

Guidance Note for Mental Health and Psychosocial Support Haiti Earthquake Emergency Response - January 2010

This statement reflects the views of the *Interagency Standing Committee (IASC) Mental Health and Psychosocial Support (MHPSS) Reference Group* in response to the Haiti crisis¹. This guidance is based on the *IASC Mental Health and Psychosocial Support Guidelines in Emergency Settings*² and highlights those aspects of the Guidelines that are particularly relevant for the current response in Haiti. It also draws on knowledge and experiences of MHPSS responses in previous emergencies, including the 2004 tsunami response and the 2009 Gaza crisis.

Well integrated mental health and psychosocial supports that build on existing capacities and cultural norms reach more people and are more likely to be sustained once humanitarian aid engagement ceases. Relevant MHPSS interventions are usually derived locally and fall into the following four categories, depicted in the “intervention pyramid” and described further on pages 3-6:

- Social considerations in basic services & security
- Strengthening community & family supports
- Focused non-specialised supports
- Specialised services

Affected community members are not viewed as passive beneficiaries but actors who have assets and resources. Support is provided from within the community as well as by outsiders, respecting that people are affected by the disaster in different ways. It is recommended that a layered system of complementary supports is put in place as expressed in the “intervention pyramid”.

Background information

On 12 January 2010, an earthquake and multiple aftershocks hit the capital and surrounding areas in Haiti. This has left an estimated 3,000,000 people in need of humanitarian assistance. In times of adversity many people show remarkable resilience and are able to cope relatively well. At the same time, the crisis has significantly exacerbated the already acute vulnerabilities and problems facing many Haitians. These include a strained national context, long term political insecurity and the impact of multiple natural disasters in recent years.

Following the earthquake in Haiti, police, legal, health, education and social services have been disrupted; many people have been displaced and most of those who remain are not in the position to work and resume their lives. Haiti is experiencing typical impacts of large crises where many lives are lost and families and communities are separated, basic services destroyed, disrupted or overwhelmed, and informal protection mechanisms weakened. This affects the way individuals and communities are able to respond to the crisis and has implications for the humanitarian response that is being put in place. People need security, basic services such as health care, psychological and social support, and legal redress. The providers of all these services must be knowledgeable, skilled, and compassionate.

¹ Action Contre la Faim (ACF), Church of Sweden, Global Psycho-Social Initiative (GPSI), InterAction (through: American Red Cross (ARC), Christian Children's Fund (CCF), International Catholic Migration Commission (ICMC), International Medical Corps (IMC), International Rescue Committee (IRC), Mercy Corps, Save the Children USA (SC-USA)), Inter-Agency Network for Education in Emergencies (INEE), International Council of Voluntary Agencies (ICVA) (through: Action Aid International, CARE Austria, HealthNet-TPO, Médicos del Mundo (MdM-Spain), Médecins Sans Frontières Holland, (MSF-Holland), Oxfam GB, Refugees Education Trust (RET), Save the Children UK (SC-UK)), International Federation of Red Cross and Red Crescent Societies (IFRC), International Organization for Migration (IOM), Office for the Coordination of Humanitarian Affairs (OCHA), Queen Margaret University, Institute of International Health and Development (IIHD), Regional Psychosocial Support Initiative for Children (REPSSI), Terre des hommes (Tdh), United Nations Children's Fund (UNICEF), United Nations High Commissioner for Refugees (UNHCR), United Nations Population Fund (UNFPA), United National Relief and Works Agency (UNRWA), World Food Programme (WFP), World Health Organization (WHO/PAHO), World Vision International (WVI).

² Inter-Agency Standing Committee (IASC) (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: IASC.

Purpose of the Guidance Note

This Guidance Note is provided for general relief workers and volunteers, health care and protection workers, programme managers, and any other personnel helping those affected by the Haiti earthquake. It provides guidance to organisations working in Haiti about how they can most appropriately communicate with communities, their own personnel and the media. The Guidance Note focuses mainly on the acute phase of the response (including early recovery) and provides basic guidance for action. Please use the IASC Guidelines for more detailed information on the appropriate response in all sectors.

