IASC
Inter-Agency Standing Committee
IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings

Mental Health and Psychosocial Support in Humanitarian Emergencies:

What Should Humanitarian Health Actors Know?

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1. Introduction

1.1 Background

This document is for humanitarian health actors working at national and sub-national level in countries facing emergencies and crises. It applies to Health Cluster partners, including governmental and non-governmental health service providers.

Based on the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007), this document gives an overview of essential knowledge that humanitarian health actors should have about mental health and psychosocial support (MHPSS) in humanitarian emergencies. Managers will need to ensure that health staff are oriented on relevant parts of this document, as applicable.

The term 'psychosocial' denotes the inter-connection between psychological and social processes and the fact that each continually interacts with and influences the other. In this document, the composite term mental health and psychosocial support (MHPSS) is used 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.

Social supports are essential to protect and support mental health and psychosocial well-being in emergencies, and they should be organised through multiple sectors (e.g. camp management, education, food security and nutrition, health, protection, shelter and water and sanitation). Humanitarian health actors are encouraged to promote the IASC Guidelines and their key messages to colleagues from other disciplines/clusters/sectors to ensure that there is appropriate action to address the social risk factors affecting mental health and psychosocial well-being.

Essential clinical psychological and psychiatric interventions need to be made available for specific, urgent problems. These latter interventions should only be implemented under the leadership of mental health professionals, who tend to work in the health sector.

Including considerations of mental health and psychosocial well-being in the general health response will protect the dignity of survivors and enhance the general health response.

1.2 Impact of emergencies

Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies erode protective supports that are normally available, increase the risks of diverse problems and tend to amplify pre-existing problems. While social and psychological problems will occur in most groups, it is important to note that every individual will experience the same event in a different manner and will have different resources and capacities to cope with the event.

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. belonging to a group that is discriminated against or marginalised; political oppression);
- Emergency-induced social problems (e.g. family separation; safety; stigma; disruption of social networks; destruction of livelihoods, community structures, resources and trust; involvement in sex work); and
- Humanitarian aid-induced social problems (e.g. overcrowding and lack of privacy in camps; undermining of community structures or traditional support mechanisms; aid dependency).

Similarly, problems of a predominantly psychological nature include:

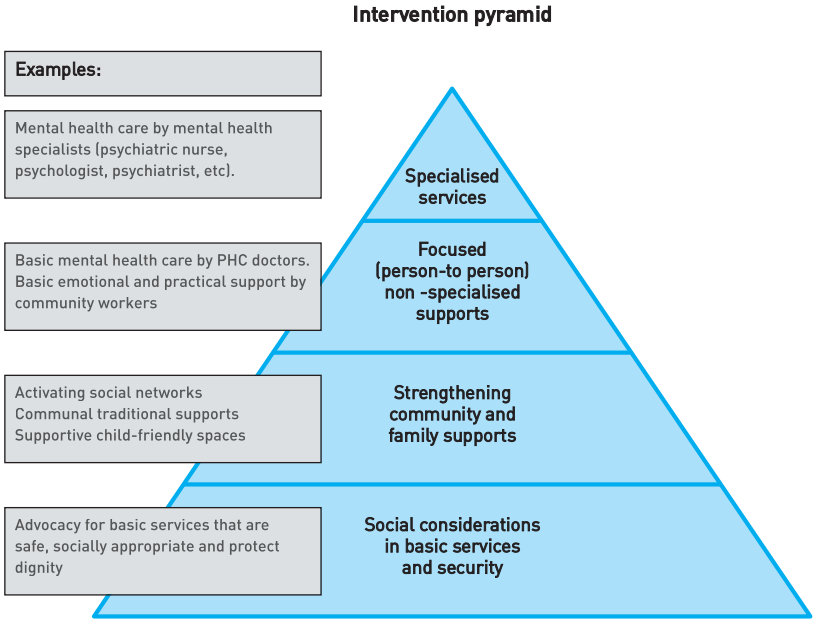
- Pre-existing problems (e.g. severe mental disorder; depression; alcohol abuse);
- Emergency-induced problems (e.g. grief; non-pathological distress; alcohol and other substance abuse; depression and anxiety disorders, including post-traumatic stress disorder (PTSD)); and
- Humanitarian aid-related 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 or disaster-induced depression. A selective focus on these two problems is inappropriate because it overlooks many other MHPSS problems in emergencies, as well as ignoring people's resources. Men, women, boys and girls have assets or resources that support mental health and psychosocial well-being. A common

error in work on MHPSS is to ignore these resources and to focus solely on deficits – the weaknesses, suffering and pathology – of the affected group. It is important to know not only the problems but also the nature of local resources, whether they are helpful or harmful, and the extent to which affected people can access them.

