




Ministry of Foreign Affairs



# mind the mind now

International Conference  
on Mental Health &  
Psychosocial Support in  
Crisis Situations 2019

Background Document  
and Recommendations



Papers edited by Mindy Ran, Production Editor of MHPSS articles for Intervention Journal since 2003

#### DISCLAIMER

The information and views set out in these background papers are those of the authors and do not necessarily reflect the official opinion of the Netherlands Ministry of Foreign Affairs.

The co-chairs and members of the working groups were invited to prepare background papers to inform participants of the International Conference on Mental Health and Psychosocial Support in Crisis Situations (Amsterdam 2019), based on their expertise, and in their personal capacity. The information set out in the background papers does not necessarily reflect the official opinion of the agencies or institutions they work with.

# Foreword

## Sigrid Kaag

Crisis situations can impact lives in a variety of ways. And yet within the domains of humanitarian assistance and development cooperation, the focus is almost solely on the treatment or reconstruction of physical damage. For too long now, the international community has focused exclusively on healing the physical injured and rebuilding devastated structures. Somewhere along the line, it has forgotten that broken souls need mending too.

This volume contains insightful recommendations to policymakers about closing this gap. These have been prepared by a large and dedicated group of experts, professionals and people with lived experience. People who have dedicated their time and energy to this volume, and to the associated conference. They are an inspiration to me and to many others, and I want to thank them for their excellent work. The recommendations they have prepared will function as guidance for the international community's work on this important issue in the years to come.

We need to continue along the path that we set out at this conference. The importance of mental health and psychosocial support in crisis situations (MHPSS) should not be up for debate. Like food or water, these are human rights. We must treat them as such and act accordingly. The essays in this volume are useful touchstones: starting points for a much needed discussion on reforming humanitarian assistance and development cooperation. They offer insights and perspectives that are a valuable addition to the discourse on MHPSS. I trust that the publication of this volume will help to further advance the important agenda of Mental Health and Psychosocial Support in crisis situations. We have a responsibility to those who suffer, and we must honour that responsibility.



**Sigrid Kaag**  
Minister for Foreign Trade and  
International Cooperation



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“In conflict affected areas, one person in five lives with some form of mental condition, from mild depression and anxiety, to psychosis. That’s three times more than the general population worldwide suffering from these conditions. Behind these statistics are people who seek to live their lives with health and dignity. Just because mental health and psychosocial needs may not be as visible as physical health needs, they are no less life-threatening. When not addressed, mental health and psychosocial needs and traumas have a far-reaching and long-term impact on people, their families, their communities, and on the whole society.”

Peter Maurer, President International Committee of the Red Cross (ICRC)



Jordan, Credit: World Bank / Dominic Chavez

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# List of Abbreviations

<b>BMZ</b>	German Federal Ministry for Economic Cooperation and Development
<b>CHD</b>	Community Healing Dialogues
<b>CHWs</b>	Community Health Workers
<b>ECHO</b>	European Civil Protection and Humanitarian Aid Operations
<b>EPAPSY</b>	Association for Regional Development and Mental Health
<b>GBV</b>	Gender-based violence
<b>GIZ</b>	Deutsche Gesellschaft für Internationale Zusammenarbeit
<b>HI</b>	Humanity and Inclusion
<b>HIV</b>	Human Immunodeficiency Virus
<b>IASC</b>	Inter-Agency Standing Committee
<b>ICRC</b>	International Committee of the Red Cross
<b>IDPs</b>	Internally Displaced Persons
<b>IFRC</b>	International Federation of Red Cross and Red Crescent Societies
<b>IMC</b>	International Medical Corps
<b>IOM</b>	International Organization for Migration
<b>LAPS</b>	Liberia Association of Psychosocial Counsellors
<b>MHPSS</b>	Mental health and psychosocial support
<b>MH</b>	Mental Health
<b>NGO</b>	Nongovernmental Organisation
<b>PSS</b>	Psychosocial Support
<b>REPSSI</b>	Regional Psychosocial Support Initiative
<b>SDGs</b>	Sustainable Development Goals
<b>STARRTS</b>	Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
<b>TPO</b>	Transcultural Psychosocial Organization
<b>UN</b>	United Nations
<b>UNFPA</b>	United Nations Population Fund
<b>UNHCR</b>	UN High Commissioner for Refugees
<b>UNICEF</b>	United Nations Children's Fund
<b>WG</b>	Working Group
<b>WHO</b>	World Health Organization

# Introduction



Disasters, conflicts, violence and other crisis situations have an enormous impact on the psychological and social wellbeing of affected populations. The psychosocial and mental health needs of individuals, families and communities are diverse, as people are impacted in various ways and have various ways to cope. It is impossible to quantify the full range of socio-emotional impacts of crisis situations.

Nevertheless, best estimates suggest that at least one in five persons exposed by conflict in the previous 10 years currently have a mental health condition. In crisis and post-crisis settings the needs greatly exceed the response capacity of local communities and outside national and international responders, leaving most people without access to appropriate support.

Mental health and psychosocial support (MHPSS) activities and services must be systematically integrated into humanitarian response. However, such activities and services tend to be fragmented and too little, and too often not in line with evidence or agreed best practices. Increasing both coverage and quality of MHPSS remains a challenge in humanitarian crises.

The planning and implementation of mental health and psychosocial support interventions needs to build on local capacities. Assessments should not only focus on problems but also existing resources, which range from professional staff to community workers, from health and protection services to informal or traditional community support mechanisms, from capacities to implement evidence-based approaches to helpful local healing practices.

One of the aims of the International Conference on Mental Health and Psychosocial Support in Crisis Situations in 2019 in Amsterdam is to present promising and evidence-based approaches and interventions and discuss how those can be integrated into routine humanitarian assistance and brought to scale. To achieve this, and to improve the quality and reach of MHPSS responses it is of critical importance to allocate more resources to MHPSS, and carefully monitor and research the effectiveness and cost-effectiveness of innovative interventions in crisis situations, including, for example, brief psychological therapies delivered by non-specialists, digital psychological

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“Do not ask whether you can afford MHPSS;  
ask whether you can afford not to.”

Shekhar Saxena, Professor of the Practice of Global Mental Health  
at Harvard T.H. Chan School of Public Health

interventions and MHPSS interventions delivered in schools and other community settings. Furthermore, understanding how these interventions can be best integrated into existing services and linked to longer-term funding will be essential to strengthen the humanitarian-development nexus.

In 2018, in preparation of this conference, the Ministry of Foreign Affairs consulted a wide range of international and national actors working on MHPSS in humanitarian settings. The ten most often mentioned topics will be covered in the conference. For each topic, invited experts have prepared a background paper with recommendations to inform conference participants. Close to 80 experts contributed to the background papers: humanitarians, policy makers in international organizations (such as the United Nations and Red Cross and Red Crescent Movement), researchers and scholars, and people with lived experience.

The topic list is not exhaustive, but rather highlights important aspects. Each background paper aims to contribute to an improved humanitarian response, and increased access to quality mental health and psychosocial support to restore day-to-day functioning and recovery.





Indonesia, Credit: Martin Dody / ERCB  
(Emergency Response Capacity Building network)

# Scaling-Up of Mental Health and Psychosocial Support During and After Emergencies: Lessons Learned Across the World



**Co-chairs:** Fahmy Hanna (World Health Organization (WHO)), and Sarah Harrison, International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre for Psychosocial Support, Denmark)

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## Introduction: Continuum of Care

Mental health and psychosocial support (MHPSS) needs do not remain static over time, they shift and change in response to both the external environment and an individual's inner resources. During crisis events, mental health and psychosocial wellbeing are affected in a variety of ways, which require a wide range of supports to be offered in the response, based on individual or community needs, and at different stages of a crisis. To ensure that psychosocial and mental health needs are met, MHPSS should be integrated as part of a continuum of care that is multi-layered.

