

Developing inter-agency guidelines on mental health and psychosocial support in emergency settings

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This paper describes how and why the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings were developed. A brief overview about the need for the guidelines, as well as the context and background, are included. Also, a discussion on the process of developing them with an eye towards identifying key issues and obstacles, and the strategies used to manage these issues and enable constructive collaboration, is provided. Also included are the processes of building positive networks and relations across agencies and sub-fields. Finally, there is a brief overview of how the Task Force worked and approached some of the issues that have been hotly contested in the field.

Keywords: Inter-Agency Standing Committee (IASC), guidelines, mental health and psychosocial support (MHPSS), consensus, emergencies

Armed conflicts, war and natural disasters can cause substantial psychological and social suffering to affected populations.¹ Worldwide, there has been an increased awareness of the importance of responding with mental health and psychosocial support (MHPSS) in emergency situations, to care for the needs of people that are affected. However, despite this growing awareness, and the inclination to respond that has accompanied it, the mental health and psychosocial support field is still developing and has lacked a unified clarity about how

to respond in the most appropriate and effective ways.

In 2007, an important step towards remedying this situation was taken when the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* were published. These guidelines are a milestone for the MHPSS field because they are the first inter-agency consensus about what are the essential first steps to be taken in an emergency. This paper tells the story of how a young, divided field is creating consensus and building a more comprehensive, contextually appropriate response to emergencies.

Why the guidelines were needed

As little as five years ago, there was no consensus among aid agencies in the field of MHPSS in emergency settings. Without a framework, based on inter-agency consensus, there was little basis for effective coordination of practice and advocacy, a weak foundation for efforts to train and prepare humanitarian workers, and significantly elevated risks that well intentioned efforts could cause harm. Therefore, these guidelines should be seen as a collective effort to address these important issues.

Do No Harm

The field of MHPSS in emergency settings has little empirical evidence regarding what

effective interventions are, due to the relatively young age of the field (Betancourt & Williams, 2008; Mollica et al., 2004; Batniji, van Ommeren, & Saraceno, 2006; Patel et al., 2007). This weak base of evidence, combined with a lack of consensus about the appropriate practices, has enabled ill conceived or poorly implemented MHPSS to occur - thereby causing harm. For example, in Sri Lanka a year after the 2004 tsunami, a door to door survey revealed that there were 27 non governmental organisations (NGOs) working in a rural community of 50 families. It was found that the presence of so many external helpers had undermined older community practices where, in the past, it was neighbours who had helped each other in emergencies (IASC, 2007).

Harm may also occur through the use of methods that are inappropriate within the socio cultural context. Following the attacks of Serb paramilitaries on Kosovar Albanians, large numbers of Kosovars fled to neighbouring countries such as Albania. In Tirana, the first author spoke with a well intentioned psychotherapist from the U.S., who had never worked during a humanitarian emergency, had no understanding of the local culture, yet felt 'called' to help. Sadly, he set up a counselling tent to conduct therapy for rape survivors. He seemed oblivious to the fact that for a woman to enter his tent would stigmatize her as someone who was raped, as well as raise the risks that she might be killed in order to preserve *family honour*.

The guidelines can therefore, in part, be seen as an effort to prevent these problems, as well as the wider array of other *Do No Harm* issues in MHPSS emergency response (Boothby et al., 2006; Bracken et al., 1995; van Ommeren et al., 2005; Wessells, 2008). Among these other issues are: over reliance on outsider approaches; the misuse of potentially harmful, yet popular, methods

such as *critical incident stress debriefing*; giving privileges to particular groups over others; over prescription of anti-anxiety drugs; conduct of duplicate assessments; lengthy delays between assessments and response; and the habit of employing under trained, under-supervised counsellors. Additionally, what is *not* done in MHPSS can be as problematic as what *is* done. Too often quality controls, social and legal protections, participatory approaches, appropriate grounding of support in the local cultures, attention to severe mental illness, minimizing harm related to alcohol and drugs, and the willingness to identify and build upon the support and resilience that the affected people already have, are missing from MHPSS efforts.

A Divided Field

The field needed positive guidance to enable it to mature beyond its divisions. Over the past fifteen years, the MHPSS field has been polarized into multiple camps, with distinct, conceptual and ideological differences between them (Betancourt & Williams, 2008; Boothby et al., 2006; Bracken et al., 1995; Galappatti, 2003; Silove et al., 2000; van Ommeren et al., 2005).

In the health sector there were two competing approaches. One used a vertical, medical model, focused on traumatic stress symptoms and posttraumatic stress disorder (PTSD). This approach often entailed the use of freestanding supports such as counselling, psychotherapy and medication. The other approach used a public health model that considered all mental disorders and placed priority on all severe mental disorders, regardless of whether these disorders were severe trauma induced depression or pre-existing psychoses to be managed through general health services and/or general mental health services (WHO, 2003). In the protection/social/community services/social

welfare sector, which includes social workers, child protection practitioners, and many other paraprofessionals, there were also at least two differing approaches. The first was a holistic, community based approach that entailed strengthening and use of non clinical community supports such as: women's support groups; child friendly spaces; means of reuniting family members who had been separated; and livelihood support to alleviate distress stemming from difficult economic circumstances. The second, although less common, followed the medical model described above and focused on counselling for traumatic stress and PTSD.

Typically, these different camps competed for funding and rarely collaborated in emergency situations. In essence, workers in the field adhered each to their own approaches, offered competing analyses grounded in divergent theories, valued different types of evidence and often showed marked disrespect for opposing views. In the absence of a solid base of evidence, dogma often dominated within these groups, limiting efforts to collaborate. Worse yet, this dogma generated absurd ideas, such as: everyone is traumatized. Or alternatively: no one is traumatized.