1.3 Principles

Figure 1. Intervention pyramid for mental health and psychosocial support in emergencies. *(for an explanation of the different layers, see pages 12-13 of the IASC Guidelines)*



In emergencies, people are affected in different ways and require different kinds of supports. One of the key principles is ensuring the availability of complementary supports. MHPSS systems require a layered system of complementary supports that meet the needs of different groups (see Figure 1). All layers of the pyramid are important and should ideally be implemented concurrently.

Another key principle is that even in the early stages of an emergency, it is important to build local capacities, supporting self-help and strengthening the resources already present. Whenever possible, humanitarian actors should build both government and civil society capacities. At each layer of the intervention pyramid, key tasks are to identify, mobilise and strengthen the skills and capacities of individuals, families, communities and society.

Activities and programming should be 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.) as much as possible. The proliferation of stand-alone services, such as those dealing only with rape survivors or only with people having a specific diagnosis, tend to be problematic, because they can fragment support systems. Activities that are integrated into wider systems reach more people, are usually more sustainable and carry less stigma.

2. MHPSS matrix: overview of minimum responses during emergencies

A number of minimum responses need to be implemented. These interventions are summarised in Table 1. Core activities for health sector involvement are highlighted in *italic blue*. Where feasible, the health sector may also get involved in any of the other actions, especially in areas of community mobilisation and support. The IASC Guidelines give guidance on how each of the minimum responses may be implemented.

Table 1: IASC Guidelines for Minimum Responses in the Midst of Emergencies (IASC Guidelines, pp.20-29)

Area		A. Common functions
1	Coordination	*1.1 Establish coordination of intersectoral mental health and psychosocial support*
2	Assessment, monitoring and evaluation	*2.1 Conduct assessments of mental health and psychosocial issues* *2.2 Initiate participatory systems for monitoring and evaluation*
3	Protection and human rights standards	*3.1 Apply a human rights framework through mental health and psychosocial support* 3.2 Identify, monitor, prevent and respond to protection threats and failures through social protection 3.3 Identify, monitor, prevent and respond to protection threats and abuses through legal protection
4	Human resources	*4.1 Identify and recruit staff and engage volunteers who understand local culture* *4.2 Enforce staff codes of conduct and ethical guidelines* *4.3 Organise orientation and training of aid workers in mental health and psychosocial support* *4.4 Prevent and manage problems in mental health and psychosocial well-being among staff and volunteers*

Area		B. Core mental health and psychosocial supports
5	Community mobilisation and support	5.1 Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors 5.2 Facilitate community self-help and social support 5.3 Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices 5.4 Facilitate support for young children (0–8 years) and their care-givers
6	Health services	*6.1 Include specific psychological and social considerations in provision of general health care* *6.2 Provide access to care for people with severe mental disorders* *6.3 Protect and care for people with severe mental disorders and other mental and neurological disabilities living in institutions* *6.4 Learn about and, where appropriate, collaborate with local, indigenous and traditional health systems* *6.5 Minimise harm related to alcohol and other substance use*
7	Education	7.1 Strengthen access to safe and supportive education
8	Dissemination of information	8.1 Provide information to the affected population on the emergency, relief efforts and their legal rights 8.2 Provide access to information about positive coping methods

Area		C. Social considerations in sectors
9	Food security and nutrition	9.1 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
10	Shelter and site planning	10.1 Include specific social considerations (safe, dignified, culturally and socially appropriate assistance) in site planning and shelter provision, in a coordinated manner
11	Water and sanitation	11.1 Include specific social considerations (safe and culturally appropriate access for all in dignity) in the provision of water and sanitation

3. Coordination and assessment

3.1 **Coordination** (IASC Guidelines, Action Sheet 1.1)

MHPSS activities should be coordinated within and across clusters/sectors. The MHPSS coordination mechanism should be contextually appropriate. There should be a mechanism for actors from different clusters/sectors to meet regularly to coordinate their MHPSS plans and actions.

MHPSS involves activities that need to be discussed and integrated within relevant cluster/sector work plans, as they are core components of core clusters/sectors (e.g. Health, Protection and Education). Accountability for MHPSS activities lies within the relevant Clusters. It is important to include MHPSS projects in relevant chapters (Health, Protection and Education) of Flash or CAP Appeal documents. Such documents should not have a separate MHPSS chapter. MHPSS should not be established as a separate Cluster.