Support can range from social care, promotion of psychosocial wellbeing (or promotion of good mental health), prevention of psychological distress and mental health conditions, to treatment and care for people with mental health conditions.

This multi-layered approach relies on: (a) capacity building of appropriately skilled, community-level, frontline humanitarian workers, MHPSS professionals and government officials; (b) strong referral networks; and (c) investment in other components of the system (including governance, service organisation, monitoring of progress and impact, national preparedness and response planning, and establishment of long-term financing).

## Implementation and Integration of MHPSS

Robust domestic and international emergency preparedness, and response systems and plans, are vital to ensure humanitarian needs arising out of emergencies are met. Therefore, MHPSS for affected populations may be addressed more efficiently by ensuring MHPSS is systematically integrated into: preparedness and emergency response plans and budgets; national legislation; disaster laws; and recovery and coordination mechanisms. MHPSS should, therefore, be embedded into local and national services, as well as linked to longer-term sustainable investments in social welfare, education and health systems, including through the implementation of universal health coverage. Services should meet international standards and be culturally relevant. Any barriers to the scaling-up of services should be strategically and systematically considered and addressed.

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### Good Practice Examples: MHPSS Integration and Implementation in Response to Humanitarian Emergencies

In **Sri Lanka**, decades of conflict, in addition to the 2004 tsunami, made MHPSS a key priority for the government, as well as affected men, women, boys and girls. As a result, over the past 15 years, major innovations in dealing with the shortage of mental health human resources have been a feature of the mental health system development in Sri Lanka. Comprehensive mental health and psychosocial services are now available in most districts.

In the **Philippines**, Typhoon Haiyan devastated the lives of millions in 2013. In the region most affected, there were only two facilities providing mental health services, as well as a shortage of MHPSS workers. A major scale-up by the government, national NGOs, international NGOs and the Red Cross Red Crescent Movement continued for years and, as of 2018, all of the general health facilities within the affected region had trained personnel to manage mental health conditions. Additionally, social work and social care assistant positions were established in the affected region.

In **Syria**, despite – or perhaps because of – the challenges presented by the ongoing conflict, MHPSS is becoming more widely available than ever before. MHPSS is now offered in primary and secondary health and social care facilities, through community and women's centres and through school-based programmes in many governorates, including some of the most affected. This is in contrast with the situation before the conflict, when mental health care was only provided in mental hospitals or private health practices in major cities, with limited psychosocial support provided through school-based counsellors.

## Coordination and Integration of MHPSS across Sectors

Multi-layered MHPSS approaches demands coordination across multiple sectors, including clusters and/or working groups and Ministries (e.g. social welfare, health, education and disaster management). The provision of complementary services across a continuum of care, requires engagement with other sectors. For example, programmes on health services, child protection, victim assistance to survivors of explosive remnants, nutrition programmes, support to survivors of sexual violence and school-based programmes should all include MHPSS components as part of their services provision. In addition, psychosocial needs should be integrated in response to 'basic' needs, such as physical health, shelter, food, livelihoods, water, sanitation and hygiene.

The integration of coordinated MHPSS service provision within and across sectors enables services to be provided at scale, and in a holistic manner for affected individuals, families and communities. Integration within and across sectors also contributes to addressing the stigmatisation and discrimination often experienced by those with mental health and psychosocial needs. This can include exclusion, violence and even deprivation of liberty based on mental health conditions, which not only cause harm and exclusion from society, it acts as a barrier to accessing appropriate services. Therefore, integrated and coordinated service provision that reduce stigma, exclusion and discrimination is required to improve mental health and psychosocial wellbeing outcomes in humanitarian settings.

The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings<sup>1</sup> recommend that country-level MHPSS technical working groups are formed in humanitarian settings to facilitate integration across humanitarian sectors and to ensure a coordinated response to the MHPSS needs of affected individuals, families and communities. MHPSS technical working groups (WG) should be inclusive of agencies providing MHPSS services (in whatever sector and irrespective of target or age groups), in addition to their mandate to support the cluster/ sectoral humanitarian architecture in a country. MHPSS WG are often jointly led by national nongovernmental organisations (NGOs), international NGOs, government line ministries and/or operational UN Agencies (where relevant). It is recommended that there be two convening agencies of MHPSS WG at a minimum, with one drawn from the protection sector and one from the health sector.

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<sup>1</sup> Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC

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## Good Practice Examples: MHPSS Coordination and Integration across Sectors

The MHPSS infrastructure in **South Sudan** has gone from strength to strength since the establishment of a unifying structure, with a network consisting of UN agencies, international and national NGOs, a university department and religious institutions, all working to create good progress to build capacity for provision of MHPSS in the country. For example, the network has enabled actors from Gender Based Violence (GBV), Child Protection, Protection and Health Sectors to work together within one MHPSS group.


In **Jordan**, a multi-disciplinary National Mental Health Steering Committee, was established to lead a MHPSS scale-up to support Iraqi refugees who had fled to Jordan from 2003 onwards. The Committee's members represented the main stakeholders in Jordan, including: service users, social, education and health sectors and community representatives. The Committee has played a leadership role in coordinating MHPSS response in the country following the Iraq refugee crisis, the Syria crisis, and also includes MHPSS actors supporting MHPSS for Palestine refugees under UNRWA's mandate.

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### Key Recommendations:

- Individuals, families and communities should be supported across a continuum of care involving complementary psychosocial and mental health supports.
- Mental health and psychosocial support in crisis situations should be implemented with a long-term programme vision and capacity building approach, as well as integrated into national response systems and plans, and across sectors.

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“As a person’s mental well-being affects every aspect of their lives, Mental Health and Psychosocial Support have to be factored into all aid response activities.”

Mark Lowcock, United Nations Under-Secretary-General  
for Humanitarian Affairs and Emergency Relief Coordinator



# Mobilising and Supporting Displaced and Host Populations Within Communities



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**[NB:** The members of this working group were selected based on their expertise and with the aim of ensuring diversity in terms of geographical experience, professional background and gender. The members do not formally represent any of the agencies or institutions they work with and that the content of this briefing paper is not necessarily endorsed by those agencies or institutions.]

Central question:

What high-level priority actions are required to restore and strengthen the mental health and psychosocial wellbeing of displaced and host communities?

## Introduction

Increasing awareness of the substantially elevated mental health and psychosocial needs of displaced populations<sup>2</sup> has led to focused interventions for mental health and psychosocial support (MHPSS) for these groups. However, despite growing attention to MHPSS for emergency-displaced populations, there are still major gaps in programming and support. Displacement often becomes protracted, and funding for services tends to decline over time. Moreover, displaced populations are often hosted within communities that are themselves poor and disadvantaged and have also been impacted by the emergency situation. It is important, therefore, to consider MHPSS needs of both displaced and host populations in a holistic manner and identify approaches that maximise benefits for both communities in sustainable ways.