These divisions contributed heavily to poor coordination across approaches, resulting in fragmented services, a lack of comprehensive supports, and startling inconsistency. In some emergency responses, such as in Bosnia, there was extensive use of clinical interventions, yet too little community based support. In other emergency responses, as in Northern Uganda, the opposite pattern prevailed. The net effect of these problems was to deprive affected people of essential support in their hour of greatest need. In addition, MHPSS was often ghettoized, forced to work in isolation from other emergency responses.

However, by 2004, MHPSS had become a common feature of many emergency humanitarian response efforts (Miller & Rasco, 2004), but it was still not regarded as a priority. Many humanitarian aid workers believed, and often still do, that actions related to MHPSS are second or third tier interventions that come only after meeting the basic needs for security, health, food, water/sanitation, and shelter.

The Asian tsunami of December 2004, more than any other single event, repositioned MHPSS as a top priority from the very beginning of an emergency response. As seen in the global media, vast numbers of people, in multiple countries, saw their loved ones, homes, and livelihoods swept away in a matter of minutes. The global audience saw a glimpse of the enormity of suffering associated with psychological anguish, social disruption and forced life transformations caused by the disaster. It clearly showed that affected people needed MHPSS immediately. This highlighted the need for guidelines that outlined how to provide that immediate support.

Establishing the Task Force

Changes in the humanitarian system and its policies are often made through the Inter-Agency Standing Committee (IASC), which includes the heads of many UN and non-UN agencies, including NGO consortia. The IASC promotes humanitarian coordination, develops humanitarian policies, and plays a key role in reforms so as to make the humanitarian system more accountable, efficient, and predictable. It was natural to work through the IASC because it had previously created Task Forces to develop global inter-sectoral guidelines on HIV/AIDS and gender based violence.

A concrete plan to begin the process of developing IASC Guidelines on MHPSS

was created just before the tsunami in November 2004, when a number of events converged. These key events are listed below.

- (1) Wide acceptance of the newly developed *IASC Guidelines on HIV/AIDS* as a politically powerful and practical tool to enhance inter-sectoral, inter-agency coordination in emergencies. These guidelines prompted the idea of similar guidelines for mental health and psychosocial support.
- (2) Inclusion of an action sheet on MHPSS in the draft of the IASC (2005) Guidelines on gender based violence interventions in humanitarian settings. This draft action sheet provided valuable experience with the IASC guideline development process and gave confidence that similar IASC Guidelines could also be possible for MHPSS.
- (3) Development of an inter-agency guide for the contentious area of harm reduction (e.g., methadone substitution treatment) among opioid users (World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC), Joint United Nations Programme on HIV/AIDS (UNAIDS) 2004) led to the argument for the development of more inter-agency guidelines in areas of contention. This led to the WHO commitment to dedicate the necessary staff time to work on such guidelines.
- (4) Interest expressed by the WHO's most senior emergency officer gave a higher profile to mental health in emergencies. It also created the political will in WHO to develop a proposal to construct IASC Guidelines on MHPSS that would be similar in format to the *IASC HIV/AIDS Guidelines* (2003) (proposals for any IASC drafted Guidelines need to be

submitted by executive heads of emergency departments of IASC agencies).

In December 2004, WHO started to informally explore the level of interest of other agencies to join in and co develop a proposal for IASC Guidelines on MHPSS in emergencies. The UN High Commissioner for Refugees (UNHCR), The International Organization for Migration (IOM), the United Nations Children's Fund (UNICEF) and the International Federation of Red Cross and Red Crescent Societies (IFRC) were all approached. Initial reactions were very positive. Meetings were also organized with facilitators of other inter-agency humanitarian products to understand the complexities involved. However, explorations on the possibility of developing IASC Guidelines on MHPSS had to be postponed when a tsunami created an unprecedented disaster across Asia.

The global awareness of the importance of MHPSS after the 2004 tsunami facilitated WHO's explorations, with other agencies, to develop the guidelines in March 2005. During April and May 2005, two informal inter-agency meetings were organized with invitations extended to all members of the IASC Working Group and their technical level representatives. This led to the collaborative inter-agency development of a proposal, which was formally submitted by WHO and accepted by the IASC Working Group in June 2005. Thereafter, the IASC established a Task Force charged with developing Guidelines on MHPSS. This resulted in mental health and psychosocial support being placed high on the humanitarian policy agenda for the first time. This proposal (which is described in the Task Force's Terms of Reference [IASC Working Group, 2005]) included four features that had a large impact on the Guidelines development:

- (1) The Guidelines would be developed along the lines of IASC Guidelines for HIV/AIDS. This implied: (a) a focus on the immediate response in the midst of emergencies; (b) focus on practical actions; (c) an inter-sectoral approach; and (d) short action sheets written by agencies according to their own expertise. As a result, the vision for the guidelines was pre defined. Although the Task Force still faced many challenges, thereafter, it did not have to grapple with conceptualizing a vision of its output.
- (2) The work would fall under the headline of *'mental health and psychosocial support'*. Despite the overlap of the concepts of *'mental health'* and *'psychosocial'*, this headline was chosen to attract both broad interest as well as to promote an inclusive approach. As a result, numerous agencies felt welcomed into the Task Force. Additionally, the Task Force members avoided the long, heated and often unproductive discussions about what to call this field and how to define it (Eventually a definition of MHPSS was developed which has been provided on page I of the guidelines).
- (3) WHO would co chair the Task Force with InterAction, a consortium of 162 international NGOs. Due to the existing tensions within the MHPSS field, other agencies suggested that the people co chairing, ideally, should have complementary professional backgrounds. Indeed one of the co chair come from the protection area, while the other works for a public health agency. In this way the Task Force's facilitators were balanced in terms of their professional interests.
- (4) Membership of the Task Force would only be open to IASC agencies, which

includes the 100s of NGO members of NGO consortia that are part of the IASC. The result of this, however, was to exclude academic institutions, professional organisations and many grass-roots organisations. Therefore, the need to reach out and consult with these groups was apparent. This was done extensively during the peer review process. Although excluding groups from membership clearly had its drawbacks, it did ensure that the Task Force: (a) consisted of agencies with broad international experience in implementing programmes; (b) steered clear from abstract academic discussion; and (c) was free of the influence of special interests from any one particular professional organisation.

