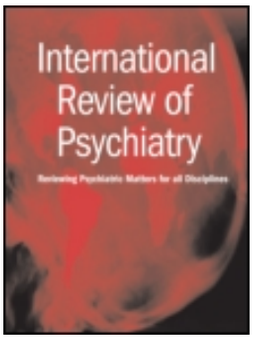

International Review of Psychiatry

ISSN: 0954-0261 (Print) 1369-1627 (Online) Journal homepage: informahealthcare.com/journals/iirp20

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To cite this article: Vijay Chandra, Rajesh Pandav, Roderico Ofrin, S. R. Salunke & Dinesh Bhugra (2006) Mental health and psychosocial aspects of disaster preparedness, International Review of Psychiatry, 18:6, 493-494, DOI: 10.1080/09540260601037664

To link to this article: https://doi.org/10.1080/09540260601037664

International Review of Psychiatry, December 2006; 18(6): 493–494

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EDITORIAL

Mental health and psychosocial aspects of disaster preparedness

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The tsunami of December 26, 2004 affected six countries of the South-East Asia Region simultaneously. The number of people affected in terms of death, injured, missing or displaced was simply overwhelming. Each and every person in the disaster-struck areas was psychologically affected directly or indirectly. It was recognized by the policy-makers and healthcare providers that any neglect of psychosocial support could impair efforts in physical rehabilitation. Although there were no precedents in this geographical region in meeting the mental health and psychosocial needs of such large numbers of people, affected countries, with the support of several international agencies, launched massive mental health and psychological relief efforts to a variable efficacy. However, there were common concerns and responses. The tsunami taught us many lessons:

- The need for early social interventions
- The need for early psychological interventions
- The need for an effective community mental health system.

These lessons must be seen as the foundation for better preparation for future disasters in general and for the affected countries in particular, bearing in mind the lack of resources.

The term 'social interventions' is used for interventions that primarily lead to social effects and benefits such as the provision of information, temporary housing, family tracing, keeping families together, early re-opening of schools and other services responding to the immediate needs of survivors so that normalization can be put in place at an early stage. It is recognized that social interventions are good for the psychological well-being of the individual. Thus the term 'psychosocial intervention' is frequently used, particularly since it is well known that psychological interventions have secondary social benefits.

Providing psychological support is crucial, but to be effective, the support has to be appropriate and culturally sensitive. The immediate need after any disaster is to reach out to all those who have been affected. Appropriately trained community workers who understand the local culture, local idioms of distress and locally acceptable ways of coping and dealing with grief can be used very effectively to provide psychological support. Not surprisingly, survivors will feel emotions like anxiety, restlessness, pessimistic thoughts and intense sadness as well as guilt about their own survival after any disaster. While such people need support from community workers, it must not be interpreted that that they are suffering from a mental disorder. 'Psychological first aid' in the form of empathy and practical support and advice is usually sufficient to set them on the path to recovery. It is also important not to 'medicalize' the problem, that is, to prescribe a pill when sympathetic hearing or kind words of support would suffice. Once again cultural competence is crucial.

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ISSN 0954–0261 print/ISSN 1369–1627 online/06/060493–2
DOI: 10.1080/09540260601037664

In every society there are some people who have pre-existing mental disorders. During an emergency, the population rates of mental disorders are expected to go up by 5 to 10%. These needs are best served by an effective community mental health system which can provide all the mental health needs of the community in the community through the primary healthcare system. A strong community mental health system can serve the immediate as well as the long-term needs of the community, provided it is sustainable and can become a part of the routine healthcare delivery system. Such a system can be rapidly scaled up in an emergency to meet the enhanced needs of the community. There are various models of community mental health systems, and certainly *one size does not fit all*. Thus, countries must adapt the structure of community mental health teams to suit their cultures, needs and the availability of financial and manpower resources.

The experience of dealing with the tsunami brought out the fact that disaster preparedness plans to meet the mental health and psychosocial needs of the community were extremely limited in the region.

The levels of intervention will vary from individual-coping to informal and formal health sectors and care. Linking all of these together is determined by the nature of the society—whether it is socio-centric or ego-centric—and what policies are in place and what policy-makers are prepared to do. For example, a year after Hurricane Katrina many issues remain to be resolved even in a resource-rich country such as the United States. There are lessons to be learnt.

Disaster preparedness has several components and is based on proper risk and hazard analysis. It should incorporate not only health risks, but also health-related and linked issues. As such, disaster preparedness and risk management are tools not only for effective response during an emergency but for development of the community in general. Sustainable development requires strategic approaches and among them is risk management of which a safer community is the main end point. Managing risks goes hand in hand with developing capacity to adequately manage emergencies and disasters when they occur.

There is a synergistic and cyclical relationship between disasters and development: the goal of disaster and emergency management is to reduce risks to create safer communities and to safeguard the existing as well as the potential gains of development. Conversely, development that is risk-approach oriented prevents and mitigates the deleterious effects of catastrophic events. A good example would be establishing good hospital systems and training health professionals to attend to affected populations of an earthquake. But then, if hospitals themselves cannot withstand tremors and earthquakes due to poor construction, all the resources invested in development, training and building hospitals is wasted. A risk to health is a risk to achieving development and vice versa. In all this, risk management with a strong preparedness component is the key.

There is no likelihood that disasters can be eliminated or averted but being prepared for managing disasters even if they are of an unprecedented scale means that the damage can be limited and people can be rehabilitated rapidly and appropriately. It is of paramount importance that every country, affected or unaffected by the tsunami, should prepare a detailed plan to meet any situation which may arise in future disasters. Mental health and psychosocial relief efforts should be an integral part of disaster preparedness plans.

The best form of disaster preparedness is to have plans in place which include a strong community mental health system to which additional services such as NGOs and care workers can be added and integrated.

This special issue is dedicated to a better future in which disasters will not impose a burden on society and destroy what society has built over decades. The papers brought together in this volume bring out the fact that a beginning has been made in countries of the South-East Asia Region to prepare themselves to respond to disasters, specifically the mental health and psychosocial issues of relevance to the affected community. As the articles in this issue of the journal suggest, a beginning has been made in countries of the South-East Asia Region, but a lot remains to be done.