

IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings



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Foreword

The Inter-Agency Standing Committee (IASC) issues these Guidelines to enable humanitarian actors to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergency.

Populations affected by emergencies frequently experience enormous suffering. Humanitarian actors are increasingly active to protect and improve people's mental health and psychosocial well-being during and after emergencies. A significant gap, however, has been the absence of a multi-sectoral, inter-agency framework that enables effective coordination, identifies useful practices, flags potentially harmful practices and clarifies how different approaches to mental health and psychosocial support complement one another.

The Guidelines offer essential advice on how to facilitate an integrated approach to address the most urgent mental health and psychosocial issues in emergency situations.

I would like to thank the members of the IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings and specifically the Task Force co-chairs, WHO and InterAction, for achieving inter-agency consensus on minimum responses in this important area of humanitarian aid.

I call upon all those who are involved in humanitarian assistance to implement these Guidelines.



Kasidis Rochanakorn

Chair, Inter-Agency Standing Committee Working Group
Director, OCHA Geneva

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Introduction

CHAPTER 1

Background

Armed conflicts and natural disasters cause significant psychological and social suffering to affected populations. The psychological and social impacts of emergencies may be acute in the short term, but they can also undermine the long-term mental health and psychosocial well-being of the affected population. These impacts may threaten peace, human rights and development. One of the priorities in emergencies is thus to protect and improve people's mental health and psychosocial well-being. Achieving this priority requires coordinated action among all government and non-government humanitarian actors.

A significant gap, however, has been the absence of a multi-sectoral, inter-agency framework that enables effective coordination, identifies useful practices and flags potentially harmful practices, and clarifies how different approaches to mental health and psychosocial support complement one another. This document aims to fill that gap.

These guidelines reflect the insights of practitioners from different geographic regions, disciplines and sectors, and reflect an emerging consensus on good practice among practitioners. The core idea behind them is that, in the early phase of an emergency, social supports are essential to protect and support mental health and psychosocial well-being. In addition, the guidelines recommend selected psychological and psychiatric interventions for specific problems.

The composite term *mental health and psychosocial support* is used in this document to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. Although the terms *mental health* and *psychosocial support* are closely related and overlap, for many aid workers they reflect different, yet complementary, approaches.

Aid agencies outside the health sector tend to speak of *supporting psychosocial well-being*. Health sector agencies tend to speak of mental health, yet historically have also used the terms *psychosocial rehabilitation* and *psychosocial treatment* to describe non-biological interventions for people with mental disorders. Exact definitions of these terms vary between and within aid organisations, disciplines and countries. As the current document covers intersectoral, inter-agency guidelines, the composite term *mental health and psychosocial support (MHPSS)* serves to unite as

broad a group of actors as possible and underscores the need for diverse, complementary approaches in providing appropriate supports.

Scientific evidence regarding the mental health and psychosocial supports that prove most effective in emergency settings is still thin. Most research in this area has been conducted months or years after the end of the acute emergency phase. As this emerging field develops, the research base will grow, as will the base of practitioners' field experience. To incorporate emerging insights, this publication should be updated periodically.

Mental health and psychosocial impact of emergencies

Problems

Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies erode normally protective supports, increase the risks of diverse problems and tend to amplify pre-existing problems of social injustice and inequality. For example, natural disasters such as floods typically have a disproportionate impact on poor people, who may be living in relatively dangerous places.

Mental health and psychosocial problems in emergencies are highly interconnected, yet may be predominantly social or psychological in nature. Significant problems of a predominantly social nature include:

- Pre-existing (pre-emergency) social problems (e.g. extreme poverty; belonging to a group that is discriminated against or marginalised; political oppression);
- Emergency-induced social problems (e.g. family separation; disruption of social networks; destruction of community structures, resources and trust; increased gender-based violence); and
- Humanitarian aid-induced social problems (e.g. undermining of community structures or traditional support mechanisms).

Similarly, problems of a predominantly psychological nature include:

- Pre-existing problems (e.g. severe mental disorder; alcohol abuse);
- Emergency-induced problems (e.g. grief, non-pathological distress; depression and anxiety disorders, including post-traumatic stress disorder (PTSD)); and

- Humanitarian aid-related problems (e.g. anxiety due to a lack of information about food distribution).