The IASC Guidelines recommend establishing a single, intersectoral MHPSS coordination group. It is appropriate to establish an MHPSS coordination group where many MHPSS actors are present. The coordination group needs to have Terms of Reference. Key inter-cluster operational issues should be addressed by the Inter-Cluster Coordination Group, where it exists. When few MHPSS actors are present, an intersectoral MHPSS coordination group may not be appropriate. In that case, it is important to organise regular meetings among MHPSS actors from different sectors or to establish a system of MHPSS focal points from within the various relevant clusters/sectors, who meet regularly.

Of note, politically and practically, it often works best to have the MHPSS coordination group co-chaired by both a health agency and a protection agency (or by both a health agency and a community services agency in the case of refugee camp settings). Lead organisations should be knowledgeable in MHPSS and skilled in inclusive coordination processes (e.g. avoiding dominance by a particular approach or sector).

The MHPSS coordination group should work with all relevant clusters/sectors to ensure that their activities are conducted in a way that promotes mental health and psychosocial well-being.

3.2 **Assessment** (IASC Guidelines, Action Sheet 2.1)

The IASC *Inter-agency Rapid Assessment: Field Assessment Form* (IRA) is a standard intersectoral tool used by the Clusters for assessment of the humanitarian situation in the first week after a major sudden-onset emergency. With respect to MHPSS in the health sector, an urgent question to be answered is whether people in mental hospitals or other institutions (e.g. old age homes, orphanages) have been forgotten or abandoned without access to clean water, food, physical health care or protection from violence and abuse. It is thus crucial that assessors visit institutions when doing the IRA.

The Global *Health Cluster's Health Resource Availability Mapping System* (HeRAMS) is a tool to support the collection and analysis of data to promote and support good practice in mapping health resources and services. HeRAMS provides a health services checklist by level of care and by health sub-sector for health facility/mobile clinic/community-based interventions at each point of delivery. There are specific mental health checklist items under the community care, primary care and secondary and tertiary care levels.

Furthermore, a pilot test version of an MHPSS tool exists to map 'Who is doing What Where until When' ('the 4Ws'). This tool is useful to gather more details on all MHPSS activities, including those by other sectors. The tool – which is available upon request from the IASC Reference Group on MHPSS – can be linked with HeRAMS.

Most assessments on MHPSS take place a few weeks or even a few months after a major sudden-onset emergency. Wherever possible, questions should be integrated into assessments by the Clusters. As in other areas of aid, assessments on MHPSS need to be coordinated. Organisations should first determine what assessments have been done and should design further field assessments on MHPSS only if they are necessary. In most emergencies, different groups (government departments, UN organisations, NGOs, etc.) in different sectors will collect information on different aspects of MHPSS in a range of geographical areas, and coordination is needed on who will collect which kind of information, and where. Those who are responsible for coordination should ensure as far as possible that all the information outlined in Table 2 below is available for the affected area.

Table 2: Summary of key information for assessments

Type of information	Including
Relevant demographic and contextual information[1]	• Size of (sub-)population • Mortality and threats of mortality • Access to basic physical needs (e.g. food, shelter, water and sanitation, health care) and education • Human rights violations and protective frameworks • Social, political, religious and economic structures and dynamics • Changes in livelihood activities and daily community life • Basic ethnographic information on cultural resources, norms, roles and attitudes
Experience of the emergency	• Local people's experiences of the emergency (perceptions of events and their importance, perceived causes, expected consequences)
Mental health and psychosocial problems	• Signs of psychological and social distress, including behavioural and emotional problems • Signs of impaired daily functioning • Disruption of social solidarity and support mechanisms • Information on people with severe mental disorders
Existing sources of psychosocial well-being and mental health	• Ways in which people help themselves and others • Ways in which the population may previously have dealt with adversity • Types of social support and sources of community solidarity
Organisational capacities and activities	• Structure, locations, staffing and resources for mental health care in the health sector (see WHO *Mental Health Atlas*) and the impact of the emergency on services • Structure, locations, staffing and resources of psychosocial support programmes in education and social services and the impact of the emergency on services • Mapping psychosocial skills of community actors • Mapping of potential partners and the extent and quality/content of previous MHPSS training • Mapping of emergency MHPSS programmes
Programming needs and opportunities	• Recommendations by stakeholders • Extent to which key actions outlined in IASC guidelines are implemented • Functionality of referral systems between and within health and other social, education, community and religious sectors

1 This information is usually readily available from existing reports.

General principles of rapid participatory assessment apply when collecting the information summarised in Table 2. Relevant qualitative methods of data collection include literature review, group activities (e.g. focus group discussions), key informant interviews, observations and site visits. Quantitative methods, involving short questionnaires and reviews of existing data in health systems, can also be helpful.

