excerpt (pp. 9 - 16) from introductions to:

IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.
Full document can be obtained from the IASC website at: http://www.humanitarianinfo.org/iasc/content/products

Core principles

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

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

3. Do no harm
Humanitarian aid is an important means of helping people affected by emergencies, but aid can also cause unintentional harm (Anderson, 1999). Work on mental health and psychosocial support has the potential to cause harm because it deals with highly sensitive issues. Also, this work lacks the extensive scientific evidence that is available for some other disciplines. Humanitarian actors may reduce the risk of harm in various ways, such as:

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

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

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

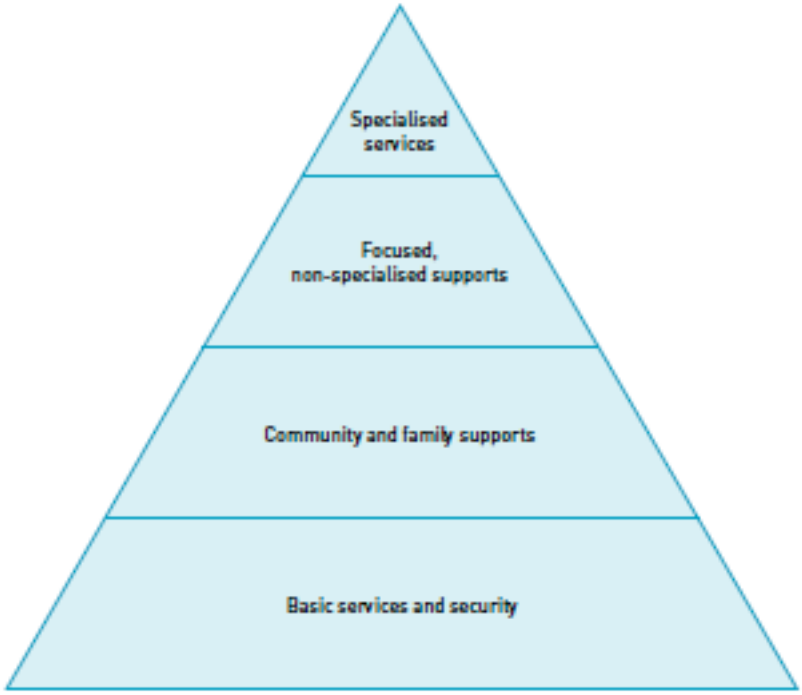
6. Multi-layered supports
In emergencies, people are affected in different ways and require different kinds of supports. A key to organising mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups. This may be illustrated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

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

ii. Community and family supports. The second layer represents the emergency response for a smaller number of people who are able to maintain their mental health and psychosocial well-being if they receive help in accessing key community and family supports. In most emergencies, there are significant disruptions of family and community networks due to loss, displacement, family separation, community fears and distrust. Moreover, even when family and community networks remain intact, people in emergencies will benefit from help in accessing greater community and family supports. Useful responses in this layer include family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women's groups and youth clubs.

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

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



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

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

DO´S AND DON´TS

Experience from many different emergencies indicates that some actions are advisable, whereas others should typically be avoided. These are identified below as 'Do's' and 'Don'ts' respectively.

Do's	Don'ts
Establish one overall coordination group on mental health and psychosocial support.	Do not create separate groups on mental health or on psychosocial support that do not talk or coordinate with one another.
Support a coordinated response, participating in coordination meetings and adding value by complementing the work of others.	Do not work in isolation or without thinking how one's own work fits with that of others.
Collect and analyse information to determine whether a response is needed and, if so, what kind of response.	Do not conduct duplicate assessments or accept preliminary data in an uncritical manner.
Tailor assessment tools to the local context.	Do not use assessment tools not validated in the local, emergency-affected context.
Recognise that people are affected by emergencies in different ways. More resilient people may function well, whereas others may be severely affected and may need specialised supports.	Do not assume that everyone in an emergency is traumatised, or that people who appear resilient need no support.
Ask questions in the local language(s) and in a safe, supportive manner that respects confidentiality.	Do not duplicate assessments or ask very distressing questions without providing follow-up support.
Pay attention to gender differences.	Do not assume that emergencies affect men and women (or boys and girls) in exactly the same way, or that programmes designed for men will be of equal help or accessibility for women.

Do's	Don'ts
Check references in recruiting staff and volunteers and build the capacity of new personnel from the local and/or affected community.	Do not use recruiting practices that severely weaken existing local structures.
After trainings on mental health and psychosocial support, provide follow-up supervision and monitoring to ensure that interventions are implemented correctly.	Do not use one-time, stand-alone trainings or very short trainings without follow-up if preparing people to perform complex psychological interventions.
Facilitate the development of community-owned, managed and run programmes.	Do not use a charity model that treats people in the community mainly as recipients 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.
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.

Do's	Don'ts
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.

CHAPTER 2

Matrix of minimum responses in midst of emergencies

Area	A. Common functions	
1 Coordination	1.1	Establish coordination of intersectoral mental health and psychosocial support (page 17)
2 Assessment, monitoring and evaluation	2.1	Conduct assessments of mental health and psychosocial issues (page 18)
	2.2	Initiate participatory systems for monitoring and evaluation (page 18)
3 Protection and human rights standards	3.1	Apply a human rights framework through mental health and psychosocial support (page19)
	3.2	Identify, monitor, prevent and respond to protection threats and failures through social protection (page 19)
	3.3	Identify, monitor, prevent and respond to protection threats and abuses through legal protection (page 20)
4 Human resources	4.1	Identify and recruit staff and engage volunteers who understand local culture (page 21)
	4.2	Enforce staff codes of conduct and ethical guidelines (page 22)
	4.3	Organise orientation and training of aid workers in mental health and psychosocial support (page 23)
	4.4	Prevent and manage problems in mental health and psychosocial well-being among staff and volunteers (page 24)

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 (page 24) 5.2 Facilitate community self-help and social support (page 25) 5.3 Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices (page 26) 5.4 Prevent separation and facilitate support for young children (0-8 years) and their care-givers (page 27)
6 Health services	6.1 Include specific psychological and social considerations in provision of general health care (page 27) 6.2 Provide access to care for people with severe mental disorders (page 28) 6.3 Protect and care for people with severe mental disorders and other mental and neurological disabilities living in institutions (page 29) 6.4 Learn about and, where appropriate, collaborate with local, indigenous and traditional health systems (page 30) 6.5 Minimise harm related to alcohol and other substance use (page 30)
7 Education	7.1 Strengthen access to safe and supportive education (page 31)
8 Dissemination of information	8.1 Provide information to the affected population on the emergency, relief efforts and their legal rights (page 31) 8.2 Provide access to information about positive coping methods (page 32)

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 (page 33)
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 (page 34)
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 (page 35)

The full guidelines include 25 action sheets that explain how to implement each of the above minimum responses (See Chapter 3).