Thus, mental health and psychosocial problems in emergencies encompass far more than the experience of PTSD.

People at increased risk of problems

In emergencies, not everyone has or develops significant psychological problems. Many people show resilience, that is the ability to cope relatively well in situations of adversity. There are numerous interacting social, psychological and biological factors that influence whether people develop psychological problems or exhibit resilience in the face of adversity.

Depending on the emergency context, particular groups of people are at increased risk of experiencing social and/or psychological problems. Although many key forms of support should be available to the emergency-affected population in general, good programming specifically includes the provision of relevant supports to the people at greatest risk, who need to be identified for each specific crisis (see [Chapter 3, Action Sheet 2.1](#)).

All sub-groups of a population can potentially be at risk, depending on the nature of the crisis. The following are groups of people who frequently have been shown to be at increased risk of various problems in diverse emergencies:

- Women (e.g. pregnant women, mothers, single mothers, widows and, in some cultures, unmarried adult women and teenage girls);
- Men (e.g. ex-combatants, idle men who have lost the means to take care of their families, young men at risk of detention, abduction or being targets of violence);
- Children (from newborn infants to young people 18 years of age), such as separated or unaccompanied children (including orphans), children recruited or used by armed forces or groups, trafficked children, children in conflict with the law, children engaged in dangerous labour, children who live or work on the streets and undernourished/understimulated children;
- Elderly people (especially when they have lost family members who were care-givers);
- Extremely poor people;
- Refugees, internally displaced persons (IDPs) and migrants in irregular situations

(especially trafficked women and children without identification papers);

- People who have been exposed to extremely stressful events/trauma (e.g. people who have lost close family members or their entire livelihoods, rape and torture survivors, witnesses of atrocities, etc.);
- People in the community with pre-existing, severe physical, neurological or mental disabilities or disorders;
- People in institutions (orphans, elderly people, people with neurological/mental disabilities or disorders);
- People experiencing severe social stigma (e.g. untouchables/dalit, commercial sex workers, people with severe mental disorders, survivors of sexual violence);
- People at specific risk of human rights violations (e.g. political activists, ethnic or linguistic minorities, people in institutions or detention, people already exposed to human rights violations).

It is important to recognise that:

- There is large diversity of risks, problems and resources within and across each of the groups mentioned above.
- Some individuals within an at-risk group may fare relatively well.
- Some groups (e.g. combatants) may be simultaneously at increased risk of some problems (e.g. substance abuse) and at reduced risk of other problems (e.g. starvation).
- Some groups may be at risk in one emergency, while being relatively privileged in another emergency.
- Where one group is at risk, other groups are often at risk as well (Sphere Project, 2004).

To identify people as ‘at risk’ is not to suggest that they are passive victims. Although at-risk people need support, they often have capacities and social networks that enable them to contribute to their families and to be active in social, religious and political life.

Resources

Affected groups have assets or resources that support mental health and psychosocial well-being. The nature and extent of the resources available and accessible may vary with age, gender, the socio-cultural context and the emergency environment. A

common error in work on mental health and psychosocial well-being is to ignore these resources and to focus solely on deficits – the weaknesses, suffering and pathology – of the affected group.

Affected individuals have resources such as skills in problem-solving, communication, negotiation and earning a living. Examples of potentially supportive social resources include families, local government officers, community leaders, traditional healers (in many societies), community health workers, teachers, women’s groups, youth clubs and community planning groups, among many others. Affected communities may have economic resources such as savings, land, crops and animals; educational resources such as schools and teachers; and health resources such as health posts and staff. Significant religious and spiritual resources include religious leaders, local healers, practices of prayer and worship, and cultural practices such as burial rites.

To plan an appropriate emergency response, it is important to know the nature of local resources, whether they are helpful or harmful, and the extent to which affected people can access them. Indeed, some local practices – ranging from particular traditional cultural practices to care in many existing custodial institutions – may be harmful and may violate human rights principles (see [Action Sheets 5.3, 6.3 and 6.4](#)).

The guidelines

Purpose of these guidelines

The primary purpose of these guidelines is to enable humanitarian actors and communities to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people’s mental health and psychosocial well-being in the midst of an emergency. **The focus of the guidelines is on implementing minimum responses, which are essential, high-priority responses that should be implemented as soon as possible in an emergency.** Minimum responses are the first things that ought to be done; they are the essential first steps that lay the foundation for the more comprehensive efforts that may be needed (including during the stabilised phase and early reconstruction).

