What is minimum response: reflections on diverse opinions regarding the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*[1]

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The authors respond to commentaries in this journal about the 2007 IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Overall, influential commentators coming from opposite academic traditions and knowledge bases appear to welcome these guidelines and value them. In this response, the authors focus on a few critical comments, which may be explained by divergent understandings about what is meant by minimum response and what priority activities may be part of that response.

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The commentaries in this journal by a diverse group of leading academic, policy and field experts have provided important learning for us for all. The richness of their opinion on the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2007) provides information about what was achieved, what was not, and what could be improved. Many of the commentators introduced numerous fresh areas of concern that may also need guidance and that should be considered for potential inclusion in the guidelines in case of a revision. For example, Abramowitz & Kleinman suggest, correctly, that culture needs to be conceptualized more clearly as a process, and Miller & Fernando point out the value of particular forms of epidemiology. Murthy and Baingana point out the importance of national leadership and the importance of learning how to implement the guidelines effectively. Silove and Rees emphasize the importance of devising methods for incorporating not only international, but also indigenous, concepts of mental disorder within clinical programmes. Many authors advocated for the urgent need to develop a stronger evidence base (Ager; Lopes Cardozo; Silove & Rees; Yule). We strongly agree.

In general, people coming from opposite academic traditions and knowledge bases welcome these guidelines and value them. For example, who would have thought that eminent medical anthropologists (Abramowitz & Kleinman), our colleagues from the World Bank (Rockhold & McDonald [see: Part II-The Guidelines: implementation]) and leading posttraumatic stress disorder (PTSD) experts (Benedek & Ursano) all would comment so positively about the same product, with the latter commenting that the principles of the Guidelines also apply in disasters in the United States? Beyond

positive words, Abramowitz & Kleinman are concerned that the guidelines (and even more so humanitarian aid in general) do not sufficiently address the practical complexities and moral implications of power differences between external and local humanitarian actors, and between them and the local population. Garcia del Soto, who points out the complexities inherent in community mobilization, also highlights issues of power difference. These concerns warrant much more reflection and action.

Although the vast majority of the commentaries are favourable, commentaries by Lopes Cardozo and Yule also contain criticism. Thankfully, they gave extremely constructive comments on the peer review version of the guidelines in 2006. Such technical comments greatly improved the quality of the final product. It proves to us, that in areas beset with dogma, much can be learned from openness to scrutiny through peer review and from genuinely trying to understand the perspective of others, regardless of momentary disagreement. This does not mean of course that the Task Force absorbed *all* peer review comments. Before addressing some of Lopes Cardozo and Yule's concerns, we need to talk first about the definition of '*minimum response*.'

Although the guidelines achieved an inter-agency consensus description of what activities are included as part of a minimum response, it is clear from the commentaries (and also from our own experience) that the term '*minimum response*' itself is often not thoroughly understood or understood to mean different things. This explains some of the disagreements in some of the commentaries.

The term '*minimum response*' has been previously used in other IASC (2003; 2005) products and also, the term '*minimum standards*' has been used by the Sphere Project (1998; 2004). However, what is '*minimum*'? According to the *IASC Guidelines* (2007);

> *'Minimum responses are the first things that ought to be done; they are the essential first steps that lay the foundation for the more comprehensive efforts that may be needed . . . Comprehensive responses [are] to be implemented once the minimum responses have been implemented.' (p. 5–7).*

As is well known, it is usually an enormous challenge to implement even the minimum responses outlined in any IASC document or the *Sphere Handbook* (Sphere Project, 2004) during an emergency in an affected area. Therefore, comprehensive response is typically reserved for the post emergency phase. Yet, it may well be, that even after the emergency, many of the relevant minimum supports are still not available. In such situations, it makes sense to keep the focus largely on minimum response before facilitating more comprehensive supports. The inverse is also possible. If, in the midst of emergency, the minimum response were available for a certain sector in a geographical area, then it would be appropriate to move immediately towards more comprehensive response for that sector in that geographical area. This situation is especially likely to occur in protracted emergencies.

This discussion on minimum versus comprehensive response is relevant to some of the commentaries. For example, we regret that Miller and Fernando - who otherwise offer five excellent recommendations that should be required reading for disaster mental health epidemiologists - conclude mistakenly that the guidelines reject epidemiology altogether. The guidelines do reflect and explain the Task Force's view that the epidemiology of

mental disorder and distress is not minimum response but, if well conducted, such epidemiology may be part of comprehensive response (see page 45 of the guidelines). Neither do the guidelines comment on the epidemiology of all sorts of other relevant variables, such as ongoing social problems, human rights violations, and available resources.