The Task Force was responsible for writing consensus based guidelines. Although consensus on MHPSS was emerging (van Ommeren et al., 2005), there was no defined consensus about the top priorities. Fortunately, there was an increasing agreement about what to do early on during emergency response (van Ommeren et al., 2005). This agreement, albeit incomplete, had been brought about by developments such as the inclusion of a section on MHPSS in the 2004 edition of the *Sphere Handbook* (Sphere Project, 2004). Across a broad spectrum of MHPSS practitioners, there was a widespread sense that it was time to develop guidelines to help systematize the field, enable effective coordination, identify useful practices, flag potentially harmful practices, and clarify how different approaches to MHPSS complement one another. If this sense of *'readiness'* was crucial, so too was the construction of an inclusive, systematic process for developing guidelines that diverse agencies could agree.

Developing the guidelines

Following the establishment of the Task Force, this group worked in a concerted manner over the next two years to develop the guidelines, which were finalized in February, 2007 and launched in Geneva in September, 2007. The discussion below outlines the strategies and processes used in developing the guidelines. Table 1 provides a brief chronology of the main steps involved.

Key Strategies

Three key challenges in the work of the Task Force were:

- (1) the broad scope of the field of MHPSS, which requires technical expertise of diverse kinds;
- (2) the polarizations described above in the field and the associated risk of getting bogged down in divisive debates; and
- (3) the lack of relationships and collaboration between practitioners in the health and protection sectors and across a wide spectrum of agencies in the field of MHPSS.

To manage these challenges, the Task Force used numerous strategies, that in most cases, were developed collectively by various Task Force members.

Inclusive approach As mentioned above, the Task Force's membership could have included each of the hundreds of agency members of the IASC and its consortia. Yet agency members had to be recruited to actually join the Task Force. Technically, it was necessary to reach beyond one camp and to draw on the comparative advantage and technical strengths of different agencies. It was clear from the outset that the acceptance and legitimacy of the guidelines required membership of numerous agencies, to balance and integrate elements from the

health and protection sectors, as well as other sectors.

Another key decision taken early on was to recruit into the Task Force a diverse array of agencies that had been highly active in different field settings. They were represented by seasoned practitioners who came mainly from the health and protection sectors, and also from diverse backgrounds such as: psychology, psychiatry, and social work. These agencies were identified through a process of networking, consultation, and outreach among UN agencies and NGOs, for example through Inter Action. The aim was to include all, or almost all, of the key UN and non-UN agencies involved in MHPSS in the Task Force. Face to face consultations were organized with non members in Dec 2005, which led to a number of agencies joining the Task Force. In the end, the Task Force was comprised of 27 agencies (Table 2). These constitute many - although certainly not all - of the main international agencies doing MHPSS in most large emergencies.

Focus on practical steps Despite conceptual divisions in the MHPSS field, there was an increasing agreement about what to do first in emergencies. The Task Force capitalized on this agreement by focusing much more on practical steps - concrete actions - than on principles and theory. In fact, the Task Force mandate was to identify the minimum response, the first steps that ought to be taken in emergencies to protect and promote MHPSS. Consistent with this mandate, the opening meeting of the Task Force invited workers from different sectors to briefly explore questions such as *"what does the term "psychosocial support" mean?"* In the beginning of the process, the Task Force did not seek consensus on such questions, but stuck to its mandate to focus on practical steps. During the discussions of practice, divergent conceptual analyses surfaced and were explored.

Table 1. A summary chronology of the Task Force

Key Events or Activities	Dates
Plan to initiate IASC Guidelines on MHPSS in Emergency Settings	November 2004
Asian tsunami causes delay in setting up Task Force, yet raises inter-agency interest in MHPSS	December 2004
Inter-agency meetings to discuss establishing a Task Force	April and May 2005
Task Force formally established by the IASC Working Group	June 2005
Zero draft of matrix developed by co chairs	July 2005
First meeting of the Task Force in Geneva	September 2005
Agencies identification to write action sheets	Autmn 2005
Pre final version of Matrix completed	October 2005
First draft of action sheets and pre final version of matrix sent for initial peer review	December 2005
New York and Geneva consultations with non Task Force agencies and with practitioners from around the world	December 2005
Second draft of action sheets completed	February 2006
Second meeting of the Task Force in Geneva	February 2006
Third draft of action sheets reviewed by co chairs	April 2006
Fourth, pre final drafts of Action Sheets (in English French, and Spanish) received peer reviewed by 100s of practitioners in	August 2006
Fifth draft of action sheets reviewed by co chairs	October 2006
Draft introduction chapter circulated for Task Force review	October 2006
Sixth and final drafts of action sheets finalized	December 2006
Final version of guidelines circulated to Task Force for technical endorsement	December 2006
Formal endorsement of guidelines as IASC document by IASC Working Group	February 2007
Launch of guidelines in Geneva	September 2007
Launch of guidelines in New York and Washington DC	November 2007
Task Force officially closes and transfers into the IASC Reference Group on MHPSS with its mandate to promote implementation of the guidelines	December 2007

Table 2 Membership of the Inter-Agency Standing Committee (IASC) and the IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings.**

