

Mental Health and Psychosocial Support in Humanitarian Emergencies

What Should Protection Programme Managers Know?



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IASC PCWG

IASC

Inter-Agency Standing Committee
Reference Group on Mental Health and Psychosocial Support

January 2010

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1. Introduction

1.1 Background

This document is for protection programme managers working at national and sub-national level in low and middle income countries. It is both for Protection Cluster coordinators (and coordinators of the five specific areas within the Cluster) and for protection programme managers in government, UN and non-UN international organisations and local NGO protection programmes.

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 protection programme managers should know about mental health and psychosocial support (MHPSS) in humanitarian emergencies. Protection programme managers will need to ensure that their 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 organized through multiple sectors (e.g., health, protection, camp management, education, food security and nutrition, shelter, and water and sanitation). Protection programme managers are encouraged to promote the IASC Guidelines and its 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 psychosocial consideration in the protection response will protect the dignity of survivors and enhance the overall protection 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 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; 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:

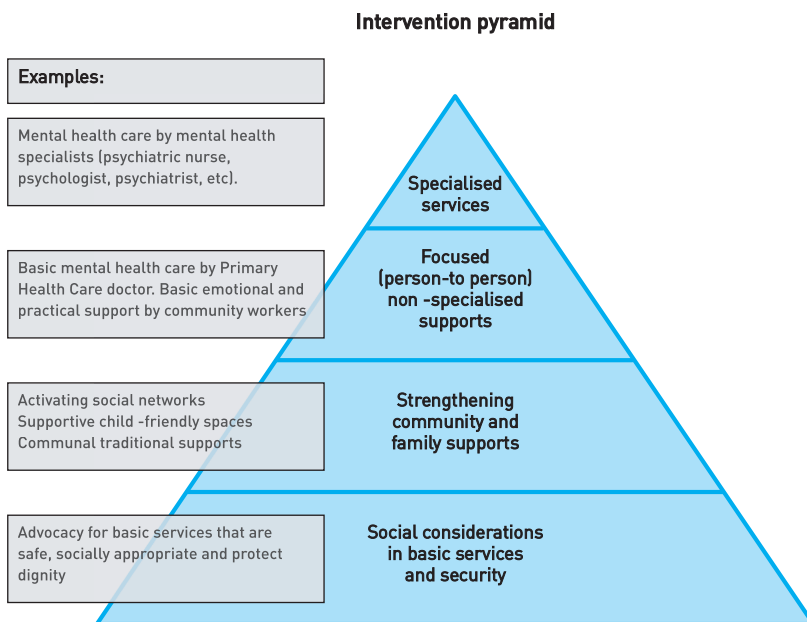
- Pre-existing problems (e.g. severe mental disorder; depression, alcohol abuse);
- Emergency-induced problems (e.g. grief, non-pathological distress, alcohol and other substance abuse, depression and anxiety disorders, including post-traumatic stress disorder (PTSD)); and
- Humanitarian aid-related 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 and focuses only on deficits.

Men, women, boys and girls have assets or resources that support mental health and psychosocial well-being. A common error in work on mental health and psychosocial well-being is to ignore these resources and focus solely on deficits – the weaknesses, suffering and pathology – of the affected group. It is important to not only know 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 (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, building local capacities is important, 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 (Figure 1), 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

During conflicts and following natural disasters populations are forced from their homes and may experience specific forms of deprivation, such as loss of shelter, and often face heightened or particular protection risks. These risks may include: armed attack and abuse while fleeing in search of safety; family separation, including an increase in the number of separated and unaccompanied children; heightened risk of sexual and gender-based violence, particularly affecting women and children; arbitrary deprivation of land, homes and other property; and displacement into inhospitable environments, where they suffer stigmas, marginalization, discrimination or harassment.

A number of minimum responses need to be implemented. These interventions are summarized in Table 1. The IASC Guidelines give guidance on how each of the minimum responses may be implemented. The sections below describe a few *selected* points on MHPSS minimum responses that are particularly relevant to protection officers.

Table 1: IASC Guidelines Minimum Responses in the Midst of Emergencies (IASC Guidelines pages 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

Table 1: IASC Guidelines Minimum Responses in the Midst of Emergencies (IASC Guidelines pages 20-29) (cont.)