Despite their popularity, surveys that seek to assess the distribution of rates of emergency-induced mental disorders tend to be challenging, resource-intensive and, frequently, controversial. Experience has shown that it requires considerable expertise to conduct surveys of mental disorders in a sound and sufficiently rapid manner to substantially and meaningfully influence programmes in the midst of an emergency.

Although well-conducted surveys of mental disorders may be part of a more comprehensive response, such surveys, according to the IASC Guidelines, go beyond minimum responses, which are defined as essential, high-priority responses that should be implemented as soon as possible in an emergency. For a more detailed discussion on the issue of surveys and the difficulties in distinguishing disorder from distress, please see p.45 of the IASC Guidelines.

4. Essential MHPSS knowledge related to the health sector

4.1 **Community mobilisation and support** (IASC guidelines, Action Sheets 5.1–5.4)

All sectors, including the health sector, have a shared responsibility to facilitate community mobilisation and support. 'Community mobilisation' in this document and in the IASC Guidelines refers to the effort to involve community members (groups of people, families, relatives, peers, neighbours or others who have a common interest) in all the discussions, decisions and actions that affect them and their future. Communities tend to include multiple sub-groups that have different needs and which often compete for influence and power. Facilitating genuine community participation requires understanding the local power structure and patterns of community conflict, working with different sub-groups and avoiding the privileging of particular groups (see Action Sheet 5.1 of the IASC Guidelines).

Facilitating community self-help and social support involves identifying naturally occurring psychosocial supports and sources of coping and resilience through participatory rural appraisal and other participatory methods. It involves, where appropriate, supporting existing community initiatives, especially encouraging those that promote family and community support for all emergency-affected community members, including people at greatest risk of MHPSS problems. In addition to supporting the community's own spontaneous initiatives, additional appropriate initiatives should be considered for all emergency-affected community members and specifically also for people at greatest risk (see IASC Guidelines, Action Sheets 5.2, 5.3 and 5.4 for detailed guidance and numerous examples, including the facilitation of communal healing and supports for very young children). Overall, a self-help approach is vital because, for people who have undergone overwhelming experiences, having a measure of control over some aspects of their lives promotes mental health and psychosocial well-being.

4.2 Psychological considerations in general health care (IASC guidelines, Action Sheet 6.1)

The following actions should be considered when offering general health care services:

- Communicating to patients, giving clear and accurate information on their health status and on relevant services inside/outside the health sector. A refresher on communicating could include basic knowledge on how to deliver bad news in a supportive manner and how to deal with angry, very anxious, suicidal, psychotic or withdrawn patients; and how to respond to the sharing of extremely private and emotional events;
- Supporting problem management and empowerment by helping people to clarify their problems, brainstorming together on ways of coping, identifying choices and evaluating the value and consequences of choices;
- Referral to tracing, social and legal services;
- Referral of undernourished children to stimulation programmes to reduce the chance of developmental disability and to enhance child development;
- Management of medically unexplained somatic complaints, mainly through non-pharmacological methods (see pp.85-101 of *Where There is No Psychiatrist,* see list of resources);
- Psychological first aid (PFA), which entails basic, non-intrusive pragmatic psychological support with a focus on listening but not forcing talk; assessing needs and ensuring that basic needs are met; encouraging but not forcing company from significant others; and protecting from further harm. PFA thus involves a non-clinical, humane, supportive response to a fellow human being who is suffering and who may need support immediately after an extremely stressful event. It is very different from psychological debriefing in that it does not necessarily involve a discussion of the event that caused the distress. **Psychological debriefing is a popular but controversial technique (which at best is ineffective) and should not be implemented.** All aid workers, and especially health workers, should be able to provide very basic PFA;
- In a minority of cases, when emergency-induced severe, acute distress limits basic functioning or is intolerable, clinical management will probably be needed (for guidance, see *Where There is No Psychiatrist*);

- With regards to clinical treatment of acute distress, **benzodiazepines are greatly over-prescribed in most emergencies**. However, this medication may be appropriately prescribed for a very short time for certain clinical problems (e.g. severe insomnia). Caution is required as use of benzodiazepines can quickly lead to dependence;
- In a minority of cases, a chronic mood or anxiety disorder (including severe presentations of PTSD) will develop. If the disorder is severe, then it should be treated by a trained clinician as part of the minimum emergency response (described in IASC Action Sheet 6.2). If the disorder is not severe (e.g. the person is able to function and tolerate the suffering), then the person should receive appropriate care as part of a more comprehensive aid response. Where appropriate, support may be given by trained and clinically supervised community health workers (e.g. social workers, counsellors) attached to health services.