Members and Standing Invitees of the IASC	Members of the IASC Task Force MHPSS
Food and Agricultural Organisation (FAO)	Action Contre la Faim (ACF)
InterAction*	InterAction*, through:
International Committee of the Red Cross (ICRC)	• American Red Cross
International Council of Voluntary Agencies (ICVA)*	• Christian Children's Fund (CCF)
International Federation of Red Cross and Red Crescent Societies (IFRC)	• International Catholic Migration Commission (ICMC)
International Organisation for Migration (IOM)	• International Medical Corps (IMC)
Office for the Coordination of Humanitarian Affairs (OCHA)	• International Rescue Committee (IRC)
Office of the Special Representative of the Secretary General on IDPs	• Mercy Corps
Steering Committee for Humanitarian Response (OHCHR)*	• Save the Children USA (SC-USA)
United Nations Development Fund (UNDP)	Inter-Agency Network for Education in Emergencies (INEE)*
United Nations Children's Fund (UNICEF)	International Council of Voluntary Agencies (ICVA)*, through:
United Nations High Commissioner for Refugees (UNHCR)	• ActionAid International
United Nations Population Fund (UNFPA)	• CARE Austria
World Bank	• HealthNet TPO
World Food Programme (WFP)	• Médicos del Mundo (MdM-Spain)
World Health Organisation (WHO)	• Médecins Sans Frontières Holland (MSF-Holland)
	• Oxfam GB
	• Refugees Education Trust (RET)
	• Save the Children UK (SC-UK)
	International Federation of Red Cross and Red Crescent Societies (IFRC)
	International Organisation for Migration (IOM)
	Office for the Coordination of Humanitarian Affairs (OCHA)
	United Nations Children's Fund (UNICEF)
	United Nations High Commissioner for Refugees (UNHCR)
	United Nations Population Fund (UNFPA)
	World Food Programme (WFP)
	World Health Organisation (WHO)

* Indicates consortium of agencies.

** The IASC exists of executive heads of agencies in the left column of this table.

Invariably, the discussion returned to issues of practice. More than any other strategy, keeping the focus on practice avoided dwelling on divisions, and made it possible to achieve consensus.

Some Task Force members wanted to start the discussion by developing a set of principles to inform the guidelines' development. However, it was decided not to go that route, as articulating principles, although important, is an abstract process and can be contentious in a field burdened with dogma. Therefore, it was decided to focus the discussions on practical actions, and to record principles whenever Task Force members spontaneously articulated them. The articulation of these principles evolved and can be found in the introductory chapter of the guidelines.

Face to face meetings Face to face meetings played a pivotal role in the work of the Task Force. It was at these meetings that Task Force members either got to know each other or to renew old bonds, to develop a common vision, and to build a sense of teamwork. The building of human relationships across sectors and agencies was a core part of the foundation for the Task Force and one of its enduring accomplishments. Members seem to have understood from the start that a division into 'tribes,' competitive agency positioning, or excessively harsh exchanges would undermine any movement toward a consensus. Fortunately, norms of collaboration and respect evolved early in the process and gained in strength with each successful step of collaboration.

Face to face discussions were also vital to discuss complex issues in an open, forthright manner. Although the Task Force conducted a large amount of its business by email, they avoided handling most contentious issues by email, as it lacks contextual cues that enable accurate interpretation, as well as

the social influences that encourages moderation. Discussions in person enabled vigorous exchanges, including some debates, which were very useful in clarifying technical issues and also areas of continuing disagreement. The participatory process of the meetings also enabled different participants to exercise developing particular ideas and to facilitate agreement on key issues. Equally important were the informal discussions that occurred in breaks and over meals. In these spaces, participants often probed issues further, and built relationships that could withstand disagreements over particular issues.

Shared vision, common vocabulary The participants came together with a strong, common goal of developing technically accurate, global guidelines that would enable comprehensive, quality supports for affected populations. In the pursuit of this goal, the participants developed a common vision, which perhaps is best expressed through six principles (see Chapter 1 of the guidelines for details) that are listed below.

- (1) *Human rights and equity* MHPSS should promote the rights of all affected people; promote equity among all affected groups, and avoid the discrimination that often harms affected people.
- (2) *Participation* Humanitarian action should stimulate the participation of affected people. Participation is a right, as well as a means of regaining a sense of control in the aftermath of overwhelming experience. Participation enables different subgroups of local people to retain, or resume, control over decisions that affect their lives and to build a sense of local ownership that contributes to programme quality, equity and sustainability.
- (3) *Do No Harm* Because MHPSS deals with highly sensitive issues and can be a

source of harm, Task Force members agreed that *Do No Harm* should be a cross cutting principle. Humanitarians should be encouraged to participate in coordination groups; to design programmes based on sufficient information; to commit to openness to scrutiny and external review; to develop cultural sensitivity and technical competence in the area one works; to stay updated on evidence; to support universal human rights; and, finally, to take into account power relationships between outsiders and emergency affected people, and the value of participatory approaches. The guidelines include a list of specific Do's and Don'ts to help make this principle operational.

- (4) *Building on available resources and capacities* All affected groups contain significant resources that may be able to provide support in an appropriate and sustainable manner. Where possible, humanitarians should activate, support, and build on local resources (existing support and services) and strengthen capacities within both civil society and the government.
- (5) *Integrated support systems* The Task Force agreed that the proliferation of stand-alone services, such as those dealing only with rape survivors, or only with people having a specific diagnosis such as PTSD, can create a highly fragmented care system that reaches few and risks stigmatizing survivors. A high priority, therefore, is to integrate support and activities into wider systems such as existing community support mechanisms, systems of formal and non formal education, health services, general mental health services, and social services.

