

A Public mental health perspective: the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

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Five dilemmas inherent in emergency response are presented and discussed from a public mental health perspective in reference to the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. These are: (1) Who should take the lead in the planning and implementation of the guidelines? (2) At what level are the guidelines to be used? (3) What evidence do we have for the usefulness of the guidelines? (4) What are the costs for the proposed interventions, and how are the activities to be financed? (5) What is the place of specific mental health and psychosocial support within the interventions?

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Introduction

The *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* are an important step toward the inclusion of mental health and psychosocial considerations in emergency response. The document provides a matrix of interventions that provides a clear overview of the key things to do and to plan. The action sheets are short, written in accessible English, and organized in a uniform way with the repeating sections (background, key actions, sample process indicators and a case example). Each section

also includes key resources, for those who may want further information. Therefore, the guidelines should be regarded as a major improvement, but it is only the first step. It will not resolve all challenges present in emergency settings. The author formulates five dilemmas, using a public mental health perspective, that are not yet sufficiently addressed in the guidelines.

Who should take the lead?

In an emergency, the main leadership actors can be divided into three groups: local leaders; policymakers and coordinators in UN agencies and non-governmental organizations; and the professionals who are actually implementing the interventions.

In the first case, there will be *local leaders* who take responsibility for the affected populations, and often do not have easy access to these guidelines. The local leaders may also be Ministry officials based in the capital cities, far from where the emergency is taking place, but they do have the power to act. It is important to involve officials in the planning and implementation of interventions, as emergency interventions can grow into national mental health and psychosocial programmes. Actions that are carried out *for them* (or on the behalf of the population), are counter productive if you do not involve the local policy makers or local leaders of

the affected populations in the planning or implementation. After all, the goal should be to empower the local populations to eventually take control of their own mental health and psychosocial wellbeing. The guidelines do make a case for the involvement of the local populations. However, this should not be just lip-service. We need to ensure that, in acute emergencies and in the post emergency period, these guidelines are disseminated to all those who are affected.

A second target group for the guidelines would be *policy makers and coordinators in UN agencies and nongovernmental organizations (NGOs)*. They shape the interventions and mobilize resources. They are the ones who recruit staff, oversee assessments, develop strategies and oversee the implementation. It is important to have specific sections that highlight the key actions required to coordinate this group. Coordination at this level includes sharing of information, including training materials, and transparency in sharing the financial details of the approved budgets, especially with the policy makers of the host countries and the target beneficiaries. Transparency is also important in the process of building up the capacity of the local policy makers, as well as ensures trust between the various stakeholders.

The third category of potential targets consists of the *'worker bees'*, the professionals sent into the conflict affected area to carry out practical, humanitarian activities. They are often hired to provide specific mental health, or psychosocial, interventions. As a result, they may not have the mandate for planning, setting up systems or even to recruit volunteers or staff, as decisions are taken at higher levels of the agencies or organisations. Guidelines for this level of worker would then have to be targeted to operations, and questions to be answered should include:

- What is the first thing to do?
- How is a mental health or psychosocial programme set up from scratch?
- How do you identify the most vulnerable?
- What should be done first in an acute emergency and what can be left until recovery or a more stable period?

At what level are the guidelines to be used?

The guidelines have to be clear about where the guidelines will be used: at a very high level, in New York or in Geneva; in the capital cities and planning centres; or at the site of the emergency? Each setting will have different consequences. If the guidelines will be used where the fundraising is done, then they should be directed towards developing strategies and mobilizing resources. If they are used in the capital of the affected country, it may also involve developing a strategy, or an action plan, mobilizing resources, and coordinating the implementation. If it is at the site of the emergency, then the guidelines should be more *'hands on'*, providing guidance on how to identify the most vulnerable, to ensure that gender is taken into account, how to assure privacy if a counselling session is taking place, as well as how to ensure the safety, security and wellbeing of the humanitarian aid workers in the field.

What evidence do we have for the usefulness of the guidelines?

The guidelines have good sections on assessment, for the baseline mental and psychosocial disorders, as well another good section on participatory monitoring and evaluation. However, they do not have a section that assesses their own usability, user friendliness, and/or usefulness. Therefore, the next question is how to measure whether the guidelines are achieving their goals? What evidence do we have? Who is using the guidelines, and

what is the experience of their use? What do they like and what do they recommend for change, and why? There are so many guidelines and user manuals on shelves, never used, with no evidence that they are useful, or on their feasibility in the field.

What does it cost and who should pay for it?

The guidelines also appear not to take into account the costs of mental health or psychosocial interventions, or how such activities might be financed. Unless we take costs into account, it is impossible to develop budgets. It also makes it impossible to develop strategies and advocate for their financing. It would be helpful if each key activity has an indicative budget, or a range, even if it is a ballpark figure. It is also important to state who is going to pay for it because although (local) government funding may be very small, they are both a sustainable source and indicate the commitment of that government to mental health. Mobilizing outside resources is important for the immediate, and especially acute, emergency period, but this should always involve government as a lead agency and on board as to where resources can be best used.

What is the place of specific mental health and psychosocial support within the interventions?

The guidelines advocate integrating mental health and psychosocial issues into the overall planning of interventions for emergency affected populations. It is very important to ensure security, safe water, sanitation facilities, shelter, food and clothing. So then, what is the place of interventions that target more specifically mental health and psychosocial support? Should they be a part of the immediate response in an emergency or

would it be better to wait until the 'survival needs' have been met? In the author's opinion, it is better to wait, but then, what should the lag period be? How do we know when to begin more specific mental health and psychosocial interventions? These issues are not discussed in the guidelines.

In the health section, the guidelines address only mental health/mental disorders and only refer to severe mental disorders and alcohol and substance abuse. This reinforces the negative myth that mental disorders are all severe mental disorders. The commonest mental disorders, in general and following a complex emergency, are depression and anxiety disorders, and these are not mentioned, even *en passant* in the guidelines.

Conclusion

The *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* are a welcome step in the right direction for getting mental health and psychosocial disorders integrated into conflict and post conflict reconstruction. There are areas where clarity can be provided, such as in who the target audience should be for the various activities, since they are not always the same. Or, how resources are to be mobilized to carry out planned activities. A useful next step would be to document the use of the guidelines in actual conflict and post conflict contexts, so they can be reviewed and strengthened.

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