To complement the focus on minimum response, the guidelines also list concrete strategies for mental health and psychosocial support to be considered mainly before and after the acute emergency phase. These ‘before’ (emergency preparedness)

and ‘after’ (comprehensive response) steps establish a context for the minimum response and emphasise that the minimum response is only the starting point for more comprehensive supports (see Chapter 2).

Although the guidelines have been written for low- and middle-income countries (where Inter-Agency Standing Committee (IASC) member agencies tend to work), the overall framework and many parts of the guidelines apply also to large-scale emergencies in high-income countries.

Target audience

These guidelines were designed for use by all humanitarian actors, including community-based organisations, government authorities, United Nations organisations, non-government organisations (NGOs) and donors operating in emergency settings at local, national and international levels.

The orientation of these guidelines is not towards individual agencies or projects. **Implementation of the guidelines requires extensive collaboration among various humanitarian actors: no single community or agency is expected to have the capacity to implement all necessary minimum responses in the midst of an emergency.** The guidelines should be accessible to all humanitarian actors to organise collaboratively the necessary supports. Of particular importance is the active involvement at every stage of communities and local authorities, whose participation is essential for successful, coordinated action, the enhancement of local capacities and sustainability. To maximise the engagement of local actors, the guidelines should be translated into the relevant local language(s).

These guidelines are not intended solely for mental health and psychosocial workers. Numerous action sheets in the guidelines outline social supports relevant to the core humanitarian domains, such as disaster management, human rights, protection, general health, education, water and sanitation, food security and nutrition, shelter, camp management, community development and mass communication. Mental health professionals seldom work in these domains, but are encouraged to use this document to advocate with communities and colleagues from other disciplines to ensure that appropriate action is taken to address the social risk factors that affect mental health and psychosocial well-being. However, the clinical and specialised forms of psychological or psychiatric supports indicated in the guidelines should only be implemented under the leadership of mental health professionals.

An overview of the guidelines

The structure of these IASC Guidelines is consistent with two previous IASC documents: the *Guidelines for HIV/AIDS Interventions in Emergency Settings* (IASC, 2003) and the *Guidelines on Gender-Based Violence Interventions in Humanitarian Settings* (IASC, 2005). All three of these IASC documents include a matrix, which details actions for various actors during different stages of emergencies, and a set of action sheets that explain how to implement minimum response items identified in the middle column (Minimum Response) of the matrix. The current guidelines contain 25 such action sheets (see Chapter 3).

The matrix (displayed in Chapter 2) provides an overview of recommended key interventions and supports for protecting and improving mental health and psychosocial well-being. The three matrix columns outline the:

- Emergency preparedness steps to be taken before emergencies occur;
- Minimum responses to be implemented during the acute phase of the emergency; and
- Comprehensive responses to be implemented once the minimum responses have been implemented. Typically, this is during the stabilised and early reconstruction phases of the emergency.

The action sheets emphasise the importance of multi-sectoral, coordinated action. Each action sheet therefore includes (hyper-)links, indicated by **turquoise text**, relating to action sheets in other domains/sectors.

Each action sheet consists of a rationale/background; descriptions of key actions; selected sample process indicators; an example of good practice in previous emergencies; and a list of resource materials for further information. Almost all listed resource materials are available via the internet and are also included in the accompanying CD-ROM.

How to use this document

Reading the document from cover to cover may not be possible during an emergency. It may be read selectively, focusing on items that have the greatest relevance to the reader’s responsibilities or capacities. **A good way to begin is to read the matrix,**

focusing on the centre column of minimum response, look for the items of greatest relevance and go directly to the corresponding action sheets. It is important to remember that no single agency is expected to implement every item in the guidelines.

The guidelines aim to strengthen the humanitarian response in emergencies by all actors, from pre-emergency preparedness through all steps of response programme planning, implementation and evaluation. They are especially useful as a tool for strengthening coordination and advocacy.