- (6) *Multi layered supports* In emergencies, people are affected in different ways and require different kinds of supports (see pyramid in Figure 1). A small percentage, who experience intolerable suffering and may have significant difficulties in basic daily functioning, immediately need access to clinical psychological, psychiatric, or other highly specialized support. Most people, however, will cope and recover well through access to local, non formal support, provided that the public wellbeing is protected through the reestablishment of security, adequate governance and services that meet basic survival needs. In between these extremes are people who have been affected by disruptions of, or separations from, key family and community support and who will benefit from efforts such as family tracing and reunification, communal healing ceremonies, formal and non formal education, livelihood activities, and the activation of social networks. In between these extremes are also people who need access to focused, non clinical supports, such as access to psychological first aid for acute trauma induced distress.

In addition to enabling the multiple, proportionate layers needed for building comprehensive supports, this layered system proved useful in quieting concerns that ones' own area of work was somehow less important than others. This layered system provides a 'home' for different sorts of MHPSS supports, emphasizes their complementarities, and underscores the importance of coordination and referrals across levels. Of note, this layered system is displayed in the form of an intervention pyramid in the introductory chapter of the guidelines. Such pyramids

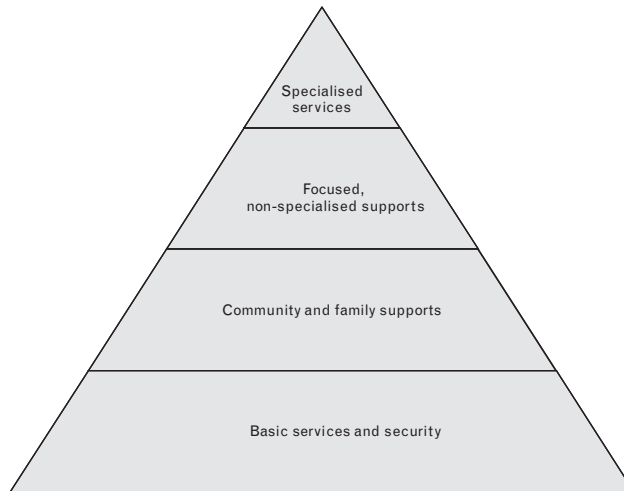


Figure 1: IASC (2007) Intervention pyramid for mental health and psychosocial support in emergencies.

are common in the field (for example, Green et al., 2003). The pyramid in the guidelines was built after reviewing about ten such pyramids available in the mental health and psychosocial literature.

Along with the need for a shared vision, came the need for a common vocabulary that would bridge various subgroups. Although the terms *mental health* and *psychosocial support* are closely related and overlap conceptually, they reflect different, yet complementary, approaches for many aid workers. Aid agencies working outside the health sector tend to speak of supporting psychosocial wellbeing. 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 (WHO, 2001). Exact definitions of these terms vary between, and within, aid organisations, disciplines and countries, and this variation often fuels confusion and debate in the field (Galappatti, 2003). Con-

sistent with the Task Force's formal Terms of Reference, the Task Force developed a norm of using the composite term '*mental health and psychosocial support*' to describe any type of local or outside support that aims to protect or promote psychosocial wellbeing, or prevent or treat mental disorder.

Adapting the matrix The Task Force did not start from scratch, but drew on previous IASC efforts that lead to the *IASC Guidelines for Gender Based Violence Interventions in Humanitarian Settings* (2005) and the *IASC Guidelines for HIV/AIDS Interventions in Emergency Settings* (2003). Structurally, both of these guidelines consisted of a matrix and a set of relatively brief Action Sheets. Each matrix outlined, in various domains and functions, the key steps to be taken in three phases: emergency preparedness, minimum response, and comprehensive response. Thus the matrix contextualizes the focus of all IASC Guidelines: minimum response relative to steps that are useful before an emergency erupts, and after the minimum

responses have been fulfilled. The Action Sheets then offer specific guidance on how to accomplish particular recommended minimum responses. Table 3 shows the minimum response part of the overall matrix, with the titles of each of the action sheets.

The Task Force made two key decisions regarding its *Matrix of Interventions*. First, it decided to use many of the matrix categories of the previous IASC Guidelines (mentioned above). Besides promoting consistency across the various guidelines, this approach was consistent with the charge to the Task Force to develop inter sectoral guidelines, as well as the idea that MHPSS is not something done only by clinicians and protection workers. Aid workers, in sectors such as food security and nutrition, shelter and site planning, education, and water/sanitation, also have a responsibility to promote MHPSS by virtue of the way in which they do their work. Second, the Task Force decided to adapt the matrices developed by previous IASC efforts. The most significant adaptation to the MHPSS topic was the addition of a row entitled *community mobilization and support*.² The Action Sheets under this heading, in particular, operationalise principles of participation and building on local resources. They outline how one can facilitate community participation and ownership of the aid effort, how to build on local resources to strengthen community supports, and how to enable the participation of marginalized people. Having community mobilization and support sit at the same level and prominence in the guidelines as Health Services or Education ensured balance, and avoided the extremes such as those inherent in a medical model.

Developing action sheets

The development of Action Sheets was time intensive, consultative, and systematic. The

process entailed a leading role taken by different agencies that also took primary responsibility for drafting a particular (and in some cases, several) Action Sheets relevant to their own specific expertise. The agencies that played a leading role were encouraged to reach down to grassroots level in their own networks, bringing forward insights from diverse contexts and cultural systems. In some cases, such as the Action Sheet on social considerations in the provision of water and sanitation, the Task Force lacked the relevant agency expertise and therefore recruited an agency (in this case, Oxfam) to play the lead role. In a few cases (for example, legal protection and training), external consultants were hired by particular agencies to do the main drafting and revision. This shared leadership approach and the investment by member agencies of significant amounts of time and resources testifies to the highly collaborative nature of the work done by the Task Force.