4.3 Care of people with severe mental disorder in PHC (IASC guidelines, Action Sheet 6.2)

Severe mental disorders often pre-date an emergency but also may have been induced by the emergency. People with such disorders are extremely vulnerable and are often abandoned in emergencies. Action Sheet 6.2 describes a range of aspects of how care for the severely mentally ill may be organised (e.g. assessment issues, training and supervision issues, advertising the service, informing the population about the service). Possible service models for organising mental health care in primary health care (PHC) include:

- Mental health professionals attaching themselves to government/NGO PHC teams;
- Training and supervising local PHC staff to integrate mental health care into normal practice and to give it dedicated time;
- Training and supervising one member of the local PHC team (a doctor or a nurse) to provide full-time mental health care alongside the other PHC services.

4.4 Psychotropic medications

Adequate supplies of essential psychotropic medications need to be ensured in PHC and other health services *(IASC Guidelines, Action Sheet 6.2)*. Humanitarian health actors should know that:

- Overall, generic off-patent medicines are recommended, because, in most countryies, they tend to be many times cheaper than patented psychotropics, and they are just as effective. Although new medications tend to have a more favourable side-effect profiles, overall adherence to these drugs is only marginally better.
- The minimum provision is one anti-psychotic, one anti-Parkinsonian drug (to manage potential extra-pyramidal side-effects), one anti-convulsant/anti-epileptic, one anti-depressant and one anxiolytic (for use with severe substance abuse and convulsions), all in tablet form, from the WHO Model List of Essential Medicines (see Appendix A). The 2010 Interagency Emergency Health Kit provides these medications.

4.5 PHC Health Information Systems (H.I.S.) (IASC Guidelines, Action Sheet 6.2)

Emergency PHC provides an important opportunity to support people with mental health problems. PHC staff should be taught to document mental health problems, using simple categories. The average PHC worker will require little guidance in use of the following seven categories (see Appendix B for UNHCR case definitions):

- Seizures/epilepsy
- Alcohol or other substance use disorder
- Mental retardation/intellectual disability
- Psychotic disorders
- Severe emotional disorders
- Other psychological complaints
- Medically unexplained somatic complaints.

4.6 **People in institutions** (IASC Guidelines, Action Sheet 6.3)

People in mental hospitals and other institutions have often been forgotten or abandoned in various emergencies, leading to them becoming the victims of violence, neglect and human rights violations. Throughout the crisis, health leaders need to check on people in institutions and address urgent needs, ensuring that such people are protected and cared for.

4.7 **Alcohol and other substances** (IASC Guidelines, Action Sheet 6.5)

The health sector in collaboration with other sectors may need to act to minimise harm related to alcohol and other substance use in emergencies where use of such substances leads to far-reaching protection, medical or socio-economic problems. The IASC Guidelines outline initial steps in an emergency to minimise harm related to alcohol and other substance use. These steps include assessments (see UNHCR/WHO, 2008), prevention of harmful use and dependence, harm reduction interventions in the community and management of withdrawal.

4.8 **Linking with other healing systems** (IASC Guidelines, Action Sheet 6.4)

It is often important to learn about and, where appropriate, collaborate with local, indigenous and traditional healing systems. Whether or not traditional healing approaches are clinically effective or harmful (which tends to vary), dialogues with traditional healers can lead to a range of positive outcomes, including increased understanding of the spiritual, psychological and social worlds of affected people and improved referral systems, among others. Some traditional healers may avoid collaboration. At the same time, health staff may be unsympathetic or hostile to traditional practices, or may be ignorant of them. Although in some situations keeping a distance may be the best option, the key actions outlined in Action Sheet 6.4 are likely to facilitate a constructive bridge between different systems of care.

5. Operational challenges: Do's and don'ts

Experience from many different emergencies indicates that some actions are advisable, whereas others should typically be avoided (see Table 3). The health programme manager should be familiar with these 'do's and don'ts' and may use them as a checklist for programme development, implementation and monitoring.