## Background and Relevant Facts

- Humanitarian emergencies often involve displacement. This can involve temporary dislocation due to natural disasters (such as an earthquake or flooding) or forced displacement due to collective violence or persecution.
- The number of forcibly displaced persons has increased over the years. Conflict has displaced 70.8 million people (around 1% of the world population): comprising 41.3 million Internally Displaced People (IDPs), 25.9 million refugees and 3.5 million asylum seekers.<sup>3</sup> The number of displaced people due to natural disasters, environmental conditions and resource depletion is also increasing, with 17.2 million newly displaced by disasters in 2017 alone.<sup>4</sup>
- A minority of forcibly displaced people live in dedicated settlements or camps, whereas most live amongst host populations, sometimes dispersed across wide geographical areas.
- The Global Compact on Refugees<sup>5</sup>, adopted by the UN General Assembly in 2018, recognises the need for a transformation in the global response to refugee situations, in order to benefit both refugees and the communities that host them. Two of the four key objectives of this Compact are: 1) to ease the pressures on host countries, and 2) to enhance refugee self-reliance.

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<sup>2</sup> Charlson, F., van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., & Saxena, S. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. *Lancet*, [http://dx.doi.org/10.1016/S0140-6736\(1019\)30934-30931](http://dx.doi.org/10.1016/S0140-6736(1019)30934-30931).

<sup>3</sup> <https://www.unhcr.org/figures-at-a-glance.html>

<sup>4</sup> <http://www.internal-displacement.org>

<sup>5</sup> [https://www.unhcr.org/gcr/GCR\\_English.pdf](https://www.unhcr.org/gcr/GCR_English.pdf)

- Based on a review of the relevant literature, the following sources of information identified four essential elements that should underpin MHPSS to displaced and host populations within communities:
- Multisectoral responses: MHPSS is not the domain of one sector, but needs to be realised through coordinated and complementary actions within the multiple sectors and clusters of the humanitarian response, including (but not limited to) child protection, community-based protection, sexual gender-based violence prevention and response, health, education and nutrition;
- Community-based perspectives that take the needs experienced by the affected populations as the starting point for analysis and intervention;
- Strengths and resilience-based approaches to interventions and supports that not only respond to problems, deficits and prevalence of mental health conditions, but also build on existing strengths and resources within affected communities, recognising especially the role that non-specialists and community members can play.
- Long-term, flexible approaches that take into consideration that the needs may change over time and that the trajectories of displaced and host communities are fundamentally intertwined and longer-term initiatives foster sustainability better.

## Key Recommendations

These recommendations cover two interlinked areas: 1) conceptualising the humanitarian MHPSS responses for displaced and host populations as closely intertwined, and 2) using approaches to MHPSS that are community-driven and community-based.

1. **In humanitarian crises, the MHPSS needs of displaced and host communities must be assessed and addressed in an inclusive, comprehensive and sustainable way.** From the onset of a humanitarian emergency, while addressing immediate MHPSS needs for affected populations must be prioritized, this must be combined, wherever possible, with approaches to build capacities with a focus on integrating displaced populations within systems and services for host communities.
  - a. ‘Humanitarian Needs Overviews’ and ‘Humanitarian Response Plans’ must contain a dedicated section addressing the MHPSS needs for both displaced and host populations that work in concert, cross-referencing MHPSS elements that are integrated within core sectors or clusters, such as health and protection.
  - b. Humanitarian policies and practice must promote \ to MHPSS that build bridges between host communities and displaced people, and that actively avoid exclusion and discrimination.
  - c. Host governments should consider the MHPSS needs of displaced populations in national and local policies and services.
  - d. Humanitarian actors should prioritise building the long-term capacities of local government services, nongovernmental organisations (NGOs) and community actors to support MHPSS.

- e. Humanitarian actors should also prioritise building long-term capacities of local service providers (i.e. primary care workers), NGOs and other community actors to support MHPSS.
  - f. Humanitarian actors must seek to strengthen appropriate linkages and referral systems between professional MHPSS actors and local civil society actors, as well as informal supports available from within local social and cultural systems.
  - g. Support institutionalising of procedures and systems developed to respond to the humanitarian emergency and integrate them into local, provincial and national government structures, as appropriate.
2. **Humanitarian actors should facilitate and encourage community-based MHPSS in which local actors, including displaced people and members of host communities, are enabled to build resources and competencies to support the wellbeing of all crisis-affected people.**
- a. Local stakeholders from within displaced and host communities need to be meaningfully involved in the planning of a MHPSS response. Action by local community members is important for a contextual, low cost, sustainable approach and is a necessary complement to expert-led interventions by NGOs, the UN and other international agencies and governments.
  - b. Humanitarian response plans should include support for self-help actions on MHPSS by displaced and host populations, building their capacity for mutual care and support in light of the challenges of their respective circumstances.
  - c. Humanitarian actors should promote community empowerment and resilience by creating space for discussion, decision-making and implementation of actions to support MHPSS by members of both displaced and host groups. These locally-led actions should build on local resources by engaging local and religious leaders, traditional healers, women and children, and encourage collaborative efforts by displaced and host communities to support the dignity and wellbeing of all.
  - d. It is also important to emphasise community-led and family-based support programmes and services at the local level, as well as underscore the responsibility of government and other formal systems for delivery of both basic services and implementation of more focussed and specialised programmes to address MHPSS needs. For example, existing local government units, health centres, educational services, etc. should be activated and strengthened to provide appropriate support services to displaced families and communities.
  - e. Humanitarian donors should make available flexible, longer-term funding to support community-level actions to support MHPSS in humanitarian crises.

## Annex 1: Sources of Information

To answer the central question the WG members reviewed and built upon key document such as:

- Systematic reviews that synthesise the scientific evidence on the effectiveness of MHPSS interventions;<sup>6 7 8</sup>
- Key policy documents around MHPSS from interagency platforms<sup>9 10 11</sup> and technical guidance from key international agencies;<sup>12 13 14 15 16 17</sup>
- Reports and conclusions from three major technical meetings:
- One of the recommendations of the The Hague Symposium on adolescents growing up in conflict settings (Netherlands, 2015)<sup>18</sup> was to increase community empowerment. The following three specific actions were proposed: (1) listening and dialogue with the community to understand how they could solve their own problems; (2) linking informal and formal systems driven by community; and (3) documenting examples of community empowerment and engagement in humanitarian emergencies.
- The Wilton Park Dialogue ‘Healing the Invisible Wounds of War’ (United Kingdom, 2018)<sup>19</sup> contained recommendations that included the need for multi-sectoral programming and coordination, for engaging young people, and for strengthening national capacity.
- The Meeting Rebuilding Lives: Addressing Needs, Scaling Up and Increasing Long-term Structural MHPSS Interventions in Protracted and Post-Conflict Settings (Berlin, 2018)<sup>20</sup> addressed ‘People on the Move: Refugees and Internally Displaced Persons’ as one of four thematic areas. Specific actions and recommendations around this area included (a) the recognition that establishing

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6 Bangpan, M., Dickson, K., Felix, L., Chiumento, A. (2017). *The impact of mental health and psychosocial support interventions on people affected by humanitarian emergencies: A systematic review*: Oxfam, Feinstein International Center, UKAID

7 Tol, W. A., Barbui, C., Galappatti, A., Silove, D., Betancourt, T. S., Souza, R., van Ommeren, M. (2011). Mental health and psychosocial support in humanitarian settings: linking practice and research. *Lancet*, 378(9802), 1581-1591.

8 Lee, C., Haroz, E., Nguyen, A., Aules, Y., Tol, W., Bolton, P. (2018) *Scientific Evaluation of Psychosocial Support Programs in Low-Resource Humanitarian Settings. Stage 1: Literature Review and Stakeholder Evaluation*. Baltimore, Johns Hopkins Bloomberg School of Public Health

9 IASC (2007). *Guidelines for Mental Health and Psychosocial Support in Emergency Settings*

10 ASC Reference Group on MHPSS (2015). *Submission for the World Humanitarian Summit*.

11 Sphere Association (2018). *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response* (fourth edition). Geneva.

12 ACT Alliance. (2011). *Community Based Psychosocial Support for ACT Alliance programmes Guiding Principles*. Geneva.

13 Reference Centre for Psychosocial Support (2014). *Strengthening Resilience: A global selection of psychosocial interventions*. International Federation of Red Cross and Red Crescent Societies.