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 disorder³. The term “psychosocial” refers to the dynamic relationship that exists between psychological and social effects, each continually inter-acting with and influencing the other. “Psychological effects” are those that affect different aspects of individual functioning including cognitive (perception and memory as a basis for thoughts and learning), affective (emotions), physical, and behavioural. “Social effects” pertain to altered relationships, family and community networks, and economic status. The MHPSS composite term serves to unite the various approaches focused on by different actors in the emergency response. It aims to emphasise the need for diverse, complementary approaches in providing appropriate supports to those affected in Haiti.

In the Haiti crisis many people want to help. The priority must be given to identifying and supporting qualified MHPSS staff from Haiti. Other MHPSS professionals should only go to Haiti to help if:

- They have an invitation from a local or international organisation based in Haiti and agreement on their role
- They have a basic understanding of the IASC MHPSS guidelines and the recommended approaches
- They have knowledge of the Haitian context or experience in disaster response outside own cultural context
- They receive a basic orientation on the context including the situation in Haiti before and after the disaster
- They are able to work in French and/or Creole (including through translators)

Introduction

Despite widespread distress and grief, self recovery and resilience in the face of disasters is the norm. The severity of the earthquake has affected almost everyone. For the vast majority of the population the disruption and stress caused by this natural disaster will cause a normal response of intense emotional distress. However, a proportion of the population will experience mental distress that persists and is out of proportion to what is expected. This limits their ability to function and may amount to mental disorder.

Normal reactions to the crisis include, but are not limited to:

- grief, sadness, hopelessness and a sense of being overwhelmed
- emotional difficulties including anxiety, fear, anger, guilt
- behavioural problems such as lack of concentration, risk of increased use of violence or alcohol and drug use within communities
- social problems such as isolation, tension or violence in families, increased collective fear, anger and frustration regarding humanitarian aid
- increases in social tensions and violence in communities due to basic needs going unmet, the lack of law and order, or difficulties in ensuring assistance is provided in timely and fair manner.

People with the following severe reactions should be immediately recognized and responded to:

- are disoriented (e.g., not knowing where they are)
- not responding to conversation
- put themselves or others in danger
- threaten to harm themselves or others
- are unable to do basic activities of daily life (i.e., walking, talking, grooming, eating).

³ IASC, 2007; p.1.

People who experience normal, yet intense emotions do not necessarily require immediate clinical mental health assistance. Having access to basic services, such as shelter, water and food in a dignified manner, psychological first aid, community and family supports and continuous information about the relief response will assist in attenuating distress. Communities should be provided with clear messages about positive coping strategies, such as spending time with family, returning to normal routines, eating and sleeping as well as they can and avoiding excessive use of alcohol or drugs.

People have the right to access and receive relief assistance (e.g. food aid and non-food items) in a dignified manner that does not compromise their safety or well-being. Whenever relief distributions are being planned and conducted, steps should be taken to enable local people to help organize the distribution of aid and to become empowered actors. Helping to organize relief enables Haitian people to regain a sense of control following overwhelming experiences. Organisations providing this assistance should ensure access by marginalised groups, respect to the extent possible dietary beliefs and practices, pay attention to gender norms and family roles, and not least ensure security measures around distributions that minimise the risk of riots and fighting among recipients.

For a quick guide on what is known on cultural, community and family support in Haiti, see

Nicolas, G., Schwartz, B., & Pierre, E. (2009). Weathering the storm like Bamboo: the Strengths of Haitians in Coping with Natural Disasters. In A. Kalayjian, D. Eugene, & G. Reyes (Ed.) *International handbook of emotional healing: ritual and practices for resilience after mass trauma*. Westport, CT: Greenwood Publishing Group, Inc. This chapter is online at: <http://education.miami.edu/News/pdfs/Haiti.pdf>

In the context of the Haiti earthquake, several vulnerabilities affect psychosocial well-being and ability to function. Detailed assessments will identify particularly vulnerable people; however the needs of certain groups are expected to be a key priority:

People with severe reactions. People with these kind of reactions need to be referred to a health service or, if accessible, to a mental health service. Where possible, persons with severe reactions need to be moved away from dangerous areas; they need to be safe and cared for.