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
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.a. Coordination

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 plans as they are core components of core clusters/sectors (e.g. Health, Protection, and Education). Accountability for MHPSS activities remains 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 a 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 may not be appropriate. In that case, it is important to organize 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 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 and sector).

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

3.b. Assessment

Coordinating MHPSS assessments is a high priority. Organisations should first determine what assessments on MHPSS have been done and design further field assessments *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 (Table 1) in a range of geographical areas. Coordination is needed to identify which organisations will collect which kinds of information, and where. Those responsible for coordination should ensure as far as possible that all the information outlined in the table is available for the affected area. Wherever possible, questions should be integrated in assessments by the Clusters.

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. A 4Ws tool on MHPSS is in development to map *Who is doing What Where until When* in MHPSS.

Context permitting, ask questions such as these, taking care to avoid causing harm:

- Who are the people who seem to be most overwhelmed and unable to cope or function? What is being done to support these highly vulnerable people?
- What do affected people see as their greatest current sources of distress and what is being done to address those sources?
- What is being done to support people without adequate care and support e.g. those who had been living in institutions, isolated persons or separated children?
- How has the crisis affected the MHPSS coping mechanisms that were previously active? What do people see as their greatest source of support now?

Table 2: Summary of key information needed from assessments

Type of information	Including (data disaggregated by sex and age in so far as possible)
Relevant demographic and contextual information	<ul style="list-style-type: none"> • Size of (sub)population • Mortality and threats to 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	<ul style="list-style-type: none"> • Local people’s experiences of the emergency (perceptions of events and their importance, perceived causes, expected consequences)
Mental health and psychosocial problems	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Ways people help themselves and others (e.g. religious beliefs & practices; seeking support from family/friends) • Ways in which the population may previously have dealt with adversity • Types of social support and sources of community solidarity
Organisational capacities and activities	<ul style="list-style-type: none"> • Structure, locations, staffing and resources for mental health care in the health sector 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 (e.g. community workers, religious leaders, counsellors) • Mapping of potential partners and the extent and quality/content of previous MHPSS training • Mapping of emergency MHPSS programmes
Programming needs and opportunities	<ul style="list-style-type: none"> • Recommendations by different stakeholders • Extent to which key actions outlined in IASC guidelines are implemented • Functionality of referral systems between and within health , social, education, community and religious sectors

4. Essential MHPSS knowledge related to the protection sector

4.a. Building psychosocial considerations into the protection sectors

All protection interventions affect the MHPSS of the affected population. A compassionate and supportive registration process may have very different effects than an unsupportive, cold process. Particular Areas of Responsibility under the Protection Cluster involve extensive psychosocial programming responsibilities. Illustrative areas of psychosocial work might include the following types of interventions.

- ☑ **Psychosocial considerations in Child protection:** Rapidly organize safe spaces where children can play and participate in structured, supportive activities and where children and adults can receive or mobilize psychosocial support; provide sports that promote nonviolent conflict resolution; organize youth clubs that promote joint problem-solving and life skills; organize social support for parents, especially mothers of very young children; ensure that community-based child protection committees monitor and respond to risks and support highly vulnerable children; support parents and community members to better support and care for their children. Remember to give children control and power over the decisions that affect them. Also keep them regularly informed of events, or even non events such as “we haven’t found your parents yet, we looked here and here”. This is often forgotten and is an enormous source of distress.

- ☑ **Psychosocial considerations in Gender-based violence:** Establish a system for confidential referrals including psychosocial support; organize appropriate psychological first aid post-incident and link with the health services for basic mental health care; organize psychological and social supports for survivors of rape and their families; organize community-based supports to reduce stigma; provide information about how to stay safe and access services including

psychosocial, legal, livelihoods, health and education services; consider obstacles to women's and children's access to services, such as issues of emotional distress and fear, discrimination, security, costs, privacy, language, cultural (e.g. need for permission or accompaniment of male relative); recruit female staff with good social skills where possible; involve women in decisions on accessibility, and on supportive, non-stigmatising services; avoid excessive targeting of survivors in programmes. Understand that programmes may need to include men and boys, because they may be least obviously in need of services as well as for prevention.