14 IOM (2019). *Manual on Community-Based Mental Health and Psychosocial Support in Emergency and Displacement*.

15 United Nations Children’s Fund (2018). *Operational guidelines on community based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families*. New York, UNICEF.

16 UNHCR (2013). *Operational Guidance: Mental Health & Psychosocial Support Programming for Refugee Operations*. <https://www.refworld.org/docid/53a3ebfb4.htm>

17 UNHCR (2017). *Community-Based Protection & Mental Health & Psychosocial Support*. <https://www.refworld.org/docid/593ab6add.html>

18 Reference Centre for Psychosocial Support (2014). *Strengthening Resilience: A global selection of psychosocial interventions*. International Federation of Red Cross and Red Crescent Societies. <http://www.unicefinemergencies.com/downloads/eresource/docs/MHPSS/Growing%20up%20in%20a%20conflict-20160104112554.pdf>

19 <https://www.wiltonpark.org.uk/wp-content/uploads/WP1581-Report.pdf>

20 <https://www.mhinnovation.net/resources/rebuilding-lives-mhpss-protracted-and-post-conflict-settings>

quality, sustainable national MHPSS services and systems requires long-term commitment and (b) taking new opportunities presented by emergencies to strengthen MHPSS systems. The meeting called for donors to provide long-term (for at least five years), flexible funding to allow for broader and more sustainable capacity development. With regard to the provision of MHPSS, the meeting recommended ensuring accessibility of MHPSS for all by involving and supporting all actors in MHPSS programming, including the host community and various vulnerable groups. The meeting also recommended developing sustainable solutions to make MHPSS services accessible (e.g. inclusion in insurance schemes and in the basic package of health services).

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Iraq, Credit: Cordaid / Mickael Franci

# A Just and Inclusive Society: Supporting Societal Shifts, Addressing Stigma and Discrimination



**Chair:** Julian Eaton, CBM

**Members of Expert Group:** Michael Njenga (Users and Survivors of Psychiatry Kenya), Sarah Rizk (Humanity and Inclusion (HI), Psychology), Marian Tankink (MHPSS and Peacebuilding, Medical Anthropologist, Psychiatric Nurse), Ben Adams (CBM), Christine Ogaranko (Open Society Foundation, Social Worker), Chris Dolan (Director Refugee Law Project) Prakash Goossens (Fracarita), Hippolyte Manirakiza (Fracarita)

## Introduction

The social context in which we live and the quality of relationships we have are central to our mental wellbeing and contribute to risks of developing mental health problems. This is also true in terms of the social context within humanitarian crises. The focus on the individual in the modern mental health field tends to under-emphasise the importance of social and structural drivers of wellbeing and illness. This has many consequences, for example placing the focus of recovery on individual treatment and not on the underlying causes, blaming people for their condition, and not challenging inequity, injustice and abuse that perpetuates social and individual suffering. As a reaction to this, there is now an increased focus on research and potential interventions related to social determinants of mental health and ill health, and it is important that this shift is extended to humanitarian settings, with research and implementation focusing more on creating environments where people can recover and have better mental wellbeing.

## Recent Evidence and Consensus on Social Context, Prevention and Promotion

The Inter Agency Standing Committee (IASC) Guidelines for Mental Health and Psychosocial Support in Emergency Settings<sup>21</sup> lay out an approach that ensures that people receive the most appropriate care for their level of need, with the great majority not needing focused professional treatment, but the re-establishment of basic needs and supportive networks.

The Report of the Special Rapporteur<sup>22</sup> to the Human Rights Council (2019) on the right to the enjoyment of the highest attainable standard of physical and mental health highlighted the critical role of social and underlying determinants of health in advancing the realisation of the right to mental health.

The Lancet Commission on Global Mental Health and Sustainable Development<sup>23</sup> (2018) emphasised that without addressing social determinants, it would not be possible to reduce the burden of mental health conditions and meet wider developmental goals. It advocated a shift in focus to research and interventions to strengthen prevention and promotion of mental health.

The Disease Control Priorities report<sup>24</sup>, 3rd Edition (2016) for the first time included mental and neurological health in its recommendations for the most cost-effective in prevention and promotion.

People with lived experience of mental ill health will often state that it is stigma and social exclusion that is the most damaging to their daily lives. This is aligned with the social model of disability and states that it is the barriers to participation in society experienced by individuals affected that results in disabilities. In many humanitarian crises, aid workers find that people with severe mental health conditions and psychosocial disabilities are excluded from participation in the response and have difficulties accessing services.

Therefore, in emergency response and conflict, the need to respond rapidly to suffering and distress needs to be balanced by recognising that it is in inclusive and just societies that people can find sustained recovery, and that sometimes ‘interventions’ that undervalue the importance of existing, culturally appropriate, mechanisms of support and healing may actually do harm.

Mental health and wellbeing after emergencies rely on just societies that are able to include all members. **The principle of ‘leave no-one behind’** has been emphasised in the Sustainable Development Goals and is applicable to the specific contexts of humanitarian emergencies and protracted conflicts. In these circumstances, when social structures that protect vulnerable populations are weak or have been weakened through crisis, particular attention must be paid to their needs. In 2019, the IASC underwent a major review of recommendations across sectors to strengthen consideration of inclusion of people with disabilities, including those with psychosocial and intellectual disabilities.

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<sup>21</sup> Inter-Agency Standing Committee. Guidelines for mental health and psychosocial support in emergency settings. IASC, 2007

<sup>22</sup> Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Human Rights Council Forty-first session June/July 2019 A/HRC/41/34

<sup>23</sup> Patel et al. The Lancet Commission on Global Mental Health and Sustainable Development. Lancet, 2019

<sup>24</sup> Mental, Neurological, and Substance Use Disorders. Disease Control Priorities, third edition, volume 4. Washington, DC: World Bank.

A second core principle that must increasingly apply to emergency response is **'nothing about us without us'**. Historically, people directly affected by humanitarian and development interventions have had little voice in the decisions taken about interventions developed for them. This is particularly the case for people with mental health problems and other marginalised groups. This is also increased when people are disadvantaged in multiple ways. Structures and procedures can be put in place to ensure proper participation and access to equal rights, for all people, both in the intense phases of emergency response and in the long-term rebuilding of communities. It is communities themselves who best understand what justice, reconciliation and fairness means to them, and local cultural understanding and leadership is central to effective work in restoring communities after emergencies.

## Key recommendations

These proposed recommendations are based on the deliberations of the 'Just and Inclusive Society' group established to support the Summit, and aims to also build on previous consensus, e.g. the BMZ/UNICEF 'Rebuilding Lives' meeting held in Berlin in July 2018, the recent IASC work on inclusion, and reports detailed above.

**Promote wellbeing and recovery during and after emergencies by shifting to a greater focus on the things that promote mental wellbeing (like security, justice and strong communities), and addressing risk factors for mental ill health (like poverty, unemployment and exposure to violence). Policies and practices to do this must ensure that all groups are equally able to meaningfully participate and access response and recovery activities.** A just and inclusive society is inherently more likely to lead to greater wellbeing and recovery after conflicts/human-made and natural emergencies. There must be greater investment in addressing social exclusion of marginalised groups, including through evidence-based anti-stigma work, as an essential complement to access to appropriate treatments for mental health problems. This mainstreaming approach promotes equal access to human rights for all.