To achieve high levels of technical accuracy, each Action Sheet was subjected to five rounds of review. Task Force members conducted three reviews, and the first and fourth revisions were reviewed externally, as well as internally. For the external review, the Action Sheets were translated into French and Spanish and sent to hundreds of practitioners, academics, and professional associations worldwide, with a request for their peer review and input. (The matrix was translated and circulated in French, Spanish and Arabic.) This robust external peer review engaged a much wider range of perspectives than existed on the Task Force and helped the Task Force to avoid becoming too isolated, or entrapped in their own discourse. Each co chair assumed responsibility for overseeing review of half the action sheets. This entailed checking whether all external peer review comments were appropriately

Table 3. Mental Health and Psychosocial Support: Suggested Minimum Responses in the Midst of Emergencies*

Category	Minimum Response
A. Common functions	
Coordination	Establish coordination of inter-sectoral mental health and psychosocial support
Assessment, monitoring and evaluation	Conduct assessments of mental health and psychosocial issues Initiate participatory systems for monitoring and evaluation
Protection and human rights standards	Apply a human rights framework through mental health and psychosocial support Identify, monitor, prevent and respond to protection threats and failures through social protection Identify, monitor, prevent and respond to protection threats and abuses through legal protection
Human resources	Identify and recruit staff and engage volunteers who understand local culture Enforce staff codes of conduct and ethical guidelines Organise orientation and training of aid workers in mental health and psychosocial support Prevent and manage problems in mental health and psychosocial well being among staff and volunteers
B. Core mental health and psychosocial supports	
Community mobilisation and support	Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors Facilitate community self-help and social support Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices Facilitate support for young children (0–8 years) and their care givers
Health services	Include specific psychological and social considerations in provision of general health care Provide access to care for people with severe mental disorders Protect and care for people with severe mental disorders and other mental and neurological disabilities living in institutions Learn about and, where appropriate, collaborate with local, indigenous and traditional health systems Minimise harm related to alcohol and other substance use

Table 3. (Continued)

Category	Minimum Response
Education	Strengthen access to safe and supportive education
Dissemination of information	Provide information to the affected population on the emergency, relief efforts and their legal rights Provide access to information about positive coping methods
C. Social considerations in sectors	
Food security and nutrition	Include specific social and psychological considerations (safe aid for all in dignity, considering cultural practices and household roles) in the provision of food and nutritional support
Shelter and site planning	Include specific social considerations (safe, dignified, culturally and socially appropriate assistance) in site planning and shelter provision, in a coordinated manner
Water and sanitation	Include specific social considerations (safe and culturally appropriate access for all in dignity) in the provision of water and sanitation

*The guidelines include 25 short action sheets of 4 that explain how to implement each of the above minimum responses.

addressed, and making technical suggestions where these seemed indicated. Each co chair also reviewed, and often edited, the other co chair's suggestions before these were sent back to the authors. In addition, many agencies organized their own peer reviews of action sheets that they had written. One agency hired the previous editor of the prestigious journal *Culture Medicine and Psychiatry* to review and comment on the entire document. The reviewers included academics from 29 universities (see page v of the guidelines). Their critical, science-informed reviews ensured that the final text of the guidelines is consistent with our current, scientific knowledge basis. Also crucial were the reviews by people from different backgrounds and regions. Their insights ensured that the guidelines did not reflect only the ideas from a few countries. To enable inputs from partners from low income countries, a

global consultation with national MHPSS workers from those countries was conducted in Geneva, with the results used to make substantive revisions. Similarly, the guidelines benefited from a peer review workshop, spontaneously organized in Sri Lanka by its national Consortium of Humanitarian Agencies.

Controversial issues

The Task Force analyzed many contentious, complex issues that admit no easy answers. Although space limits preclude a full discussion of these issues, it is worthwhile considering how the Task Force considered a few charged issues, and these are discussed below.

Coordination Inter agency coordination is at the heart of effective emergency response. A recurrent problem, however, has been the creation of separate MHPSS coordination

groups that neither coordinate, nor communicate, with each other. Usually, a Ministry of Health establishes a mental health coordination group that reflects the emphases of the health sector, whereas self help and community led supports are coordinated independently through the protection sector.

The Task Force discussed these issues during a period of humanitarian reforms that created the cluster system for delivering humanitarian support in emergencies. Typically, MHPSS work in emergencies is facilitated by agencies working in multiple clusters, in particular the Health and Protection Clusters. Animated discussions occurred around the question of who should have the primary responsibility for MHPSS coordination. Some members argued that to give the Health Cluster the primary MHPSS responsibility would result in a narrow approach and potential overuse of the medical model. Other Task Force members argued that if the coordination responsibility were handed to the Protection Cluster, people with preexisting or disaster induced mental disorders would be ignored. There were also members who suggested that either the Health Cluster or the Protection Cluster might be a good home for MHPSS coordination. There was additional concern that asking both the Protection and the Health Clusters to share the coordination responsibility would produce confusion and poor accountability. In the end, the importance of multi sectoral coordination rose as the highest priority. A consensus emerged that the guidelines should encourage the establishment of a single, overarching coordination group. They do not, however, specify where this group sits within the overall humanitarian coordination system. In essence, these decisions are left to the local actors in the field.

It is encouraging to note that at the time of this writing (June 2008), there is one inter sectoral MHPSS coordination group in Myanmar, which is a direct result of use of the guidelines.

The creation of a workable, accountable system of coordination remains an ongoing challenge that must be met in different ways depending upon the context. The very high priority of this task was one of the reasons why many Task Force members preferred to reorganize themselves and continue as an IASC Reference Group. This followed the official end of the Task Force, which had successfully fulfilled its mandate by publishing the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* in 2007. It was felt that an ongoing association with the IASC as an IASC Reference Group would facilitate greater influence with the Health and Protection Clusters to promote implementation and resolve the coordination challenge. At this writing, the questions of who, as well as how, at field level will coordinate MHPSS in emergencies and remains very challenging to answer.