- ☑ **Psychosocial considerations in Housing, land, and property issues:** Organize shelter and camps with the aim of keeping family members and communities together; provide space in camps and other sites for appropriate burial and grieving rituals; provide shelter for people who are vulnerable because of MHPSS issues such as mental illness; organize housing in a manner that allows privacy, the lack of which is significant source of stress; include social, cultural and historical considerations in developing plans for housing and land use; distribute information related to land entitlements for reconstruction.

- ☑ **Psychosocial considerations in Mine action:** Psychosocial support for victims should also be provided to victims of land mines and other explosive devices in line with the principles of the IASC MHPSS Guidelines. Victims should be integrated in broader MHPSS services where possible. In addition, distress linked to the conflict may lead to affected persons continuing to display unnecessary risk taking behaviour long after the conflict ends. This can result in a blasé attitude towards mines and UXOs that can lead to unnecessary injuries/casualties, which then in turn leads to further stress on the family/community unit. Risk education and group discussions should be put in place to alter communities' perception and unnecessary risk taking behaviour as early as possible.

- ☑ **Psychosocial considerations in Rule of Law and Justice:** Provide psychosocial support to survivors who choose to report violations; avoid stigmatizing by calling attention to particular categories of survivors; orient lawyers, judges, paralegals and court advocates on the importance of confidentiality, sensitive techniques for

interviewing survivors and witnesses, and providing psychosocial support for those who testify; support mechanisms which provide advocacy and representation of survivors and witnesses in dealing with security and justice institutions; support witness protection programmes; identify and support mechanisms that contribute to ending impunity; work with community based/traditional justice mechanisms to enable social and economic reintegration of survivors/witnesses in ways which avoid stigmatization.

Note: Crisis situations have very different impacts on women, girls, boys and men. They face different risks and have different resources. In efforts to resist violence, survive and support their dependents, women and men act differently (e.g. by selling off assets essential for continuing traditional livelihoods, men may migrate for work, young men may feel there is no other option but to join armed groups, women and girls may resort to sex work, there may be an increase in early marriages, etc.)

4.b. Building psychosocial considerations into other sectors

An important part of MHPSS in emergency settings is delivering aid in different sectors in a way that protects and promotes MHPSS. Protection programme managers have a responsibility to encourage other sectors to take steps to promote MHPSS. This section illustrates some key ways in which aid in sectors of education, food aid, shelter, and water and sanitation can promote MHPSS.

- ☑ **Psychosocial considerations in Supportive education** (see Action Sheet 7.1); Rapidly organize safe spaces where children can play and participate in structured, supportive activities and where children and adults can receive or mobilize psychosocial support; Include life skills training and provision of information about the emergency; Prepare and encourage educators to support learners' psychosocial well-being, helping them, for example, to deal constructively with learners' issues such as anger, fear and grief, to cope with their own situation, and to make referrals for severely affected learners.

- ☑ **Psychosocial considerations in Food and nutritional support** (see Action Sheet 9.1): Enable participation and attention to cultural issues in planning, distribution and follow-up of food aid; Collaborating with health personnel, use food and nutrition programmes as possible entry point for identifying people who urgently need social or psychological support; Facilitate in infant feeding stimulation and positive interaction with caretakers.

- ☑ **Psychosocial considerations in Shelter and site planning** (see Action Sheet 10.1): Organize shelter and camps with the aim of keeping family members and communities together; Emphasise family-size shelters that maximize privacy and promote visibility and ease of movement; Avoid overcrowding, which causes distress; Remove the obstacles for appropriate healing practices (e.g., provide space for rituals; see Action Sheet 5.3).

- ☑ **Psychosocial considerations in Water and sanitation** (see Action Sheet 11.1): Provide access for women to menstrual cloths or other materials, the lack of which creates distress; Ensure that latrines and bathing shelters are private and culturally acceptable; Prevent conflict at water sites (e.g. by rotating access times between families).

Example: Liberia, 2004.

Following the Liberian war and its mass displacements the privacy of displaced people was increased by grouping 10-20 family shelters in U shape around a common area. To reinforce privacy, shelters were placed at an angle to one another, and each shelter had a private backyard area for storage, laundry, cooking, etc. Each shelter opened onto the common areas, where people could see water points and latrines, thereby preventing the risk of GBV.