**Strengthen the voice and representation of people with disabilities and other excluded groups so that MHPSS programming addresses their particular needs.**

In addition to mainstreaming access to rights, emergency preparedness, response and rebuilding must recognise the particular needs of groups who tend to be excluded. This can only be done by emphasising the essential role of people who are themselves affected in taking a lead in processes and organisations in the field. Concretely this means investing in strengthening Disabled Persons' Organisations (e.g. to include people with psychosocial disabilities), establishing good consultation and representation procedures, and employing people with lived experience in response organisations.

# A Just and Inclusive Society: Addressing Gender-Based Violence



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## Introduction

Gender-based violence (GBV) is a widespread and devastating problem, with wide-ranging consequences for those that have experienced it, their families and the communities affected. Prompted by a situation of chaos, disruptions of existing surveillance and support systems and the absence of the rule of law, GBV in private and public spaces is more likely to happen in situations of armed conflict, natural disasters and other emergencies. Persons who have experienced GBV may be women, girls, men or boys, and they are made vulnerable by the violations they have been exposed to and will necessarily present with varied needs. To address these needs adequately, early mental health and psychosocial support should be provided within a comprehensive response that takes into consideration a range of vulnerabilities, such as age and gender.

GBV typically goes under-reported due to fear of not being believed, fear of being accused of collaboration with the perpetrator, social stigma, and/or lack of support systems.



## Integration of MHPSS into healthcare, protection and community services

Social stigma in terms of GBV is one of the greatest obstacles for survivors to seek support or treatment. However, victims/survivors<sup>25</sup> may seek treatment for physical symptoms (e.g. injuries, fatigue, headaches, urinary tract infections, pregnancies and/or sexually transmitted infections), making health services key in helping to identify and adequately treat and support victims/survivors of GBV. Likewise, it is important to consider the role of family and community support systems, including community and religious leaders, as victims/survivors may turn to them for support and guidance. It is crucial that there is an understanding of mental health and psychosocial aspects of GBV in the community and that mental health and psychosocial support is incorporated into the framework of existing support and services available in health facilities and at community level.

It is critical that responses to GBV adopt a 'do no harm' approach that extends beyond clinical management. Health care activities, whether in health facilities or at the community level, must ensure a protective privacy and confidentiality that enables persons to come forward without fear of backlash, as well as reach out to all persons affected by violence. This approach also includes the importance of engaging those impacted actively in the support and respecting their will and voice. Victims/survivors need to be able to disclose the details of the violence they have suffered to service providers in full confidence and without risking further stigma or reprisals. All those involved in providing support and services need to act in a coordinated to assure a person-centred referral pathway.

## Gender-specific MHPSS for women/girls and men/boys who have experienced GBV

As stated in the IASC Guidelines on gender-based violence, 'women and girls everywhere are disadvantaged in terms of social power and influence, control of resources, control of their bodies and participation in public life – all as a result of socially determined gender roles and relations. Gender-based violence against women and girls occurs in the context of this imbalance. While humanitarian actors must analyse different gendered vulnerabilities that may put men, women, boys and girls at heightened risk of violence and ensure care and support for all survivors, special attention should be given to females due to their documented greater vulnerabilities to gender based violence'.<sup>26</sup>

While GBV against girls and women is especially frequent and is becoming a central protection focus, violence targeting boys and men is often ignored and engagement with male victims/survivors remains rare. This is particularly true in MHPSS for GBV victims/survivors, where cultural norms around the understanding of gender play a major role in determining causes, modalities and consequences of abuses, as well as help-seeking behaviours.

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<sup>25</sup> In this background paper the terms victim and survivor are used alternately. The term victim is more often used in international law, while the term survivor is often used in mental health and psychosocial support.

<sup>26</sup> Inter-Agency Standing Committee. 2015. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery.



It is acknowledged that in most cultures, boys and men will not disclose sexual violence due to notions of manhood, perceived social responsibilities and increased stigma related to their gendered roles. Sexual violence against men is a powerful weapon of war, which has a deep impact on their gender identity and can be related, not only to experiencing abuse, but also to being forced to sexually abuse others or witness sexual abuse against female family members. Men/boys that are victims of violence are at elevated risk of becoming perpetrators of violence. Psychological support in dealing with their psychological injuries may reduce this risk. Cultural norms related to male sexuality can also lead to marginalisation and isolation, and can be aggravated in contexts where same-sex relations are taboo or forbidden by law.

MHPSS programmes on GBV often include men as allies in programmes to end violence against girls and women, or as perpetrators, not as possible victims/survivors themselves. Some efforts have been carried out to highlight this issue, with publications referring to male victims/survivors of GBV and their need for MHPSS, and with some initiatives working on bridging the gap taking into consideration the special challenges they face and their possible needs following GBV. These are important steps; however, more efforts are critical to assure needs are addressed according to gender vulnerabilities.

## Key Recommendations

**Ensure that mental health and psychosocial support is integrated into health and community services, not only for victims/survivors of sexual and gender-based violence, but also wider community services.**

Responses must take into account a wide range of cultural specificities, vulnerabilities and health needs. Parity between health and mental health and psychosocial support services must be ensured. An integrated health response is required to deliver care that is based, not only on the needs, but also on the will of the victim/survivor. An effective response incorporates medical, psychological and psychosocial care, and links the victims/survivor with other relevant and safe services. Those that have experienced GBV may seek treatment for physical symptoms without disclosing what really happened but will nevertheless be in need of more holistic support. Likewise, a health response integrating MHPSS will increase effectiveness and enhance adherence to treatment, providing a more comprehensive support. Thus, health services play a key role in responding to the various needs of those who have experienced sexual violence. Moreover, there should be adequate integration of culturally appropriate approaches into community services. Responses must invest in and reinforce existing community support, being especially inclusive of trusted members of the community to whom victims/survivors may turn to for support. To facilitate access to support services and foster community empowerment, efforts should focus on strengthening local community capacities to address psychological and psychosocial needs, with special attention on including family support and identifying referral pathways. Additionally, MHPSS responses should adopt a specific approach that considers specific gender, age and other vulnerabilities when addressing the needs of survivors/victims of GBV at health care centres, and at community level.

**Ensure provision of mental health and psychosocial support for female and male victims/survivors of GBV and ensure that these take into account gender vulnerabilities.** MHPSS for GBV victims/survivors should always address the needs and experiences of the individual, as well as be contextually and culturally adapted. It is important to strengthen awareness among practitioners of the need for support and assistance that takes into account the specific cultural context and needs of women, men, boys and girls. Of note, men and boys may come to health-centres for treatment of injuries after being involved in any form of violence, as victim/survivors and/or perpetrators. The focus on identification of MHPSS needs should not be limited to symptoms of sexual violence, but also include identification of physical signs that indicate exposure to any form of violence. Collaborations with different actors in communities, such as religious leaders, and community leaders are crucial to reduce barriers to enable men/boys to seek support.

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“MHPSS reduces the emotional suffering of refugees and improves their social functioning; It helps them thrive instead of just survive.”

Peter Ventevogel, Senior Mental Health Officer, UNHCR



# Children, Adolescents and Their Families



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**Children and adolescents<sup>28</sup> make up a very large proportion of crisis-affected populations. They have particular vulnerabilities that may impact their optimal development. This background paper makes the case for focused attention to child and adolescent MHPSS and outlines recommendations for further action.**

## Introduction

### Mental health and psychosocial problems for children and adolescents in humanitarian settings

Current data has revealed that more than 350 million children and adolescents are living in areas affected by conflict globally<sup>29</sup>. Exposure to high levels of adversity (including violence and other distressing events) in childhood or adolescence disrupts development in cognitive, emotional, and social domains. At least 250 million children younger than 5 years of age are at risk of sub-optimal development in low and

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<sup>27</sup> The members of this working group were selected based on their expertise and with the aim of ensuring diversity in terms of geographical experience, professional background and gender. The members do not formally represent any of the agencies or institutions they work with and that the content of this briefing paper is not necessarily endorsed by those agencies or institutions.