Children. Parents are often concerned about behaviours and responses of their children. Most children and adolescents who are affected by the devastation will initially display signs of psychological distress, including memories of the event, nightmares, some social withdrawal, difficulty concentrating and sometimes regression to previous developmental behaviours, such as clinginess, bedwetting or thumb-sucking. Most children and adolescents will regain normal functioning once their basic survival needs are met, safety and security have returned, and regular activities, like play and education, have been re-established. Most importantly, they will respond best when they are engaged in a family context, with appropriate care and protection from their regular caregivers and feel a sense of belonging within their community. Additionally, parents' responses to their situation are often mirrored by their children. Therefore, a parent in distress would be a priority as this will encourage them to better support their children.

Separation of children from parents and caregivers should be avoided wherever possible (even during medical treatment) and tracing and reunification conducted. Prevention of separation should be prioritised, including ensuring that food, water and family care is provided to family members together, encouraging family members to stay together. Ensure that widows, the elderly, very young mothers and other vulnerable families are supported to continue care of their children.

Women and girls. In a country where many women and girls are already exposed to sexual and other forms of gender-based violence (GBV), it is likely that certain forms of GBV will escalate post-earthquake at both the community level and within camp settings. To save lives and maximize protection, a minimum set of activities must be rapidly undertaken in a coordinated manner (see IASC Guidelines on Gender-Based Violence) to respond to the needs of the children and women at the earliest stages of the emergency response, particularly those most vulnerable to ongoing dangers.

Isolated persons. Separated children, widows, older persons or others without their families are particularly vulnerable to various abuses and greater adjustment problems. They should be identified, supported and given access to all activities that facilitate their inclusion into social networks.

People in institutions (nursing homes, mental hospitals, old-age homes and orphanages). They should be visited, their basic needs should be addressed and they should receive ongoing support, care and protection. Children in orphanages must be registered and their family traced.

Adult and children with disabilities or special needs. They should be visited, their basic needs should be addressed and they should receive ongoing support, care and protection.

Adults and children with pre-existing mental and neuropsychiatric disorders. Often they were receiving medication (for example for epilepsy or psychosis) and are particularly vulnerable to breakdown due to disruption of their medication and the possible removal of their networks of social support. Efforts should be made to restore appropriate care and provide a continuing supply of medication.

Coordination of MHPSS activities

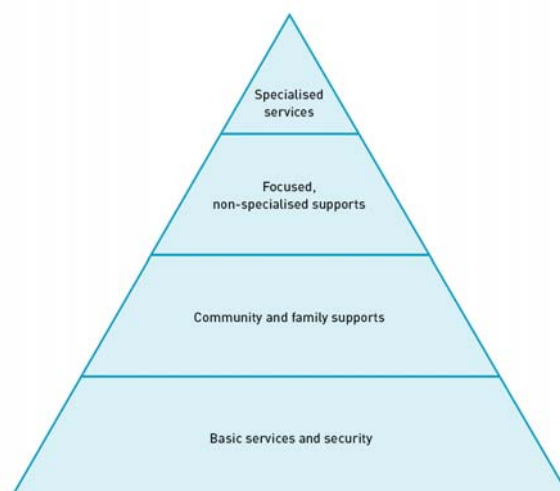
It is essential that a coordinated response to MHPSS needs and interventions is followed by all individuals and agencies, local and international. This reduces the impact of affected people being unnecessarily assessed for MHPSS needs multiple times and ensures that gaps in MHPSS efforts can be more quickly filled. Additionally, it ensures better coverage by organisations working with MHPSS and the various levels of intervention. The most effective coordination includes a multi-sectoral approach to MHPSS, involving a strong MHPSS response by the health, protection and education sectors, and by other sectors (e.g. shelter and wash) where they can be supported to implement activities in ways that promote mental health and well-being. Accountability for MHPSS activities lies within the relevant Clusters.

For the Haiti response, a MHPSS working group will be established within the Cluster system. The MHPSS working group encourages joint assessments, sharing of information and mapping of the various MHPSS interventions implemented by responding organisations, MHPSS planning and harmonisation of action such as training and advocacy. It encourages the implementation of interventions that adhere to the standards described in the IASC Guidelines. The working group advocates that the local services be made part of the response, which will assist the long-term sustainability of a MHPSS infrastructure.