4.c. Community mobilization, control and ownership

The process of response to an emergency should be owned and controlled as much as possible by the affected population, and should make use of their own support structures, including local government structures. In these guidelines, the term ‘community mobilisation’ refers to efforts made from both inside and outside the community to involve its 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. As people become more involved, they are likely to become more hopeful, more able to cope and more active in rebuilding their own lives and communities. At every step, relief efforts should support participation, build on what local people are already doing to help themselves and avoid doing for local people what they can do for themselves.

Community mobilisation may have a number of different purposes: 1/ Establishing self-protective strategies 2/ Empowering the community as a protection actor (i.e. enabling it to identify protection gaps and to advocate for solutions) and 3/ Establishing or maintaining community organizational structures to facilitate decision-making.

Critical steps in community mobilization will include:

- Recognition by community members that they have a common concern and will be more effective if they work together (i.e. ‘We need to support each other to deal with this’).
- Development of the sense of responsibility and ownership that comes with this recognition (‘This is happening to us and we can do something about it’).
- Identification of internal community resources and knowledge, and individual skills and talents (‘Who can do, or is already doing, what; what resources do we have; what else can we do?’).
- Identification of priority issues (‘What we’re really concerned about is...’).
- Community members plan and manage activities using their internal resources.
- Growing capacity of community members to continue and increase the effectiveness of this action.

(Adapted from Donahue and Williamson (1999), Community Mobilization to Mitigate the Impacts of HIV/AIDS, Displaced Children and Orphans Fund)

4.d. Community self-help and social support

Working with communities is an important protection technique that forms the foundation of sustainable effective mental health and psychosocial support. However, it also comes with ethical challenges and do-harm possibilities - traditional organizational structures may be shattered and community rivalries fostered. For example, aid agencies may encourage communities to organize themselves to advocate for participation in decision-making, only to find afterwards that their proposals are not heard by aid workers and Government officials. Specific technical guidance should be obtained from community workers who should be familiar with the entire IASC Guidelines.

In supporting community initiatives, one should recognize that communities typically include multiple subgroups that have different needs and compete for power. Facilitating community self-help requires an understanding of the local power structure and patterns of community conflict and working with different subgroups in ways that avoid the privileging of particular subgroups. Useful steps are to:

- Identify human resources in the local community.
- Facilitate community identification of priority actions using participatory methods. Support community initiatives, activating family and community supports for all emergency-affected people.
- Encourage and support additional activities that promote family and community support.
 - Establish a protection working group (PWG) for villages, camps or wider geographic areas that builds on existing initiatives. Whenever possible it incorporates diverse actors (e.g.human rights organisations) and may focus not only on protection but also on non-clinical, community-based psychosocial supports.;
 - Organize group discussions on how the community may help at-risk people (see Action Sheet 2.1);
 - Set up community child protection committees that identify at-risk children, monitor risks, intervene when possible and refer cases not only to protection authorities but also to community supports, when appropriate (see Action Sheet 3.2);

- Build networks that link communities with various services. (see Action Sheet 3.2);
- As appropriate in the context, mobilise people who have or who previously had a role in organising community-level support (see Action Sheet 5.2);
- Prevent family separations, particularly for young children (see Action Sheet 5.4)
- Facilitate the reestablishment of cultural and religious events (see Action Sheet 5.3);
- Provide access to supportive education not only as a protection measure but also as way to facilitate supports (see Action Sheet 7.1);
- To reduce people’s anxieties, organise access to information about what is happening, services, missing persons, security, etc. (see Action Sheet 8.1).
- Provide participatory training sessions where appropriate (see Action Sheet 4.3), coupled with follow-up support.
- When necessary, advocate within the community and beyond on behalf of people who are marginalized and at risk due to MHPSS issues such as being emotionally overwhelmed and unable to function.

Example: Bosnia.

In Bosnia, following the wars of the 1990s, many women in rural areas who had survived rape and losses needed psychosocial support, but did not want to talk with psychologists or psychiatrists because they felt shame and stigma. Following a practice that existed before the war, women gathered in knitting groups to knit, drink coffee and also to support each other. Outside agencies played a facilitating role by providing small funds for wool and by developing referral supports.