Traumatic stress For well over a decade, many field practitioners in emergency settings have emphasized traumatic stress, particularly PTSD (Apfel & Simon, 1996; Derluyn et al., 2004; Green et al., 2003; Marsella et al., 1994, 1996; Wilson & Drozdek, 2004). Other analysts, however, have questioned, in varying degrees, the appropriateness of this emphasis (Bracken et al., 1995; Stein et al., 2007; Wessells, 2006; Wessely, 2003). There is clearly no consensus in this area (van Ommeren et al., 2005). A significant question for many members was how the Task Force would view the emphasis on trauma, and how it would dispose itself toward PTSD and other forms of mental illness.

Within the Task Force discussions there was, perhaps surprisingly, little interest in a focus on traumatic stress. Many practitioners, especially those from the health sector, had previously focused on traumatic stress in emergencies but had slowly moved away. We believe that this is not due to a 'selection bias' of the Task Force members. More likely, we believed it reflects a tendency of highly experienced international emergency practitioners - those who have actively worked for extended periods in international disasters - to see traumatic stress as only one of numerous issues. Less experienced workers are more likely to see trauma as the key issue. Health professionals on the Task Force pointed out that, although traumatic stress and PTSD can be significant problems, grief and depression are often greater problems that often receive little attention. Those with a public health perspective were concerned that trauma is too frequently approached in a singular (vertical/stand alone) manner that fragments the mental health care system as a whole. According to this approach, attention is needed on a much wider array of mental health issues covering both preexisting and disaster induced mental disorders, including mood disorders, substance use disorders, and acute and chronic psychoses, among others. Due to the awareness that categories of mental health and illness are partially culturally constructed, quite a few Task Force members emphasized the importance of also considering indigenous knowledge and practices that diverge from Western categories and practices. There was widespread agreement that severely or chronically mentally ill people are often invisible in emergencies, as well as being at very high risk. Therefore, those working on MHPSS cannot ignore them. This discussion led to consensus that the top layer of the intervention pyramid includes interventions,

not only for severely traumatized people, but also for those having other severe mental health problems requiring specialized supports.

Lively discussion explored the complexities of surveys of mental disorders in emergency contexts. Despite being published in prestigious journals, few practitioners seemed to hold them as credible. Members pointed out that too often surveys entail the use of scales that have not been validated for emergency affected contexts, in which reports of high distress may not necessarily imply mental disorders. Task Force members working outside the health sector were particularly concerned with issues of the cultural validity of the constructs measured. Most health sector workers saw the cultural validity of constructs such as PTSD and mood disorder as less of an issue. Yet, they noted that the reactions seen during the first month of an emergency often tend to improve over time and usually do not convert into full blown mental disorder. This is especially common when people experience social supports and basic needs are met. Those in the protection sector pointed out that reported severe distress might result not from traumatic experiences, but from difficult environmental conditions arising from current living arrangements or loss of livelihoods, etc. For example, refugees and internally displaced persons often say that their greatest sources of distress is the lack of privacy in camps, fear of being sexually assaulted when they go to the latrines or collect firewood, and/or not knowing the whereabouts of loved ones. Nonetheless, most members agreed that severe, acute trauma induced distress and any subsequent severe disorder remains an issue for a minority of disaster survivors.

As a result of its' mandate on minimum response, the Task Force agreed that the

guidelines would include as essential supports: (a) psychological first aid to people with acute trauma induced distress and (b) care for people with severe mental disorders, including severe (highly disabling) presentations of PTSD, by trained and supervised health staff. However, care for mild and moderate mental disorders (including mild and moderate presentations of PTSD) was relegated to the more comprehensive response, i.e. to be implemented after the population has access to essential supports. Part of the comprehensive response, indeed, is the building of a community mental health system that includes care for PTSD, alongside that of many other disorders.

Conclusion

The development of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* led to concrete guidance for all humanitarian actors on how to organize the necessary supports, in a collaborative manner that respects the *Do No Harm* imperative. As explained, in part, in some of the papers in this issue, the guidelines are now in use by multiple agencies in countries such as Sri Lanka, Peru, Colombia, Philippines, Kenya, Jordan, Syria, Myanmar, and China, among many others. We strongly encourage readers to support the use of the guidelines in their own agencies and especially by the coordination groups in emergencies. Coordination groups will want to use the guidelines as a checklist to identify whether appropriate minimum responses are being implemented in various regions, thereby identifying potential gaps and improving planning. A coordinated, intersectoral approach is essential to address the diverse mental health needs and psy-

chosocial suffering of people in emergency situations.

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Although the guidelines do reflect formal inter-agency agreement, the views expressed in this current paper are those of the authors as individuals and may not necessarily reflect the decisions, policies or views of their employers nor may they reflect the views of other Task Force members.