For more information about the coordination see “Haiti MHPSS group” on the following website: www.psychosocialnetwork.net

Key interventions

The core principles of the IASC Guidelines are grounded in human rights and equity, community participation, a do no harm framework, aiming to build upon existing community resources and capabilities and the development of integrated and multi-layered support systems for affected populations. It is important to ensure that psychosocial care is implemented in a complementary, integrated and multi-sectoral approach. Stand-alone services are rarely sustainable, generate stigma and fragment already splintered care systems.



1. Basic services and security

Ensure access to basic needs and security. Psychosocial wellbeing and mental health require access to the full range of basic needs: food, shelter, livelihood, protection and health care and education services. Access to humanitarian assistance for the affected population is thus urgently needed. All assistance should be conducted in a manner that enhances rather than disrupts psychosocial wellbeing and ensures the dignity and participation of the affected population in any assistance provided. All professionals working with the affected population should have a basic understanding of how to interact with disaster affected populations and Haitian culture. MHPSS actors should work with other sectors to find ways to provide assistance in ways that promote psychosocial wellbeing (such as through advocacy, joint field missions or planning, orientations etc.).

Advocate for careful management of dead bodies. To make the grieving process easier, wherever possible bodies need to be identified for people to have certainty that the person has died and to allow for death and burial rituals. Space and time should be set aside for these rituals and for contextually appropriate burials. Unceremonious disposal of the bodies of the deceased should thus be avoided and families supported and facilitated to find ways in which they can bury or cremate their loved ones in accordance with traditional custom or their personal wishes. Media coverage of dead bodies should be respectful and appropriate. It is a myth that dead bodies cause disease in natural disasters. It is far more important to insure that the dead are identified by family members than to bury them quickly. Those providing assistance should understand and respect the culturally appropriate ways that children and adults grieve; this depends on the culture, age of children, gender and individual differences.

Provide credible and accurate information. Affected communities and individuals tend to feel anxious to know what has happened, what is likely to happen next, where they are going, who is doing what for them, what their choices are, and where they can glean further information. Access to information is a right and also reduces unnecessary anxiety and distress. Information should be provided on the nature and scale of the emergency, efforts to establish shelter and care for the population and the specific types of relief activities being undertaken by local authorities and aid organizations, and their locations. Dissemination should be according to principles of risk communication: e.g., it should be uncomplicated (understandable to local 12-year olds).

2. Community and family supports

If peoples' basic needs have been addressed, the majority of people recover their mental health and well-being once they have reconnected with normal community and family support systems.

Facilitate access to appropriate religious and cultural support, including mourning activities. For some people, participation in religious or traditional cultural practices has a calming effect and offers a sense of meaning and perspective regarding their situation. Further, if people have opportunity to bid farewell to their loved ones in a culturally accepted way, this will assist their own grief recovery and usually that of others in their families or communities. Those providing assistance to families and children should understand and respect the culturally appropriate ways in which mourning occurs; this depends on the culture, age of children, gender and individual differences.

Ensure participation and consultation. Not only a right and good humanitarian practice, it is another way for communities to become empowered about meeting their own needs as well as the needs of their families and communities. This can lead to strengthened family and community supports. One example is the design of shelters that accommodate space for children, families, community groups with common interests, religious spaces, traditional cooking practices and so forth.

Ensure re-establishment of normal routines and activities. This helps provide a sense of control and predictability for people. Ways to re-establish routines and activities include the timely establishment of formal and informal education opportunities, spaces for children to play safely and encouraging adults and family providers to engage in work, livelihoods restoration or participation in relief efforts. Purposeful activity is particularly important for adolescents.

Maximise opportunities for groups of people to join together. By linking groups with similar needs, interests or ages (e.g. youth) for recreation, production or relief-related activities social networks amongst communities are formed. These groups share information and resources, assist individuals and engage with each other to promote traditional and positive coping strategies.