4.e. Direct person-to-person basic psychological support

Most individuals experiencing acute mental distress following exposure to extremely stressful events recover over time without formal MHPSS intervention. As such, all people should have *access* to basic psychological support. One form of such support is psychological first aid (PFA), which is an appropriate way to support people. All aid workers, and especially health and protection workers, should be able to provide very basic PFA. PFA is not a clinical or psychiatric intervention but a humane, supportive response to a fellow human being who is suffering and who may need support. PFA is very different from psychological debriefing in that it does not necessarily involve a discussion of the event that caused the distress. To provide PFA, one should:

- Protect from further harm. Where appropriate, inform distressed survivors of their right to refuse to discuss the events with (other) aid workers or with journalists; assist survivors in developing realistic safety plan
- Provide the opportunity for survivors to talk about the events, but without pressure. Respect the wish not to talk and avoid pushing for more information than the person may be ready to give;
- Listen patiently in an accepting and non-judgmental manner;
- Convey genuine compassion;
- Identify basic practical needs and ensure that these are met;
- Ask for people's concerns and try to address these;
- Discourage negative ways of coping (specifically discouraging coping through use of alcohol and other substances, explaining that people in severe distress are at much higher risk of developing substance use problems);
- Encourage participation in normal daily routines (if possible) and use of positive means of coping (e.g. culturally appropriate relaxation methods, accessing helpful cultural and spiritual supports);
- Encourage, but not force, company from one or more family member or friends;
- Offering the possibility to return for further support, as appropriate;
- Refer to locally available support mechanisms or to trained clinicians, as appropriate

5. Operational challenges

Experience from many emergencies indicates that some actions are advisable, whereas others should typically be avoided (see Table 3). The protection programme manager should be familiar with these do's and don't's 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 – women, men, girls and boys, people with a disability, people with chronic illness, the elderly, people from marginalised racial, ethnic or caste groups etc - 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.

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

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.
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 psychosocial recovery activities by the protection sector

A pervasive problem is that many emergency supports are organized without sufficient attention to sustainability. Not uncommonly, supports collapse following the end of funded programmes even though the MHPSS needs of affected populations remain extensive. This can be minimised by planning all emergency MHPSS supports with an eye toward ensuring that supports will remain following the end of the funded programmes. In the protection sector, it is important to build MHPSS into protection systems, particularly through the promotion of effective policies and capacity building in social service systems, including education. Also important is the development of emergency preparedness. These steps are useful in this regard:

- Ensure that policies are in place that support effective, community-based practice. For example, ensure there are policies at regional and national level to support holistic mental health and psychosocial programs, organize all layers of the intervention pyramid, and limit harmful programmes such as counselling by poorly trained, unsupervised counsellors.
- Strengthen the MHPSS system, including referral mechanisms. If few supports exist for the people who have been emotionally severely affected, work with health and social agencies, national universities and government to build capacities for mental health and social services by, for example, training more psychiatrists, psychologists, and social workers.
- Integrate psychosocial capacity building into sustainable training mechanisms. For example, build into teacher preparation programmes elements of training on how to meet the psychosocial needs of learners in difficult situations.
- Build the protection capacities in social services by integrating content on MHPSS into programs that prepare practitioners such as social workers.
- Work with both civil society and government structures to provide MHPSS. For example, develop community-based psychosocial supports that are complemented by Government provided clinical mental health services. Simultaneously increase government outreach and strengthen knowledge and skills in civil society about

how to access government supports.

- Strengthen livelihoods and support implementation of community and economic development initiatives since these key transitional initiatives build hope and enable people to enter appropriate, meaningful roles.
- Develop inter-agency efforts to document good practices, identify harmful practices, and assess systematically which interventions are most effective.
- In countries prone to emergencies, make emergency preparedness a priority. For example, integrate psychosocial issues into emergency response policies and structures and ensure that emergency personnel are trained in and understand psychosocial support.

7. Human resources

Protection agencies may recruit psychosocial programme managers. A suggested profile for such person is:

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

Action Sheet 4.1 of the IASC Guidelines gives detailed advice on identifying and recruiting any staff or volunteers. Protection programme managers should seek to recruit psychosocial support providers who have knowledge of, and insight into, the local culture and appropriate modes of behaviour. Local staff should deliver any direct person-to-person psychosocial support. The protection programme manager should use available criteria to

carefully evaluate offers of help from individual foreign mental health professionals (including social workers) who may seek to parachute in to offer their services (see IASC Guidelines, pages 72-73).

