

Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings

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	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.

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 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.
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.

<p>Use basic medications that are on the essential drug list of the country.</p>	<p>Do not introduce new, branded medications in contexts where such medications are not widely used.</p>
<p>Establish effective systems for referring and supporting severely affected people.</p>	<p>Do not establish screening for people with mental disorders without having in place appropriate and accessible services to care for identified persons.</p>
<p>Develop locally appropriate care solutions for people at risk of being institutionalised.</p>	<p>Do not institutionalise people (unless an institution is temporarily an indisputable last resort for basic care and protection).</p>
<p>Use agency communication officers to promote two-way communication with the affected population as well as with the outside world.</p>	<p>Do not use agency communication officers to communicate only with the outside world.</p>
<p>Use channels such as the media to provide accurate information that reduces stress and enables people to access humanitarian services.</p>	<p>Do not create or show media images that sensationalise people's suffering or put people at risk.</p>
<p>Seek to integrate psychosocial considerations as relevant into all sectors of humanitarian assistance.</p>	<p>Do not focus solely on clinical activities in the absence of a multi-sectoral response.</p>