Coordination

In emergencies, coordination of aid is one of the most important and most challenging tasks. This document provides detailed guidance on coordination (see [Action Sheet 1.1](#)) and is a useful coordination tool in two other respects. First, it calls for a single, overarching coordination group on mental health and psychosocial support to be set up when an emergency response is first mobilised. The rationale for this is that mental health supports and psychosocial supports inside and outside the health sector are mutually enhancing and complementary (even though in the past they have often been organised separately by actors in the health and protection sectors respectively). Because each is vital for the other, it is essential to coordinate the two. If no coordination group exists or if there are separate mental health coordination and psychosocial coordination groups, the guidelines can be used to advocate for the establishment of one overarching group to coordinate MHPSS responses.

Second, the guidelines – and in particular the matrix – provide reference points that can be used to judge the extent to which minimum responses are being implemented in a given community. Any items listed in the matrix that are not being implemented may constitute gaps that need to be addressed. In this respect, the matrix offers the coordination group a useful guide.

Advocacy for improved supports

As an advocacy tool, the guidelines are useful in promoting the need for particular kinds of responses. Because they reflect inter-agency consensus and the insight of numerous practitioners worldwide, the guidelines have the support of many humanitarian agencies and actors. For this reason, they offer a useful advocacy tool in addressing gaps and also in promoting recommended responses – i.e. minimum, priority responses – even as the emergency occurs. For example, in a situation where

non-participatory sectoral programmes are being established, the guidelines could be used to make the case with different stakeholders for why a more participatory approach would be beneficial. Similarly, if very young children are at risk and receiving no support, Action Sheet 5.4 could be used to advocate for the establishment of appropriate early child development supports.

Working with partners to develop appropriate mental health and psychosocial supports is an important part of advocacy. Dialogue with partners, whether NGO, government or UN staff, may help steer them, where needed, toward the kinds of practices outlined in this document. The guidelines may also be used for advocacy in other ways. For example, the inclusion of a comprehensive response column in the matrix facilitates advocacy for long-term planning (e.g. for the development of mental health services within the health system of the country concerned).

However, **these guidelines should not be used as a cookbook.** Although the matrix suggests actions that should be the minimum response in many emergencies, a local situation analysis should be conducted, to identify more precisely the greatest needs, specify priority actions and guide a socially and culturally appropriate response.

The guidelines do not give details for implementation, but rather contain a list of key actions with brief explanations and references to further resource materials regarding implementation.

Core principles

1. Human rights and equity

Humanitarian actors should promote the human rights of all affected persons and protect individuals and groups who are at heightened risk of human rights violations. Humanitarian actors should also promote equity and non-discrimination. That is, they should aim to *maximise fairness* in the availability and accessibility of mental health and psychosocial supports among affected populations, across gender, age groups, language groups, ethnic groups and localities, according to identified needs.

2. Participation

Humanitarian action should maximise the participation of local affected

populations in the humanitarian response. In most emergency situations, significant numbers of people exhibit sufficient resilience to participate in relief and reconstruction efforts. Many key mental health and psychosocial supports come from affected communities themselves rather than from outside agencies. Affected communities include both displaced and host populations and typically consist of multiple groups, which may compete with one another. Participation should enable different sub-groups of local people to retain or resume control over decisions that affect their lives, and to build the sense of local ownership that is important for achieving programme quality, equity and sustainability. From the earliest phase of an emergency, local people should be involved to the greatest extent possible in the assessment, design, implementation, monitoring and evaluation of assistance.

3. Do no harm

Humanitarian aid is an important means of helping people affected by emergencies, but aid can also cause unintentional harm (Anderson, 1999). Work on mental health and psychosocial support has the potential to cause harm because it deals with highly sensitive issues. Also, this work lacks the extensive scientific evidence that is available for some other disciplines. Humanitarian actors may reduce the risk of harm in various ways, such as:

- Participating in coordination groups to learn from others and to minimise duplication and gaps in response;
- Designing interventions on the basis of sufficient information (see [Action Sheet 2.1](#));
- Committing to evaluation, openness to scrutiny and external review;
- Developing cultural sensitivity and competence in the areas in which they intervene/work;
- Staying updated on the evidence base regarding effective practices; and
- Developing an understanding of, and consistently reflecting on, universal human rights, power relations between outsiders and emergency-affected people, and the value of participatory approaches.