<sup>28</sup> Defined as 0-18 years of age

<sup>29</sup> Save the Children (2018) The War on Children Time to end grave violations against children in conflict

middle-income countries. Yet, oftentimes, governments are ill-prepared to respond in a timely manner to meet the MHPSS needs of children and adolescents. Children exposed to poverty, insecurity, violence, and poor parental mental health are most vulnerable to adverse mental health, poor educational outcomes and functional changes in brain regions associated with learning, social interaction and memory.

An adequate response involves promoting the resilience of children and adolescents, the availability of adequate and coordinated mental health and social service systems and caring for and increasing the capacity of caregivers in children and adolescents' direct environment – in order to address the negative impact of violence and ensure nurturing care. Currently, there is a serious lack of capacity for child and family focused MHPSS services and a need for workforce capacity development and improved coordination across health, protection and education sectors to meet the wellbeing needs of the most vulnerable.

## What do we propose?

### 1. Strengthen MHPSS systems for children and adolescents in humanitarian settings (in line with IASC, 2007 principles).

- 1.1. **Involve the social environment of children and adolescents**, emphasising the importance of contextual factors in supporting children and adolescents' healthy development, emphasising the multiple levels at which both risks and protective factors operate – including the level of the child themselves, families, schools, communities and the larger society. When children need support the most, such as when disasters hit, it is family and the community who are closest to children and provide first-line support and care. Indeed, families and communities are first responders. Thus, keeping families and communities at the centre of interventions and in healing and therapeutic approaches is the most feasible and sustainable way forward. In doing so, it is important to support parents and caregivers who are also directly affected by the crisis event and may have difficulties in providing the necessary care to children due to their own distress.
- 1.2. **The importance of 'acting early'**, recognising mental health problems among children and caregivers, and connecting them to entry points for tailored services, is essential for effective prevention and treatment of mental health problems in efforts to overcome the massive treatment gap for children and adolescents. Additionally, acting early in the life-course to address risk factors, translates to prevention of mental health problems later in life,

improved health capital, and potential benefit for the next generation. Pregnancy and the first three years in a child's life are especially important as a period in which the brain develops most rapidly, and the majority of brain development occurs, with enhanced susceptibility to environmental influences and associated epigenetic changes. Nurturing care<sup>30</sup> is what the brain expects and needs for optimal development. The increased neural plasticity during puberty provides a second window of opportunity to improve wellbeing and developmental trajectories, especially in children exposed to early adverse experiences, and ensure adequate cognitive, emotional and social resources for later life.

- 1.3. **Ensure a cross-sectoral approach**, incorporating MHPSS within health, social services/child protection and education services. There is now strong evidence for the manner in which social determinants within humanitarian emergencies (such as poverty, HIV, violence, and forced migration) influence the mental health of populations and are linked to both the health and non-health Sustainable Development Goals (SDGs)<sup>31</sup>. Interagency and cross-sectoral coordination is critical for ensuring effective MHPSS support. The current system lacks mechanisms to hold sectors accountable for their contributions to the broad spectrum of MHPSS needs. Implementing partners should harmonise data collection tools and information across agencies working with children and adolescents.

## 2. Evidence-based work

- 2.1. **Ensuring translation of evidence into practice.** While building evidence on effective programming is accruing, a stronger evidence-base is needed for MHPSS intervention in humanitarian settings. Future studies should focus on strengthening interventions for younger children and for non-traumatic stress complaints<sup>32</sup>. Furthermore, there is a need to balance a research agenda to include more attention on mental health promotion and prevention interventions.

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<sup>30</sup> <https://apps.who.int/iris/bitstream/handle/10665/272603/9789241514064-eng.pdf>

<sup>31</sup> Lund, C., Brooke-Sumner, C., Baingana, F., Baron, E.C., Breuer, E., Chandra, P., Haushofer, J., Herrman, H., Jordans, M.J.D., Kieling, C., Medina-Mora, M.E., Morgan, E., Omigbodun, O., Tol, W., Patel, V., Saxena, S. (2018). Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. *Lancet Psychiatry*, 5,4, 357-69.

<sup>32</sup> Purgato, M., Gross, A.L., Betancourt, T., Bolton, P., Bonetto, C., Gastaldon, C., Gordon, J., O'Callaghan, P., Papola, D., Peltonen, K., Punamaki, R.L., Richards, J., Staples, J.K., Unterhitzberger, J., van Ommeren, M., de Jong, J., Jordans, M.J.D., Tol, W.A. & Barbui, C. (2018). Focused psychosocial interventions for children in low-resource humanitarian settings: a systematic review and individual participant data meta-analysis. *Lancet Global Health*, 6: e390-400.

## Key Recommendations

### Involving the Social Environment

- Ensure that funding is targeted to MHPSS programmes that **incorporate the broader social environment of children**, including a focus on care providers, families, schools, community structures, resources, and the local context and environment. Special attention should go to **promoting family-centred care** that benefits the mental health of parents: focused and tailored MHPSS should be provided to parents/caregivers, particularly mothers, in humanitarian settings that are dealing with an overwhelming amount of additional stress factors, such as having to care for a child under extreme duress and in highly resource-limited settings<sup>33</sup>.
- Provide multi-year funding that includes **evidence-informed capacity development for carers**, which includes self-care/staff care mechanisms for carers (including parents, other primary caregivers, teachers and others).
- **Use human-centred design approaches**: Children and adolescents, caregivers and community members should be effectively and meaningfully engaged in the design and delivery of MHPSS programmes within their contexts to meet their unique needs<sup>34</sup>.

### 'Acting Early'

- Acknowledge and emphasise **early detection and prevention** of MHPSS problems occurring in childhood.
- Ensure dedicated proportion of health, education and protection/social services budgets to focus on **MHPSS for children of different ages and development stages** – with tailored promotion, prevention, treatment approaches from pregnancy to infancy and through to adolescence.

### A Cross-Sectoral Approach

- Prioritise funding to **multi-sectoral programming** initiatives, ensuring mainstreaming and integration within health, education and protection/social services in particular. Child protection and education services should increasingly be used as entry-points for non-specialised MHPSS services for children and adolescents by orienting duty bearers on how to integrate MHPSS into their action plans.
- Ensure that all relevant sectors include **MHPSS considerations and commonly agreed indicators** in their sectoral plans, programming and routine monitoring.
- **Scale-up response strategies** combined with a focus on quality of care, by ensuring that the workforce is properly trained and supervised in delivery of evidence-informed approaches and integrated within structures to better reach children, adolescents and families, including through health, education, protection and social services.

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<sup>33</sup> Alsop-Shields, L. & Mohay, H. (2001). John Bowlby and James Robertson: theorists, scientists and crusaders for improvements in the care of children in hospital. *Journal of Advanced Nursing*, 35, 1, 50–8.

<sup>34</sup> <https://www.who.int/pmnch/mye-statement.pdf>



#### **For Research**

- Humanitarian agencies working on MHPSS for children and adolescents need to adhere to an **evidence-based approach** to working.
- **Research should focus** on establishing and translating evidence based MHPSS interventions for children and adolescents. This includes strategies to overcome barriers to care and support, and strategies towards maintaining quality care at scale.
- MHPSS programmes should be based on up-to-date information on the **vulnerability and resilience of different groups of children, adolescents and their carers** for a better understanding of their unique needs for MHPSS and other services.
- Ensure that MHPSS programmes utilise the most **effective delivery platforms for children, adolescents and families within communities** (e.g. to reach children and adolescents both in and out of school).

