be taught quickly to both volunteers and professionals. Health workers are cautioned to avoid widespread prescription of benzodiazepines because of the risk of dependence.

4. **Care for urgent psychiatric complaints:** psychiatric conditions requiring urgent care include dangerousness to self or others, psychoses, severe depression and mania.

5. **Community-based psychological interventions:** interventions should be based on an assessment of existing services and an understanding of the socio-cultural context. They should include use of functional, cultural coping mechanisms of individuals and communities to help them regain control over their circumstances. Collaboration with community leaders and indigenous healers is recommended when feasible. Community-based self-help groups should be encouraged. Community workers should be trained and supervised to assist health workers with heavy caseloads and to conduct outreach activities to facilitate care for vulnerable and minority groups.”

**ADDITIONAL INFORMATION CAN BE FOUND IN THE WHO/HQ PUBLICATION "MENTAL HEALTH IN EMERGENCIES" WHICH CAN BE FOUND ON THE WHO WEB SITE.**