4. Building on available resources and capacities

As described above, all affected groups have assets or resources that support mental

health and psychosocial well-being. A key principle – even in the early stages of an emergency – is building local capacities, supporting self-help and strengthening the resources already present. Externally driven and implemented programmes often lead to inappropriate MHPSS and frequently have limited sustainability. Where possible, it is important to build both government and civil society capacities. At each layer of the pyramid (see Figure 1), key tasks are to identify, mobilise and strengthen the skills and capacities of individuals, families, communities and society.

5. Integrated support systems

Activities and programming should be integrated as far as possible. The proliferation of stand-alone services, such as those dealing only with rape survivors or only with people with a specific diagnosis, such as PTSD, can create a highly fragmented care system. Activities that are integrated into wider systems (e.g. existing community support mechanisms, formal/non-formal school systems, general health services, general mental health services, social services, etc.) tend to reach more people, often are more sustainable, and tend to carry less stigma.

6. Multi-layered supports

In emergencies, people are affected in different ways and require different kinds of supports. A key to organising mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups. This may be illustrated by a pyramid (see Figure 1). All layers of the pyramid are important and should ideally be implemented concurrently.

i. Basic services and security. The well-being of all people should be protected through the (re)establishment of security, adequate governance and services that address basic physical needs (food, shelter, water, basic health care, control of communicable diseases). In most emergencies, specialists in sectors such as food, health and shelter provide basic services. An MHPSS response to the need for basic services and security may include: advocating that these services are put in place with responsible actors; documenting their impact on mental health and psychosocial well-being; and influencing humanitarian actors to deliver them in a way that promotes mental health and psychosocial well-being. These basic services should be established in participatory, safe and socially appropriate

Figure 1. Intervention pyramid for mental health and psychosocial support in emergencies. Each layer is described below.



ways that protect local people’s dignity, strengthen local social supports and mobilise community networks (see [Action Sheet 5.1](#)).

ii. Community and family supports. The second layer represents the emergency response for a smaller number of people who are able to maintain their mental health and psychosocial well-being if they receive help in accessing key community and family supports. In most emergencies, there are significant disruptions of family and community networks due to loss, displacement, family separation, community fears and distrust. Moreover, even when family and community networks remain intact, people in emergencies will benefit from help in accessing greater community and family supports. Useful responses in this

layer include family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women’s groups and youth clubs.

iii. Focused, non-specialised supports. The third layer represents the supports necessary for the still smaller number of people who additionally require more focused individual, family or group interventions by trained and supervised workers (but who may not have had years of training in specialised care). For example, survivors of gender-based violence might need a mixture of emotional and livelihood support from community workers. This layer also includes psychological first aid (PFA) and basic mental health care by primary health care workers.

iv. Specialised services. The top layer of the pyramid represents the additional support required for the small percentage of the population whose suffering, despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning. This assistance should include psychological or psychiatric supports for people with severe mental disorders whenever their needs exceed the capacities of existing primary/general health services. Such problems require either (a) referral to specialised services if they exist, or (b) initiation of longer-term training and supervision of primary/general health care providers. Although specialised services are needed only for a small percentage of the population, in most large emergencies this group amounts to thousands of individuals.

The uniqueness of each emergency and the diversity of cultures and socio-historic contexts makes it challenging to identify universal prescriptions of good practice. Nevertheless, experience from many different emergencies indicates that some actions are advisable, whereas others should typically be avoided. These are identified below as ‘Do’s’ and ‘Don’ts’ respectively.