Although research is not defined as minimum response in this, or in any other IASC Guidelines (or in the 2004 *Sphere Handbook*), it is valuable to interweave research with the minimum response, thereby helping to build a stronger evidence base for the field. For example, conducting a series of randomized controlled trials on the psychosocial effects of child friendly spaces would make a lot of sense, given the widespread use of this emergency intervention. We want to be clear that we have never suggested that research is off limits during the emergency phase. In contrast, we advocate for more research in emergencies, while insisting that such research should be sufficiently well designed to properly answer highly meaningful questions.

Should treatment of mild and moderate PTSD and depression be a part of a minimum response in emergencies? Should epidemiology of mental health problems also be included as part of a minimum response in emergencies?

The policy decision on what to include in '*minimum*' is extremely difficult, and as far as we know, other IASC Task Forces, as well as the Sphere Project, have struggled with this decision. It reminds one of the difficulties of deciding on what is '*essential*' and what should be included in '*essential health packages*' and in '*essential medicines lists*'.

In our field, if data were available, one could make a set of priorities based on (for example):

- burden of problem (frequency of problem combined with disability);
- cost effectiveness of supports;
- horizontal equity (equitable access to resources among people with equal levels of problems);
- vertical equity (e.g. better access to supports for people with severe problems);
- protection of human rights; and
- feasibility and acceptability of supports (WHO, 2006).

It is possible to give such criteria different weights for local people and prioritize accordingly, but to do so one would need to have sufficient data on the burden and cost effectiveness (Baltussen et al., 2006).

In the absence of well-accepted, hard data and due to the controversies surrounding the current prevalence data (Bolton & Betancourt, 2004), the Task Force used the following criteria *de facto* to decide what minimum response is:

(a) what they have seen to be effective or harmful and what was known to the Task Force members from the literature, which has been subsequently systematically reviewed by Hobfoll et al., (2007). He concluded that there is a strong evidence base for action in disasters that promotes a sense of safety, calming, a sense of self and community efficacy, connectedness, and hope (all very much consistent with the inter-sectoral actions advocated in guidelines);
(b) horizontal and vertical equity; and
(c) human rights protection.

The implicit absorption of human rights protection and the vertical equity principle (e.g., prioritizing severe problems) by the Task Force, is evident in the specification

of care and human rights protection of people with severe mental disorders as a minimum response, while not assigning the same priority to the treatment of mild and moderate mental disorders. This is an issue that raises concern for both Baingana and Yule.

The guidelines do specifically state that epidemiology of mental disorder is not minimum response. Lopes Cardozo disagrees with this and champions the importance of data driven programmes. If the word *'data'* were to be replaced with *'information'* we would agree that information driven programming is the goal. Data without understanding of meaning are just that, data. Data (whether qualitative or quantitative in nature) with a well-understood and agreed meaning is information and extremely valuable. We agree that information collected from especially representative (population based) samples (as quantitative data from surveys more often are) is invaluable. Yet data of an unclear validity are not that useful, and no sampling approach can address this. The concern of many Task Force members has been that most surveys on mental disorders in emergencies, even when they involve the best forms of sampling, give little information, because the meaning of the data is unclear when the (criterion and construct) validity of the data is unknown (van Ommeren, 2003). Many of the action sheets included in the guidelines start with participatory (mostly qualitative) assessment, and therefore highlight the importance of information driven support. We agree that much work needs to be done to ensure that representative quantitative and qualitative information is collected for assessment, monitoring and evaluation. We also fully endorse the suggestion that agencies should partner with research institutes and universities.

The commentators are right: enormous, collaborative efforts and investments are needed to give our field a broad, deep, and contextually rich evidence base. Our hope is that diverse actors in this still young field will do their part to implement the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* and help build an evidence base, thereby enabling everyone to strengthen practice and policy in support of people affected by armed conflict and natural disasters.

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[1] Although the IASC Guidelines do reflect formal inter-agency agreement, the views expressed in this current paper are those of the authors as individuals and may not necessarily reflect the decisions, policies or views of their employers nor may they reflect the views of other IASC Task Force members.

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