Editorials

Inter-agency agreement on mental health and psychosocial support in emergency settings

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Armed conflicts and natural disasters cause substantial psychological and social suffering to affected populations.[1–3]

Despite a long history of disagreements,[4] international agencies have now agreed on how to provide such support. The Inter-Agency Standing Committee (IASC), established in response to United Nations General Assembly Resolution 46/182, is a committee of executive heads of United Nations agencies, intergovernmental organizations, Red Cross and Red Crescent agencies and consortia of nongovernmental organizations responsible for global humanitarian policy. In 2005, the IASC established a task force to develop guidelines on mental health and psychosocial support in emergencies.

The guidelines[5] use the term "mental health and psychosocial support" to describe any type of local or outside support that aims to protect or promote psychosocial well being or to prevent or treat mental disorders. Although "mental health" and "psychosocial support" are closely related and overlap, in the humanitarian world they reflect different approaches. Aid agencies working outside of the health sector have tended to speak of supporting psychosocial well being.[1,6] Health sector agencies have used the term mental health, yet historically also use "psychosocial rehabilitation" and "psychosocial treatment" to describe non-biological interventions for people with mental disorders.[7] Exact definitions of these terms vary between and within aid organizations, disciplines and countries, and these variations fuel confusion.[8] The guidelines' reference to mental health and psychosocial support serves to unite a broad group of actors and communicates the need for complementary supports.

The guidelines outline minimum responses; that is, the first steps to occur in supporting mental health and psychosocial well being during an emergency. This definition matters because agencies often attempt to set up specialized programmes without checking whether more basic mental health and psychosocial supports are in place. The focus on minimum, intersectoral response helped task force members find agreement in an area of aid that still has a weak evidence base.[9]

The structure of these guidelines is consistent with the IASC documents on HIV/AIDS[10] and on gender-based violence.[11] These three documents include a matrix, which describes actions for various sectors during different stages of emergencies, and a set of short action sheets that explain how to implement minimum responses during the acute phase of an emergency. The current guidelines describe 25 such minimum-response action sheets. These mostly focus on protection and social support, but also include attention to pre-existing or emergency-induced severe mental disorders,[12] acute trauma-induced distress and substance use. Each action sheet includes descriptions of key actions, sample process indicators, an example of good practice and references to resource materials.

The guidelines highlight the importance of mobilizing groups of disaster-affected people to organize their own supports and participate fully in the relief effort. In this respect, local people are not passive beneficiaries but actors who have assets and resources, and support is provided from within the community as well as by outsiders.

Possibly the most far-reaching innovation of the guidelines is its emphasis on multisectoral action. The concept underlying this approach is that the way any type of humanitarian response is provided has implications, beneficial or detrimental, for the mental health and psychosocial well being of the affected population. Effective or harmful supports may result from the ways in which aid is organized or delivered. For example, shelter assistance helps to meet basic survival needs, but it can also be a barrier to mental health depending on whether it is implemented without concern for massive overcrowding and absence of privacy, sources of great distress among displaced people. Similarly, water and sanitation can be organized in a manner that risks or supports protection of women and girls through the establishment of secure or insecure facilities for women, thereby increasing or reducing, respectively, the distress associated with realistic fear of rape. The guidelines outline participatory approaches that reduce the risk that aid is provided in harmful ways.

Interagency coordination is at the heart of efficient emergency response. Yet poor coordination of mental health and psychosocial support has been prominent in many emergencies because of institutionalized divisions in the humanitarian world. In most emergencies, two broad approaches emerge: one focused on clinical assistance through the health sector and the other focused on community self-help and social support activities organized by people working in the protection sector. Often these complementary approaches develop into independent sets of activities that compete for funding and influence. In numerous crises, this schism has led to separate coordination groups that do not communicate with each other.

The guidelines recommend a single, overarching coordination group and, where a single coordination group is unfeasible, advocate the establishment of subgroups that coordinate with each other. The guidelines describe an integrated framework within which divergent and complimentary approaches find a common home. The process of developing the guidelines has healed numerous interagency divisions in this young field. We call upon all agencies to implement these guidelines. ■

References

Available at: http://www.who.int/bulletin/volumes/85/11/07-047894/en/index.html

[a] For task force membership and acknowledgements see http://www.who.int/bulletin/volumes/85/11/07-047894/en/index.html.

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