Do's	Don'ts
Establish one overall coordination group on mental health and psychosocial support.	Do not create separate groups on mental health or on psychosocial support that do not talk or coordinate with one another.
Support a coordinated response, participating in coordination meetings and adding value by complementing the work of others.	Do not work in isolation or without thinking how one's own work fits with that of others.
Collect and analyse information to determine whether a response is needed and, if so, what kind of response.	Do not conduct duplicate assessments or accept preliminary data in an uncritical manner.
Tailor assessment tools to the local context.	Do not use assessment tools not validated in the local, emergency-affected context.
Recognise that people are affected by emergencies in different ways. More resilient people may function well, whereas others may be severely affected and may need specialised supports.	Do not assume that everyone in an emergency is traumatised, or that people who appear resilient need no support.
Ask questions in the local language(s) and in a safe, supportive manner that respects confidentiality.	Do not duplicate assessments or ask very distressing questions without providing follow-up support.
Pay attention to gender differences.	Do not assume that emergencies affect men and women (or boys and girls) in exactly the same way, or that programmes designed for men will be of equal help or accessibility for women.
Check references in recruiting staff and volunteers and build the capacity of new personnel from the local and/or affected community.	Do not use recruiting practices that severely weaken existing local structures.
After trainings on mental health and psychosocial support, provide follow-up supervision and monitoring to ensure that interventions are implemented correctly.	Do not use one-time, stand-alone trainings or very short trainings without follow-up if preparing people to perform complex psychological interventions.
Facilitate the development of community-owned, managed and run programmes.	Do not use a charity model that treats people in the community mainly as beneficiaries of services.
Build local capacities, supporting self-help and strengthening the resources already present in affected groups.	Do not organise supports that undermine or ignore local responsibilities and capacities.

Do's	Don'ts
Learn about and, where appropriate, use local cultural practices to support local people.	Do not assume that all local cultural practices are helpful or that all local people are supportive of particular practices.
Use methods from outside the culture where it is appropriate to do so.	Do not assume that methods from abroad are necessarily better or impose them on local people in ways that marginalise local supportive practices and beliefs.
Build government capacities and integrate mental health care for emergency survivors in general health services and, if available, in community mental health services.	Do not create parallel mental health services for specific sub-populations.
Organise access to a range of supports, including psychological first aid, to people in acute distress after exposure to an extreme stressor.	Do not provide one-off, single-session psychological debriefing for people in the general population as an early intervention after exposure to conflict or natural disaster.
Train and supervise primary/general health care workers in good prescription practices and in basic psychological support.	Do not provide psychotropic medication or psychological support without training and supervision.
Use generic medications that are on the essential drug list of the country.	Do not introduce new, branded medications in contexts where such medications are not widely used.
Establish effective systems for referring and supporting severely affected people.	Do not establish screening for people with mental disorders without having in place appropriate and accessible services to care for identified persons.
Develop locally appropriate care solutions for people at risk of being institutionalised.	Do not institutionalise people (unless an institution is temporarily an indisputable last resort for basic care and protection).
Use agency communication officers to promote two-way communication with the affected population as well as with the outside world.	Do not use agency communication officers to communicate only with the outside world.
Use channels such as the media to provide accurate information that reduces stress and enables people to access humanitarian services.	Do not create or show media images that sensationalise people's suffering or put people at risk.
Seek to integrate psychosocial considerations as relevant into all sectors of humanitarian assistance.	Do not focus solely on clinical activities in the absence of a multi-sectoral response.

Frequently asked questions

1. What is meant by mental health and psychosocial support?

Mental health and psychosocial support (MHPSS) is a composite term used in these guidelines to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder.

2. Why do the guidelines use the overlapping terms *mental health* and *psychosocial support*?

For many aid workers these closely-related terms reflect different, yet complementary, approaches. Agencies outside the health sector tend to speak of *supporting psychosocial well-being*. People working in the health sector tend to speak of *mental health*, but historically have also used the terms *psychosocial rehabilitation* and *psychosocial treatment* to describe non-biological interventions for people with mental disorders. Exact definitions of these terms vary between and within aid organisations, disciplines and countries.

3. Are these guidelines for mental health professionals only?

No, this publication offers guidance on how a wide range of actors in diverse sectors can protect and improve mental health and psychosocial well-being. However, some action sheets cover clinical interventions that should be implemented only under the leadership of mental health professionals.

4. Why do these guidelines cover sectors that are not within the traditional concern or expertise of mental health professionals?

There is increasing inter-agency consensus that psychosocial concerns involve all sectors of humanitarian work, because the manner in which aid is implemented (e.g. with/without concern for people's dignity) affects psychosocial well-being. A parallel may be drawn with multi-sectoral efforts to control mortality. Mortality rates are affected not only by vaccination campaigns and health care but also by actions in the water and sanitation, nutrition, food security and shelter sectors. Similarly, psychosocial well-being is affected when shelters are overcrowded and sanitation facilities put women at risk of sexual violence.