Table 3: Do's and don'ts

Do's	Don'ts
Establish one overall coordination mechanism or 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 MHPSS, 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.

Table 3: Do's and don'ts (cont.)

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.

6. Post-emergency recovery activities by the health sector

The four-layer pyramid (see Figure 1) and multi-sector framework described in this document are also the basis of post-emergency recovery MHPSS work. Recovery activities for different sectors are described in the comprehensive column of the matrix presented on pp.22-29 of the IASC Guidelines. Below is a description of specific activities by the health sector.

For the health sector, the most essential post-emergency recovery activities are:

- Initiate updating of national mental health policy and legislation, as appropriate;
- Develop the availability of mental health care for a broad range of emergency-related and pre-existing mental disorders through general health care and community-based mental health services;
- Work to ensure the sustainability of any newly established mental health services;
- For people in psychiatric institutions, facilitate community-based care and appropriate alternative living arrangements.

It is important to note that a humanitarian emergency is not solely a tragedy, but also an enormous opportunity to build a mental health system to support people. No matter how one reads the available epidemiological literature, rates of a wide range of mental disorders (mood and anxiety disorders, including PTSD and substance use disorders) do go up as a result of emergencies and thus there is a good rationale for building long-term, basic, sustainable community mental health services in districts affected by emergencies. All communities in the world should have such services, and especially so if they have been struck by disasters. Reports from Albania, China, Indonesia, Jordan, Iraq, Kosovo, Macedonia, the occupied Palestinian territory, Peru, Sri Lanka and Timor-Leste show how an emergency can lead to the long-term development of sustainable mental health care.

Although most care should be provided in the community, paradoxically one of the cornerstones of most sustainable district-level mental health systems is a staffed acute psychiatric care inpatient unit. This unit often forms the nucleus of activities to (a) organise

community outreach outpatient care throughout the district and (b) support and supervise much-needed mental health activities in PHC clinics. Thus, in districts without psychiatric inpatient care, plans for new general hospitals as part of health recovery investment should include planning for a staffed acute psychiatric care inpatient unit. However, post-emergency (re)construction plans sometimes involve building new tertiary-care mental hospitals. Unfortunately, such plans are typically ill advised. Decentralisation of mental health resources – staff, budgets and beds – from tertiary care to secondary and primary care is a key strategy when organising and scaling up effective treatment coverage of people with mental disorders in the community. Key to sustainable development of mental health care are human resources. Any long-term investment in the training of community level staff (doctors, nurses, other PHC workers) should include mental health in the curriculum.

7. Human resources

7.1 Recruitment

Humanitarian health actors may recruit mental health programme managers to lead the organisation's mental health response. A suggested profile for such person is:

- Advanced degree in public health/medicine/nursing or behavioural/social science
- Field-based experience in programme management and mental health and psychosocial support (MHPSS) in humanitarian settings
- Field-based experience of working within the health sector in low- or middle-income countries
- Relevant language knowledge
- Good knowledge about MHPSS as emergency response (as outlined in IASC Guidelines)
- Good knowledge about different cultural attitudes, practices and systems of social support
- Good knowledge of the UN and NGO humanitarian community
- Appreciation for inter-agency and intersectoral collaboration
- Cultural sensitivity

Action Sheet 4.1 of the IASC Guidelines gives detailed advice on identifying and recruiting staff or volunteers. Health programme managers should seek to recruit MHPSS providers with knowledge of, and insight into, the local culture and appropriate modes of behaviour. Clinical or any other direct person-to-person psychosocial support tasks should be performed mainly by local staff. The health programme manager should use available criteria to carefully evaluate offers of help from individual foreign mental health professionals who may seek to 'parachute in' to offer their services (see IASC Guidelines, pp.72-73).

7.2 Orientation and training of aid workers in MHPSS

Inadequately oriented and trained workers without the appropriate attitudes and motivation can be harmful to populations they seek to assist. Action Sheet 4.3 distinguishes between brief orientation seminars and training. Orientation seminars (half- or full-day seminars) should provide immediate basic, essential, functional knowledge and skills relating to psychosocial needs, problems and available resources to everyone working at each level of response. Possible participants include all aid workers in all sectors (particularly from social services, health, education, protection and emergency response divisions). Training seminars – involving the learning of more extensive knowledge and skills – are recommended for those working on focused and specialised MHPSS (see top two layers of the pyramid in Figure 1). The timing of seminars must not interfere with the provision of emergency response.