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# Research and Innovation: Adapting to the Future of Mental Health



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## Introduction: Why are Research and Innovation Important?

Armed conflicts and disasters are associated with marked psychological and social suffering.<sup>35</sup> In accordance with international recommendations, mental health and psychosocial support (MHPSS) seeks to address diverse needs of individuals, families, and communities through multi-layered complimentary supports that ‘protect or promote psychosocial wellbeing and/or prevent or treat mental disorder’.<sup>36</sup>

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<sup>35</sup> Fiona Charlson et al., “New Who Prevalence Estimates of Mental Disorders in Conflict Settings: A Systematic Review and Meta-Analysis,” *The Lancet* (2019); F. J. Charlson et al., “Post-Traumatic Stress Disorder and Major Depression in Conflict-Affected Populations: An Epidemiological Model and Predictor Analysis,” *Glob Ment Health (Camb)* 3 (2016).

<sup>36</sup> Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, “Iasc Guidelines on Mental Health and Psychosocial Support in Emergency Settings,” ed. IASC (Geneva2007).

Programme planning, monitoring and evaluation are used to assess the progress and outcomes of MHPSS programmes, and if they have achieved the desired results.<sup>37</sup> Dedicated research can be used to identify the most pressing mental health and psychosocial needs of populations, select appropriate MHPSS programmes, develop and test measurement tools that can be used to assess population needs and monitor programmes, test whether interventions work, examine underlying assumptions and how best to implement interventions and disseminate them for widespread use.

## Context: Current Situation

Recent estimates suggest that 1 in 5 individuals in conflict affected settings are living with mental disorder at any given point in time.<sup>38</sup> Additionally, rates of depression, posttraumatic stress disorder, and anxiety disorders are higher in conflict affected populations relative to the global average.<sup>39</sup> According to international recommendations, multi-layered and complementary MHPSS programmes should include psychological and social elements within the context of humanitarian assistance, strengthening existing family and community supports, and providing focused care for those with existing mental health and psychosocial problems<sup>40</sup>. The majority of research on MHPSS to date has evaluated focused MHPSS interventions, such as individual or group psychotherapies delivered by non-specialist providers, with much less research examining the broader impact of MHPSS, despite widespread implementation.<sup>41</sup>

In terms of children, research has demonstrated that focused MHPSS interventions are effective for reducing symptoms of posttraumatic stress disorder and functional impairment, and improving hope, coping, and social support in humanitarian settings<sup>42</sup>. Whereas for adults, psychological

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37 "A Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings," ed. IASC (2017).

38 Charlson et al. Fiona, Mark van Ommeren, Abraham Flaxman, Joseph Cornett, Harvey Whiteford, and Shekhar Saxena. "New Who Prevalence Estimates of Mental Disorders in Conflict Settings: A Systematic Review and Meta-Analysis." *The Lancet* (2019).

39 Ibid.; Vindya Attanayake et al., "Prevalence of Mental Disorders among Children Exposed to War: A Systematic Review of 7,920 Children," *Medicine, Conflict and Survival* 25, no. 1 (2009).

40 Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, "Iasc Guidelines on Mental Health and Psychosocial Support in Emergency Settings.," Surendra Sherchan et al., "Post-Disaster Mental Health and Psychosocial Support: Experience from the 2015 Nepal Earthquake," *WHO South-East Asia Journal of Public Health* 6, no. 1 (2017).

41 M. J. Jordans, H. Pigott, and W. A. Tol, "Interventions for Children Affected by Armed Conflict: A Systematic Review of Mental Health and Psychosocial Support in Low- and Middle-Income Countries," *Curr Psychiatry Rep* 18, no. 1 (2016); W. A. Tol et al., "Mental Health and Psychosocial Support in Humanitarian Settings: Linking Practice and Research," *Lancet* 378, no. 9802 (2011).

42 M. Purgato et al., "Focused Psychosocial Interventions for Children in Low-Resource Humanitarian Settings: A Systematic Review and Individual Participant Data Meta-Analysis," *Lancet Glob Health* 6, no. 4 (2018).

therapies have been shown to effectively reduce posttraumatic stress disorder, depression and anxiety symptoms in humanitarian settings<sup>43</sup>. Among research studies evaluating psychosocial support, person-focused interventions (including non-specific supportive counselling programmes) have been most frequently investigated.<sup>44</sup> Evidence from the literature on psychosocial support interventions suggests that interventions focused on improving parent/child interactions, interpersonal relationship, and stress management in low- and middle-income countries may be effective in reducing mental health symptoms and improving life skills and daily functioning for both children and adults.<sup>45</sup> Some evidence exists for the use of other psychosocial support interventions, such as child friendly spaces for improving children's wellbeing,<sup>46</sup> the provision of quality psychological first aid in complex emergencies<sup>47</sup> and integrated mental health and disaster preparedness interventions for improving preparedness, mental health symptoms, and social cohesion in the context of natural hazard induced disasters.<sup>48</sup>

## What are the most critical research gaps?

Among adults, the short-term effectiveness of psychological therapies in reducing symptoms of mental disorder have been identified, however further research is needed to assess the longer-term effectiveness of these therapies.<sup>49</sup> Key challenges, identified by stakeholders in assessing the effectiveness of psychosocial support, include: a lack of capacity; limited resources; a lack of consensus on the definition of psychosocial support; a lack of culturally and contextually appropriate measurement tools; and minimal coordination with governments and ministries.<sup>50</sup> Confidence in MHPSS programme effectiveness could be improved by replicating results and conducting high quality studies.

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43 M. Purgato et al., "Psychological Therapies for the Treatment of Mental Disorders in Low- and Middle-Income Countries Affected by Humanitarian Crises," *Cochrane Database Syst Rev* 7, no. 7 (2018).

44 C. Lee et al., "Scientific Evaluation of Psychosocial Support Programs in Low-Resource Humanitarian Settings Stage 1: Literature Review and Stakeholder Evaluation.," (Johns Hopkins Bloomberg School of Public Health, 2018).

45 Daisy R. Singla et al., "Implementation and Effectiveness of Adolescent Life Skills Programs in Low- and Middle-Income Countries: A Critical Review and Meta-Analysis," *Behaviour Research and Therapy* (2019).

46 Janna Metzler et al., "Short- and Longer-Term Impacts of Child Friendly Space Interventions in Rwamwanja Refugee Settlement, Uganda," *Journal of Child Psychology and Psychiatry* 0, no. 0 (2019); J. Metzler et al., "Evaluation of Child Friendly Spaces: An Inter-Agency Series of Impact Evaluations in Humanitarian Emergencies," (New York and Geneva: Columbia University Mailman School of Public Health and World Vision International, 2015).

47 Rebecca Horn et al., "The Myth of the 1-Day Training: The Effectiveness of Psychosocial Support Capacity-Building During the Ebola Outbreak in West Africa," *Global mental health (Cambridge, England)* 6 (2019).

48 Courtney Welton-Mitchell et al., "An Integrated Approach to Mental Health and Disaster Preparedness: A Cluster Comparison with Earthquake Affected Communities in Nepal," *BMC psychiatry* 18, no. 1 (2018).

49 M. Purgato et al., "Focused Psychosocial Interventions for Children in Low-Resource Humanitarian Settings: A Systematic Review and Individual Participant Data Meta-Analysis," *Lancet Glob Health* 6, no. 4 (2018).