7.a Orientation and training of aid workers in MHPSS

Inadequately oriented and trained workers without the appropriate attitudes and motivation can unintentionally harm affected populations. To prevent harm and support effective action, one can organize brief orientation seminars and trainings (see Action Sheet 4.3).

- 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 promote the learning of more extensive knowledge and skills and are recommended for those working on focused and specialised MHPSS (the top two layers of the pyramid in Figure 1). Local trainers or co-trainers with prior experience and/or knowledge of the affected location are preferred when they have the essential knowledge and skills. The length and content of training seminars vary according to trainees' needs and capacities. Inexperienced staff will require longer periods of training. 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.

Seminars involving skills training should always be followed up with field-based support and/or supervision. Training advanced psychosocial skills without organizing a system for follow-up is irresponsible. Action sheet 4.3 provides key guidance on organizing orientation and training (e.g., selecting trainers, learning methodologies, content of sessions and challenges in organizing Training of Trainers).

7.b. Well-being of staff and volunteers

In emergency settings, staff members and volunteers often work long hours under pressure and within difficult security constraints. For many workers, the greatest stress comes from insufficient managerial and organisational support. 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 to 4) describe key actions to facilitate a healthy working environment and 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 (PFA); see above).
- When survivors' acute distress is so severe that it limits their *basic* functioning (or they are judged to be a risk to themselves or others), they must stop working and receive immediate care by a mental health professional trained in evidence-based treatment of acute traumatic stress. An accompanied medical evacuation may be necessary.

- Organize mental health professional contacts for 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 referral to clinical treatment for those with substantial problems that have not healed over time (*Action Sheet 4.4, points 6 and 7*).

8. Links to tools and key resources for further reading

- Action by Churches Together (ACT) Alliance, Lutherhjälpen, Norwegian Church Aid and Presbyterian Disaster Services (2005). *Community Assessment of Psychosocial Support Needs*. Chapter 6, Community Based Psychosocial Services: A Facilitator's Guide. <http://www.svenskakyrkan.se/tcrot/lutherhjalpen/psychosocialservices/pdf/psychosocialservices.pdf>
- Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) (2003). *Participation of Crisis- Affected Populations in Humanitarian Action: A Handbook for Practitioners*. Assessments, Chapter 3. http://www.odi.org.uk/ALNAP/publications/gs_handbook/gs_handbook.pdf
- Antares Foundation (2005). *Managing Stress in Humanitarian Workers: Guidelines for Good Practice*. <http://www.antaresfoundation.org/download/Managing%20Stress%20in%20Humanitarian%20Aid%20Workers%20-%20Guidelines%20for%20Good%20Practice.pdf>
- IASC (2005). Action sheet 8.3: Provide community-based psychological and social support. In: *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*. IASC, pp 69-71. <http://www.humanitarianinfo.org/iasc/content/products> (also in Arabic, French, & Spanish)
- 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, & Spanish; hard copy of guidelines includes a CD-ROM with resource documents)

- IASC (2008). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings: Checklist for Field Use*. IASC.
<http://www.humanitarianinfo.org/iasc/content/products>
- IFRC (2003). 'Promoting community self-help', in *Community-based Psychological Support: A Training Manual*, pp.57-65. International Federation of the Red Cross and Red Crescent Societies: Geneva. Available in English, Arabic, French and Spanish at: <http://psp.drk.dk/sw2995.asp>
- PAHO/WHO (2004). Sociocultural aspects. In: *Management of Dead Bodies in Disaster Situations*, pp.85-106. Washington: PAHO.
<http://www.paho.org/English/DD/PED/DeadBodiesBook.pdf> (also in Spanish)
- Refugee Studies Centre and UNICEF (2002). 'Addressing the needs of children, their families and communities', in *Working with Children in Unstable Situations – Principles and Concepts for Psycho-social Interventions* (draft), pp.47-79.
<http://psp.drk.dk/graphics/2003referencecenter/Doc-man/Documents/1Disaster-general/WorkWithChild.UnstableSitua.pdf>
- 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 & Spanish).

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Suggested citation:

© Inter-Agency Standing Committee (IASC) Global Cluster Working Group and IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2010. *Mental Health and Psychosocial Support in Humanitarian Emergencies: What should Protection Programme Managers Know.*

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