The use of short, consecutive modules for cumulative learning is recommended, because (a) this limits the need to remove staff from their duties for extended periods and (b) it allows staff to practise skills between training sessions. Each short module may last only a few hours or days (according to the situation) and is followed by practice in the field with support and supervision, before the next new module is introduced in a few days' or weeks' time. **Training seminars should always be followed up with supervision and/or other field-based support**. This may, for example, entail in-service training/supervision or regular supervision meetings involving role-plays of recent, challenging clinical encounters. Training on advanced mental health skills without organising a system for follow-up is irresponsible. Action Sheet 4.3 provides key guidance on organising orientation and training (e.g. selecting trainers, learning methodologies, content of sessions and challenges in organising Training of Trainers).

7.3 Well-being of staff and volunteers

Staff members and volunteers working in emergency settings tend to work many hours under pressure and within difficult security constraints. Many workers experience insufficient managerial and organisational support, and they tend to report this as their biggest stressor. Moreover, confrontations with horror, danger and human misery are emotionally demanding and potentially affect the mental health and well-being of workers. Action Sheet 4.4 (points 2–4) describes key actions to facilitate a healthy working environment and to address potential day-to-day work-related stressors.

Psychological debriefing is no longer recommended. Staff who have experienced or witnessed extreme events (critical incidents, potentially traumatic events) need to have access to basic psychological support (psychological first aid, or PFA – see Section 4.2 above). When survivors' acute distress is so severe that it limits their basic functioning (or that they are judged to be a risk to themselves or others), they must stop working and receive immediate care from a mental health professional trained in evidence-based treatment of acute traumatic stress. An accompanied medical evacuation may be necessary.

It is important to ensure that a mental health professional contacts all staff members who have survived a critical incident one to three months following the event. The mental health professional should assess how the survivor is functioning and feeling and make a referral to clinical treatment for those with substantial problems that have not healed over time (see Action Sheet 4.4, points 6 and 7).

8. Key tools and resources

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- IASC (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. IASC. http://www.humanitarianinfo.org/iasc/content/products (also in Arabic, French and Spanish; hard copy of guidelines includes a CD-ROM with resource documents).
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- UNHCR/WHO (2008). *Rapid Assessment of Alcohol and Other Substance Use in Conflict-affected and Displaced Populations: A Field Guide*. Geneva: UNHCR/WHO.
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- WHO (2006). *Mental Health and Psychosocial Well-being among Children in Severe Food Shortage Situations*. Geneva: WHO. http://www.who.int/nmh/publications/msd_MHChildFSS9.pdf (also in French and Spanish).
- WHO (2009). *Pharmacological Treatment of Mental Disorders in Primary Health Care*. Geneva: WHO.
- WHO/UNHCR/UNFPA (2004). *Clinical Management of Survivors of Rape: Developing Protocols for Use with Refugees and Internally Displaced Persons* (revised edition). Geneva: WHO/UNHCR. http://www.who.int/reproductive-health/publications/clinical_mngt_survivors_of_rape/ (also in Arabic and French).

Appendix A

Relevant medicines on the WHO Model List of Essential Medicines (2009)

Psychotherapeutic medicines

❑ chlorpromazine	injection: 25 mg (hydrochloride)/ml in 2 ml ampoule; oral liquid: 25 mg (hydrochloride) / 5 ml; tablet: 100 mg (hydrochloride).
❑ fluphenazine	injection: 25 mg (decanoate or enantate) in 1 ml ampoule.
❑ *haloperidol*	injection: 5 mg in 1 ml ampoule; tablet: 2 mg; 5 mg
❑ *amitriptyline*	tablet: 25 mg (hydrochloride).
fluoxetine	solid oral dosage form: 20 mg (present as hydrochloride).
carbamazepine	tablet (scored): 100 mg; 200 mg
lithium carbonate	solid oral dosage form: 300 mg.
valproic acid	tablet (enteric coated): 200 mg; 500 mg (sodium valproate)
❑ *diazepam*	tablet (scored): 2 mg; 5 mg
clomipramine	capsule: 10 mg; 25 mg (hydrochloride).

Antiparkinsonism medicines (to deal with potential extra-pyramidal side effects of anti-psychotics)

biperiden	injection: 5 mg (lactate) in 1 ml ampoule; tablet: 2 mg (hydrochloride).