5. The guidelines focus on minimum responses in the midst of emergencies, but what is an *emergency* and what is a *minimum response*?

The annual IASC Consolidated Appeal Process (CAP) documents (www.reliefweb.int) provide useful examples of the situations that the IASC considers to be *emergencies*. These include situations arising from armed conflicts and natural disasters (including food crises) in which large segments of populations are at *acute* risk of dying, immense suffering and/or losing their dignity.

Minimum responses are essential, high-priority responses that should be implemented as soon as possible in an emergency. Comprehensive responses should only be implemented after ascertaining that the population has access to at least the minimum response.

6. These guidelines are overwhelming. How can any one humanitarian actor (agency, community) do everything? Do all the action sheets have to be implemented in every emergency?

No single community or agency is expected to have the capacity to implement all necessary minimum response interventions in the midst of an emergency. The orientation of the guidelines is not towards individual agencies or projects. Because these guidelines are *inter-agency*, they require coordinated action by different actors to implement their various elements. Furthermore, the actions described as minimum response in the guidelines are likely to be *minimum responses* in most, but not all, emergencies. Local situation analyses are essential to determine what specific actions are priorities in the local context and at different points in time.

7. Why is there no timeline for when to implement actions?

Although the humanitarian aftermath of some disasters (e.g. earthquakes, cyclones) is predictable to some extent, many emergencies, such as those which arise from armed conflict, are unpredictable and defy a linear timeline. Also, most complex emergencies persist for years.

8. What is the role of emergency-affected individuals, groups or communities in implementing these guidelines?

Although the document is written by aid organisations in the language of humanitarian aid, affected populations should be involved to the greatest extent

possible in the design and implementation of all aid, and should play a lead role insofar as this is possible (see [Action Sheets 5.1 and 5.2](#)). For this reason, the guidelines should be translated into relevant local languages.

9. Why do the guidelines not focus on traumatic stress and post-traumatic stress disorder (PTSD)?

The types of social and psychological problems that people may experience in emergencies are extremely diverse (see the section on ‘Problems’ on page 2). An exclusive focus on traumatic stress may lead to neglect of many other key mental health and psychosocial issues. There is a wide range of opinion among agencies and experts on the positive and negative aspects of focusing on traumatic stress. The present guidelines aim to provide a balanced approach of recommended minimum actions in the midst of emergencies. The guidelines include (a) psychological first aid for people in acute trauma-induced distress by a variety of community workers (see [Action Sheets 4.3, 4.4, 5.2 and 6.1](#)) and (b) care for people with severe mental disorders, including severe PTSD, by trained and supervised health staff only (see [Action Sheet 6.2](#)).

10. Does this document aim to set standards? What is the relationship between these guidelines and the Sphere Handbook?

This document outlines *guidelines* for minimum responses but does not set *standards* for minimum response. This document is nevertheless consistent with Sphere Project (2004) standards. Implementing the guidelines is likely to contribute to achieving relevant Sphere standards, including the standard on Mental and Social Aspects of Health.

11. How do these IASC intersectoral guidelines relate to the IASC Cluster approach?

The IASC Cluster Approach is a new IASC mechanism intended to improve the coordination and overall performance of sectors. Whenever necessary in an emergency, Clusters are instituted to fill gaps in aid (see <http://www.humanitarianinfo.org/iasc/content/Cluster>). The following IASC Clusters have relevance to these mental health and psychosocial support guidelines: Camp Coordination and Camp Management; Early Recovery; Education; Emergency Shelter; Health; Nutrition; Protection; and Water, Hygiene and Sanitation.

During an emergency, each Cluster should take responsibility for implementing the interventions covered in these guidelines that are relevant to

its own domain of work. Moreover, in any large emergency, one intersectoral, inter-agency mental health and psychosocial support coordination group should be established and should aim to secure compliance with guidelines such as those outlined in this document (see [Action Sheet 1.1](#) on coordination).

12. What is the IASC?

The Inter-Agency Standing Committee (IASC), established by the United Nations General Assembly, is an inter-agency forum for coordination, policy development and decision-making by the executive heads of key humanitarian agencies (UN agencies, Red Cross and Red Crescent societies, and consortia of non-government humanitarian organisations. See <http://www.humanitarianinfo.org/iasc/content/about/default.asp>.

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