References

- Apfel, R. & Simon, B. (Eds.) (1996). *Minefields in their hearts*. New Haven: Yale University Press.
- Batniji, R., van Ommeren, M. & Saraceno, B. (2006). Mental and social health in disasters: relating qualitative social science research and the Sphere standard. *Social Sciences and Medicine*, 62, 1853-1864.
- Betancourt, T. & Williams, T. (2008). Building an evidence base on mental health interventions for children affected by armed conflict. *Intervention*, 6(1), 39-56.
- Bolton, P. & Betancourt, T. (2004). Mental health in postwar Afghanistan. *JAMA*, 292(5), 626-628.
- Boothby, N., Strang, A. & Wessells, M. (Eds.) (2006). *A World Turned Upside Down: Social Ecologies of Children and War*. Westport, CT: Kumarian Press.
- Bracken, P., Giller, J. & Summerfield, D. (1995). Psychological responses to war and atrocity: the limitations of current concepts. *Social Sciences and Medicine*, 40, 1073-1082.
- de Jong, J., Komproe, I. & van Ommeren, M. (2003). Common mental disorders in post-conflict settings. *Lancet*, 361, 2128-2130.
- Derluyn, I., Broekaert, E., Schuyten, G. & De Temmerman, E. (2004). Post-traumatic stress in former Ugandan child soldiers. *Lancet*, 363, 861-863.
- Galappatti, A. (2003). What is psychological intervention? *Intervention*, 2(2), 3-17.
- Green, B., Griedman, M., deJong, J., Solomon, S., Keane, T., Fairbank, J., Donelan, B., Frey-Wouters, E. (Eds.) (2003). *Trauma interventions in war and peace*. New York: Kluwer.
- Inter-Agency Standing Committee (2003). *Guidelines for HIV/AIDS in emergency settings*. Geneva: Author.
- Inter-Agency Standing Committee (2005). *Guidelines for gender-based violence interventions in humanitarian settings*. Geneva: Author.
- Inter-Agency Standing Committee (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: Author. <http://www.humanitarianinfo.org/iasc/content/products>.
- Inter-Agency Standing Committee Working Group (2005). *Proposal to set up an IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings: Proposed Terms of Reference*. IASC Working Group 61st meeting 22-23 June 2005. Geneva.
- Marsella, A., Bornemann, T., Ekblad, S. & Orley, J. (Eds.) (1994). *Amidst peril and pain*. Washington, DC: American Psychological Association.

- Marsella, A., Friedman, M., Gerrity, E. & Surfield, R. (Eds.) (1996). *Ethnocultural aspects of posttraumatic stress disorder*. Washington, DC: American Psychological Association.
- Miller, K. & Rasco, L. (Eds.) (2004). *The Mental Health of Refugees*. Mahwah, NJ: Erlbaum.
- Mollica, R., Cardozo, B., Osofsky, H., Raphael, B., Ager, A. & Salama, P. (2004). Mental health in complex emergencies. *Lancet*, 364, 2058-2067.
- Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M., Hosman, C., McGuire, H., Rojas, C. & van Ommeren, M. (2007). Treating and preventing mental disorders in low and middle in countries - is there evidence to scale up? *Lancet*, 370, 991-1005.
- Psychosocial Working Group (2003). *Psychosocial Intervention in Complex Emergencies: A Conceptual Framework*. Edinburgh: Author. Downloaded from <http://www.forcedmigration.org/psychosocial/papers/Conceptual%20Framework.pdf>.
- Reyes, G. & Jacobs, G. (Eds.) (2006). *Handbook of international disaster psychology, vol. I*. Westport, CT: Praeger.
- Silove, D., Ekblad, S. & Mollica, R. (2000). The rights of the severely mentally ill in post-conflict societies. *Lancet*, 355, 1548-1549.
- Stein, D., Seedat, S., Iversen, A. & Wessely, S. (2007). Post-traumatic stress disorder: medicine and politics. *Lancet*, 369, 139-144.
- van Ommeren, M., Saxena, S. & Saraceno, B. (2005). Mental and social health during and after acute emergencies: emerging consensus? *Bulletin of the World Health Organisation*, 83, 71-76.
- Wessells, M. (2006). *Childsoldiers: From violence to prevention*. Cambridge, Massachusetts: Harvard University Press.
- Wessells, M. (2008). Do No Harm: Challenges in organizing psychosocial support to displaced people in emergency settings. *Refugee*, 25, 6-14.
- Wessely, S. (2003). War and the mind: Psychopathology or suffering? *Palestine-Israel Journal of Politics, Economics and Culture*, 10, 6-16.
- WHO (2001). *World Health Report 2001 - Mental Health: New Understanding, New Hope*. Geneva: WHO.
- WHO (2003). *Mental Health in Emergencies: Mental and Social Aspects of Health of Populations Exposed to Extreme Stressors*. Geneva: WHO.
- WHO, UNODC, UNAIDS (2004). *WHO/UNODC/UNAIDS position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*. Geneva, Switzerland: WHO.
- Wilson, J. & Drozdek, B. (Eds.) (2004). *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims*. New York: Brunner-Routledge.

¹ There is extensive literature about this subject: Bolton & Betancourt (2004), Boothby, Strang, & Wessells (2006); de Jong, Komproe, & van Ommeren (2003); Green et al. (2003); Miller & Rasco (2004); Mollica, Cardozo, Osofsky, Raphael, Ager, & Salama (2004); Psychosocial Working Group (2003); Reyes & Jacobs (2006); Wilson & Drozdek (2004).

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Announcement

Ananda Galappatti receives the Ramon Magsaysay Award

The editorial board of *Intervention* is pleased to congratulate Mr. Ananda Galappatti on his receiving the 2008 Ramon Magsaysay Award for Emergent Leadership. Mr. Galappatti, a member of the editorial board of *Intervention* since its inception, was recognised by the Board of Trustees of the Ramon Magsaysay Award Foundation for *'his spirited personal commitment to bringing appropriate and effective psychosocial services to the victims of war trauma and natural disasters in Sri Lanka.'*

The Ramon Magsaysay Awards were established in 1957 and are annually awarded to Asian individuals or organisations in East, Southeast, and South Asia for achieving excellence in their respective fields. The award is given in six categories. More than two hundred and fifty individuals and organizations have been named Magsaysay award winners since 1958. Among them are some of Asia's greatest humanitarians, community leaders, intellectuals, and artists. For further information please visit: www.rmfa.org.ph/Awardees/Citation/CitationGalappattiAna.html

Peter Ventevogel
Editor-in-chief, *Intervention*