Provide staff Care. Professionals in government and civil society as well as the staff of international organisations pre-existing the emergency have been deeply affected by this crisis. Provision of appropriate, timely support for professionals is an important priority. This should be based on the guidance in the IASC MHPSS guidelines Action Sheet 4.4. In addition, local and international staff providing relief and emergency assistance may also be affected, and may require similar support.

Provide information about positive coping mechanisms. It is important that communities are provided with information about effective coping mechanisms. This information should acknowledge the suffering but focus on positive ways of coping with the disaster. It should be based on both local coping methods and experience from other disasters about effective coping. It should be harmonised across organisations to avoid contradictory or potentially harmful messages to the community. See section below that includes key advocacy messages for communities.

3. Focused, non-specialised supports

While the majority of people restore functionality and cope well enough if their basic needs and normal community and family supports have been re-established, some people require focused and structured interventions that better facilitate their emotional and mental well-being. Activities at this intervention level include psychological first aid (see box), basic mental health care by primary health care workers, or case management.

Psychological debriefing – including critical incident stress debriefing - is NOT recommended. This intervention was developed for use in homogenous groups of co-workers but was found to be ineffective. It is a potential harmful intervention when adapted for support of individuals' in disaster situations.

Although supervised cognitive-behavioural therapy can be effective, “trauma counselling” should not be the point of departure for psychosocial care in this intervention level. Structured activities that enhance communally based supports, normalising of responses and empowering activities within a safe environment will assist the majority of people to recover over time.

Psychological first aid is simple, easily taught and involves a practical and compassionate approach based on the following points:

A= Assess (assess for safety, obvious urgent physical needs, persons with serious reactions, and persons’ needs and concerns)

B= Be (be attentive, respectful and aware)

C= Comfort (Comfort through your presence, through good Communication and by helping people to Cope)

D= Do (do address practical needs, do help problem solve, do link people with loved ones and supports)

E= End/Exit strategy (End your own assistance by referring the person to other supports as needed, End for yourself taking time for self-care)

4. Specialised services: psychological or psychiatric interventions

Rates of mild and moderate mental disorders (e.g. mild and moderate mood and anxiety disorders, including posttraumatic stress disorder) tend to double in disaster situations, and a small proportion of the adult population will suffer from severe mental disorders. The latter group needs priority mental health care which should be supervised or provided by specialists. Many of the people with severe mental disorders have experienced such disorders prior to the emergency and their conditions may have been exacerbated by their experiences and lack of basic needs and social supports during and after the emergency. This is an extremely vulnerable group of people. Particular attention needs to be paid to:

- Children or adults who have been in physical restraints in family homes or institutions of any kind
- Those in institutional care
- Those on long term medication
- Children or adults with previous neuro-psychiatric disorders (including epilepsy) vulnerable to exacerbation in the current conditions
- Children or adults with developmental disorders or mental retardation

All these groups require access to skilled care or the urgent establishment of continuing care that attends to their basic needs and respects their rights. Outpatient mental health care should be established at general hospitals, while at least one staff at each primary health care fixed or mobile clinic needs to have one staff skilled in mental health care. In the absence of mental health care:

- Do not untie or unchain physically restrained patients until they have had a psychiatric assessment and are adequately medicated as required.
- Try to ensure physically humane and comfortable conditions. Treat physical wounds and illnesses. Ensure access to food and drink.
- Identify a medical care provider with sufficient knowledge to prescribe psychotropic medication if needed.
- The sudden discontinuation of psychotropic medication, particularly anti-psychotics, antidepressants and antiepileptic medication should be avoided, and it is potentially very harmful in the case of anti-epileptics. Frontline health care workers and primary health care facilities accessible to the displaced population should ensure a continuing supply of such medications and their inclusion in emergency medical kits.

Long term programming

The long term effects on affected populations depend very much on how the current crisis is handled now. Taking care of people humanely and treating them with dignity and respect is essential. Failure to do this is likely to lead to anger and frustration that will compound and prolong any stress reactions. People are much less likely to need individual professional support if they are able to meet their basic needs, and are supported by those around them as soon as possible.

