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The author lauds the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings as a remarkable achievement, but in his view they have not sufficiently used scientific evidence. The author also deplores that the concepts of 'trauma' and 'traumatic stress' remain underplayed and makes a case for early psychological group interventions, as well as for more specific attention to childhood mental disorders in general.

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Mental health response and psychosocial support following emergencies has grown slowly, but with increasing importance in recent years. It has become recognised that the psychological morbidity in an affected community can impose great burdens on individuals, their families and community services for many years following an emergency. It is also therefore understandable that the first priority of emergency services is to save lives and make the environment as safe as possible, and that the basic emergency plans in many countries still give priority to such activities. However even, as emergency plans are updated, it is often still difficult for mental health professionals to get their views represented.

A further structural problem in developing appropriate mental health responses has been the increasing practice of governments to '*outsource*' the mental health response to charitable and non governmental organizations (NGOs). Historically and contemporaneously, such organisations play important roles in helping survivors, but they often do not have expertise in current, evidence based mental health interventions. This can only be deleterious to the survivors.

Indeed, the constitution of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* involves many humanitarian agencies, but it is notable that no mental health professional bodies were represented in drafting the document. This separation of NGOs and the professions mirrors the reality in the field. There, traditionally, NGOs have gone into affected areas quickly and mental health professionals arrive on the scene later. They are still often viewed as being solely concerned with providing expensive and scarce '*therapy*' to a few individuals.

Indeed, the language of the guidelines still suggests mental health professionals are '*medicalizing*' and '*pathologizing*' and are therefore seen as a '*bad thing*'. The idea that accurate formulation of needs may lead to more effective interventions is not properly considered. It must be agreed that when mental health professionals began to intervene after disasters, too often they wrote about individual cases, even though they may well have undertaken much wider, community based approaches. What is needed is recognition, by all sides, that a public health perspective (including educational services) is required.

Furthermore, many excellent therapists may not be adequately trained in public health approaches, and this should be rectified before they enter the field after a disaster.

In other words, the guidelines mirror a basic division between many NGOs and professional mental health workers. Also, there does not appear to have been a systematic review of scientific literature to back up the assertions and assumptions contained within them.

The author fully realizes that the work of UN agencies and NGOs has not been often subjected to scientific evaluation, and instead has relied on '*qualitative*' opinions rather than hard evidence. Even so, this means that one has to be all the more aware of the sources of these opinions. This also means that without mental health expertise and systematic reviews of evidence, the Action Sheets are inevitably open to opinions that may well be shared across a number of agencies, but that may either not be grounded in evidence, or even fly in the face of evidence.

It seems to the author that it is now well established that traumatic events lead to traumatic responses in those exposed to them. Not everyone develops serious post-traumatic problems, but many develop isolated, distressing behaviours. These can interfere with adjustment, learning, adaptation and recovery in many survivors. By ignoring the effects of trauma, many NGOs are currently pushing ahead with, for example, initiatives on schooling for children. These initiatives are important indeed, but would be even more effective if the children's trauma reactions were dealt with in the first instance.

Underlying the whole set of Action Sheets is the assumption that, just because a high proportion of exposed individuals who develop stress reactions improve over a few weeks, nothing should be done before then (although the '*then*' is never defined). This can be taken as an excuse for delaying psychosocial intervention and psychological treatments. Normally within health services, prevention is seen as being a good thing and early intervention is recommended. The author accepts that different conditions require different approaches, and that the timing of interventions must still be shown to do no harm. Or, in the least do no more harm than good in population terms.

Recent evidence from both children and adults indicates that those who present early with the most severe reactions are most likely to continue being distressed for a long time (Meiser-Stedman, et al., 2007). Longitudinal post disaster studies have been few and far between until now. There is evidence however that post disaster mental health problems can emerge over time (Garrett, et al., 2007).

The implication is that there should not be a sharp divide between services provided in the immediate aftermath and those that are set up later. The goal should be to reduce suffering in the *here-and-now*, not just to prevent disorders of any sort occurring later. A holistic model of community care should also include *continuity of care*, albeit not necessarily by the same people, but at least by connected approaches.

It is good to see that the published guidelines have been revised in the light of commentaries sent in after earlier drafts. It is welcome to see a more cautious endorsement of '*traditional healing*' as some practices are harmful. Giving precedence to a Human Rights perspective is also welcome. However, there is still a reluctance to fully embrace an evidence based approach to the specific recommendations.

The concepts of '*trauma*' and '*traumatic stress*' remain underplayed, despite evidence of the value of early group interventions in

providing large numbers with better coping strategies and the skills to meet post disaster challenges.

The pernicious effects of the flawed original Cochrane report on psychological debriefing (Wessely, et al., 1998) which painted an inaccurate picture of well thought and early interventions and often led to banning of all early interventions. These effects still influence the guidelines. While there is general agreement these days that a single, one-off session of any sort is unlikely to be helpful, this can not be an excuse for doing nothing at all (Yule, 2001).

Furthermore, there still needs to be better recognition of the dilemma that responders face when survivors want to talk about what happened. How best to help them? What can be said and what is best not to say? For example, if a child is killed, then a teacher cannot just hold class the next day with an empty seat in the room and not acknowledge that something has happened. Children will have things to say; they will have questions that need answers; they may have fears that can be easily dispelled with the right information at the right time. Similarly, rescue workers need advice when comforting survivors. Are there ways of breaking bad news that are less destructive than others? When should they encourage the telling of the survivor's story and when is it not a good thing to do?

In other words, there is a need for good, evidence based psychological advice to all emergency workers, be they first responders or NGOs. A report of the European Federation of Psychology Associations recognizes that psychological and psychosocial support will usually be delivered by NGO personnel, but also recognises that as organizations, these NGOs will require good psychological guidance (EFPA, 2005).

Also arising from the gulf between NGOs and mental health professionals is a difference in perspectives on assessment of needs, whether that is a community, or individuals, needs.

The guidelines are strong on saying that members of a community should be monitored for physical health and even for the distribution of food. Why not also for mental health? Mollica et al. (2004) argued cogently that all countries should not only develop better emergency plans, but, as far as mental health is concerned, should ensure they have appropriate screening tools developed well in advance. Without that, people are open to criticism regarding the validity of any assessments. However, the fact that a locally valid screening measure is not available does not mean that an untrained volunteer can make an adequate evaluation of a survivor's mental health needs!

Finally, the author makes a plea to consider the needs of children more explicitly. Most children attend school and so any public health approach to mental health could be delivered through school systems. The guidelines do acknowledge that children often suffer poor concentration and have difficulties with learning after a disaster. Therefore, they suggest, that lessons should be shorter! Where is the evidence to back that up? Why not acknowledge that poor concentration is one aspect of stress reactions that can be very easily helped through appropriate skills training? Providing educational opportunities without appropriate preparation for learning seems a cruel waste of resources.

There are also other points of detail that one might challenge. However, the authors have achieved a fantastic amount in getting a disparate group of NGOs to agree on so much. Yet, please note that consensus (or inter-rater reliability) is not the same as

validity. We still need many more, well evaluated, studies of early interventions that can add to the evidence base that survivors of war and disasters deserve.

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