Anticonvulsants/antiepileptics

carbamazepine	oral liquid: 100 mg/5 ml; tablet (chewable): 100 mg; 200 mg; tablet (scored): 100 mg; 200 mg.
diazepam	Gel or rectal solution: 5 mg/ml in 0.5, 2 ml and 4ml tubes
❑ lorazepam	Parenteral formulation: 2 mg/ml in 1 ml ampoule; 4 mg/ml in 1 ml ampoule.
phenobarbital	injection: 200 mg/ml (phenobarbital sodium); oral liquid: 15 mg/5 ml (as phenobarbital or phenobarbital sodium); tablet: 15 mg-100 mg (phenobarbital).
phenotyn	capsule: 25 mg; 50 mg; 100 mg (sodium salt); injection: 50 mg/ml in 5 ml vial (sodium salt); oral liquid: 25-30 mg/5 ml; tablet: 25 mg; 50 mg; 100 mg (sodium salt); tablet (chewable): 50 mg.
valproic acid	oral liquid: 200 mg/5 ml; tablet (crushable): 100 mg; tablet (enteric coated): 200 mg; 500 mg (sodium valproate).

❑ = similar clinical performance within a pharmacological class.
Medicines in *italic blue* are included in the 2010 version of the Interagency Health Emergency Kit.

Appendix B

UNHCR (2009) Health Information System (HIS) case definitions

NEUROPSYCHIATRIC DISORDERS

1 Epilepsy/seizures
A person with epilepsy has at least two episodes of seizures not provoked by any apparent cause such as fever, infection, injury or alcohol withdrawal. These episodes are characterized by loss of consciousness with shaking of the limbs and sometimes associated with physical injuries, bowel/bladder incontinence and tongue biting.

2 Alcohol or other substance use disorder
A person with this disorder seeks to consume alcohol (or other addictive substances) on a daily basis and has difficulties controlling consumption. Personal relationships, work performance and physical health often deteriorate. The person continues consuming alcohol (or other addictive substances) despite these problems.
Exclusion criteria: The category should not be applied to people who are heavy alcohol (or other substance) users if they can control their consumption.

3 Mental retardation/ intellectual disability
The person has very low intelligence causing problems in daily living. As a child, this person is slow in learning to speak. As an adult, the person can work if tasks are simple. Rarely will this person be able to live independently or look after oneself and/or children without support from others. When severe, the person may have difficulties speaking and understanding others and may require constant assistance.

4 Psychotic disorder
The person may hear or see things that are not there or strongly believe things that are not true. They may talk to themselves, their speech may be confused, or incoherent and their appearance unusual. They may neglect themselves. Alternatively they may go through periods of being extremely happy, irritable, energetic, talkative, and reckless. The person's behaviour is considered "crazy"/highly bizarre by other people from the same culture.

5 Severe emotional disorder
This person's daily normal functioning is markedly impaired for more than two weeks due to (a) overwhelming sadness/apathy and/or (b) exaggerated, uncontrollable anxiety/fear. Personal relationships, appetite, sleep and concentration are often affected. The person may be unable to initiate or maintain conversation. The person may complain of severe fatigue and be socially withdrawn, often staying in bed for much of the day. Suicidal thinking is common.
Inclusion criteria: This category should only be applied if there is marked impairment in daily functioning.

OTHER COMPLAINTS OF CLINICAL CONCERN

6 Other psychological complaint
This category covers complaints related to emotions (e.g., depressed mood, anxiety), thoughts (e.g., ruminating, poor concentration) or behavior (e.g., inactivity, aggression). The person tends to be able to function in all or almost all day-to-day, normal activities. The complaint may be a symptom of a less severe emotional disorder or may represent normal distress (i.e., no disorder).
Inclusion criteria: This category should only be applied if (a) if the person is requesting help for the complaint and (b) if the person is not positive for any of the above five categories.

7 Medically unexplained somatic complaint
The category covers any somatic/physical complaint that does not have an apparent organic cause.
Inclusion criteria: This category should only be applied (a) after conducting necessary physical examinations. (b) if the person is not positive for any of the above six categories and (c) if the person is requesting help for the complaint.

IASC
Inter-Agency Standing Committee
IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings

This document is for humanitarian health actors working at national and sub-national level in countries facing humanitarian emergencies. It applies to Health Cluster partners, including governmental and non-governmental health service providers.

Based on the **IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings** (IASC, 2007), this document gives an overview of essential knowledge that humanitarian health actors should have about mental health and psychosocial support (MHPSS) in humanitarian emergencies. Managers will need to ensure that health staff are oriented on relevant parts of this document, as applicable.

This document by the IASC Reference Group for Mental Health and Psychosocial Support was developed in consultation with the IASC Global Health Cluster.