Longer term interventions with displaced populations should be based on the following principles:

- Participatory assessment of the specific community's needs and circumstances
- Collaboration with the community in addressing those needs
- Particular attention to minorities and the most vulnerable within the community
- Building upon and mobilising the populations existing social supports and formal and informal resources
- A focus on interventions that foster the rebuilding of normal life and reintegration into society, whether through return to an original living situation or starting anew elsewhere
- Continuing access to social and psychological services and supports integrated in community structures and basic services such as education, health and social welfare as required
- Building back better –to create sustainable community-based mental health services and integrate mental health care in non-specialized health services to deal with increased rates of mental health problems.

Key advocacy messages for the media and humanitarian organisations

It is commonplace for aid agencies, the media and advocacy networks to reflect on the psychological consequences of disasters as this assists them to communicate the overall human impact of the crisis to others. While it remains essential that such messages are not diluted, the ways we communicate these concerns to others, and the terminologies we use, can either help or hinder the dignity of and respect for children, adults, families and communities affected by the disaster.

Mental health and psychosocial problems in emergencies encompass far more than the experience of posttraumatic stress disorder (PTSD) or disaster-induced trauma, depression and anxiety. A selective focus on these types of problems overlooks many other mental health and psychosocial support problems in emergencies and ignores pre-existing problems as well as the assets or resources that communities possess to support their own mental health and psychosocial well-being. A common problem with communications on mental health and psychosocial well-being is to ignore these resources and to focus solely on deficits – the weaknesses, suffering and pathology. It is important to accurately reflect the wide-ranging resilience of people's mental health and psychosocial resources, without diminishing the seriousness of their situations.

When communicating with non-specialists, terminology should be used in ways that:

- Are understandable and non-clinical
- Normalise common reactions to extremely challenging situations
- Reflect and reinforce the ability of people to deal with and overcome difficult situations
- Acknowledge and strengthen existing social support mechanisms within families and communities
- Reflect the collective and structural nature of causes and responses to distress
- Empower and do not lead to stigmatisation of people in distress.

Examples of recommended terms (✓)	Examples of terms to be avoided ⁴ (✗)
Distress, anguish, tormented, or overwhelmed Psychological and social problems. Alternatives include: <ul style="list-style-type: none"> - Emotional and social problems - Emotional and developmental problems (for children) - Can also add descriptions such as ‘severe or serious’ emotional and social problems. - Problems can also be replaced by similar words such as ‘effects, difficulties, reactions’ etc. - Mental health problems to describe those with prolonged and relatively excessive reactions If possible, good to explain that most people will be extremely upset but a small minority will have extreme reactions that leave them unable to function	Trauma
Terrifying/life-threatening/horrific events /devastation	Traumatic events
Distress or stress Psychological and social effects of emergencies	Trauma
Reactions to difficult situations Signs of distress Problems	Symptoms
Distressed children or adults (with normal reactions to the emergency/disaster) Severely distressed children or adults (with extreme or severe reactions to the emergency)	Traumatised children or traumatised adults
Mental illness or disorder Note: this should only be used for the minority of population with a confirmed mental disorder, not for the vast majority with normal reactions	Crazy, mad
Structured activities , community social support etc Note: This refers to psychosocial supports provided by communities or focused non-specialised supports, not specialised services	Therapy, counselling, treatment
Survivors	Victims, the unfortunate, beneficiaries

Advocacy messages for specific groups in Haiti (e.g. communities, children, women etc) will be posted on www.psychosocialnetwork.net

⁴ Examples of terms to be avoided unless appropriately used in a technical/clinical capacity by personnel qualified in mental health care.

Annex 1: Example of key messages for the media on MHPSS and children on the emergency in Haiti

- Children and their families have suffered enormously from this emergency, and are deeply distressed.
- In order to address this, children and their families need access to food, shelter and water in a dignified manner as quickly as possible, as well as information about where they can get assistance.
- Priority should be given to establishing security in places where children and families are gathering and establishing safe spaces for children to resume their regular activities with adult supervision as quickly as possible.
- Children should remain with their families, and families and others in contact with children need help to continue caring for and protecting children in these difficult circumstances. With the right family and community support, most children will be able to begin the process of healing.
- However, some children and their caregivers will need more specialised support and services for those people should be established quickly.
- The coordination of all these different kinds of services and supports is essential.