50 C. Lee et al., "Scientific Evaluation of Psychosocial Support Programs in Low-Resource Humanitarian Settings Stage 1: Literature Review and Stakeholder Evaluation.," (Johns Hopkins Bloomberg School of Public Health, 2018).

Additional research is needed to better understand the real-world effectiveness of MHPSS interventions, how these interventions can be better integrated with other programmes across humanitarian sectors, and how these interventions can be effectively and responsibly scaled-up to reach large numbers of people in humanitarian settings.<sup>51</sup> The needs of the elderly, marginalised and vulnerable populations, and those with severe mental disorders and substance use problems have been previously neglected populations in MHPSS research and therefore, also deserve further study.<sup>52</sup>

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<sup>51</sup> Tol et al; L. E. Chase et al., “Building Back Better? Taking Stock of the Post-Earthquake Mental Health and Psychosocial Response in Nepal,” *Int J Ment Health Syst* 12 (2018).

<sup>52</sup> W. A. Tol et al., “Mental Health and Psychosocial Support in Humanitarian Settings: Linking Practice and Research,” *Lancet* 378, no. 9802 (2011).

## Recommendations

- Where positive effects of MHPSS programs have been identified, interventions should be implemented, and research should be conducted to improve their design and delivery.
- The development of new interventions for humanitarian settings should consider their implementation in settings of highly constrained resources and damaged health systems.
- MHPSS program design, implementation, and evaluation should be supported by strong relationships between MHPSS practitioners, research scholars, and decision and policy makers working in humanitarian support.

### Further research is specifically needed to investigate:

- MHPSS effectiveness when integrated with humanitarian programming in other sectors.
- The challenges of using evidence-based psychosocial support interventions delivered by non-specialist providers in resource-constrained settings.
- The development of tools and guidelines for assessing the quality of evidence based MHPSS interventions when implemented in real world settings.
- How to effectively and responsibly scale-up existing interventions to enhance their reach in humanitarian settings.
- The effectiveness of locally available and locally utilised supports, including non-formal supports (e.g. social networks and traditional supports) and their long-term impacts.
- The needs of neglected populations (e.g. the elderly, marginalised and vulnerable groups, those with severe mental disorders, physically disabled and substance use problems).

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Uganda, Credit: Cordaid / Arie Kievit

# Workforce Development





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## Introduction

Almost all individuals affected by crisis will experience psychological distress.

When basic services, security, community and family supports are restored, this distress usually improves over time. However, recent data on the prevalence of mental disorders in conflict settings now suggest the burden of mental disorder in emergencies is higher than previously estimated. One person in five (22%) are estimated to have depression, anxiety, posttraumatic stress disorder, bipolar disorder or schizophrenia at any point in the 10 years following the emergency period<sup>53</sup>. Findings show that supporting the mental health and psychosocial support (MHPSS) needs of all people is necessary to reduce suffering, improve functioning and save lives. This includes people living in camps, host communities or urban areas, and in transit in low, middle and high income countries. MHPSS needs to be addressed in all phases of emergency response and substantial investment in a

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<sup>53</sup> Figures from: Charlson, F., van Ommeren, M., Flaxman, A., Cornett, Jo., Whiteford, H., & Saxena, S. (2019). New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. *The Lancet*, Published Online June 11, 2019. [http://dx.doi.org/10.1016/S0140-6736\(19\)30934-1](http://dx.doi.org/10.1016/S0140-6736(19)30934-1).

competent workforce is imperative to ensure the provision of quality MHPSS services and care. This is especially urgent in contexts with limited or low quality mental health services that lack capacity.

## Workforce Development

Workforce development refers to processes or activities that have the potential to develop work-based knowledge, expertise, productivity and job satisfaction; and is generally aimed to benefit organisations, communities, individuals, or the ‘whole of humanity’<sup>54</sup>. Workforce development may include supporting people in pre-service training (e.g., part of curricula at academic/training institutions), in-service training (e.g., for existing workers who may have never provided MHPSS or who have never worked with emergency-affected people) or for individuals seeking to participate in new workforce opportunities (e.g., ‘new’ trainees).

Building on literature and evidence, the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings<sup>55</sup> and in consultation with MHPSS programme responders working in the field, a single but comprehensive recommendation is put forth to support workforce development for MHPSS programmes during and after emergencies.

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<sup>54</sup> Gary N. McLean & Laird McLean (2001) *If we can't define HRD in one country, how can we define it in an international context?*, *Human Resource Development International*, 4:3, 313-326, DOI: 10.1080/13678860110059339

<sup>55</sup> Inter-Agency Standing Committee (IASC) (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: IASC.

### Key Recommendation

**Ensure a competent MHPSS workforce to deliver quality MHPSS services across the humanitarian development nexus by working with and building local capacity; assuring competency-based training with supervision; and financially supporting the immediate and long term MHPSS workforce needs of programmes.**

Working with and building local capacity – Identifying, working with and strengthening the capacity of local staff, community members (including refugees) and people with lived experience of MHPSS difficulties is a first step. Local people share local language, cultural understanding and behaviours, and familiarity of culturally sensitive practices. This results in stronger adaptation of MHPSS approaches, known to be valuable and to improve outcomes for crisis-affected communities, families and people receiving

MHPSS care<sup>56</sup>. Local engagement will also help facilitate service user engagement in the emergency response and MHPSS programmes and encourage integration of the MHPSS workforce into local services, systems and structures. Further, local workforce development is a well-established ingredient for ‘building back better’<sup>57</sup> mental health services.

Assuring competency-based training with supervision – Training for focused MHPSS helpers needs to predominantly address the development of skills, not just increasing knowledge. Training should therefore include assessments that demonstrate competency and trainee readiness to safely deliver support or interventions. Multiple approaches to training for different cadres of MHPSS helpers are important; and could include informal training for, for example, lay helpers, formal education (e.g., tertiary education for general health and mental health professionals) and supervised practice-based training (i.e., in-service training involving continued development while working with clients). Additionally, coordinating with other organisations, local institutions or workforce structures can facilitate learning pathways (e.g., from lay-helper to certified practitioner to tertiary education). Long-term quality assurance should be guided by a central inter-agency database or repository where organisations can record quality and competency levels, combined with minimum standard recommendation, leading to increased quality and refinement of evidence based care. This will likely assist in maintaining the competency of the MHPSS workforce; particularly if competency-based trainings are aligned with local institutional requirements.

Supervision in the mental health and social care sectors is a well-established best practice. It directly influences the safety, quality and effectiveness of MHPSS services and care, protecting both clients and the MHPSS workforce. Supervision involves helpers meeting regularly to discuss client challenges and ensure fidelity to therapeutic approaches. It provides opportunities for continued competency development and protects clients from poor practice or misconduct<sup>58</sup>. Supervision is commonly provided by a professional mental health worker, social care professional, protection specialist or a local worker with well-advanced MHPSS helper skills. Supervision is known to improve self-efficacy<sup>59</sup>

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<sup>56</sup> Rathod, S., Gega, L., Degnan, A., Pickard, J., Khan, T., Husain, N., Munshi, T., & Naeem, F. (2018). The current status of culturally adapted mental health interventions: a practice-focused review of meta-analyses. *Neuropsychiatric Diseases and Treatment*, 14, 165-178. DOI: 10.2147/NDT.S138430

<sup>57</sup> World Health Organization (WHO). *Building back better: Sustainable mental health care after emergencies*. WHO: Geneva, 2013.

<sup>58</sup> Norris, D.M., Gutheil, T.G., & Stransburger, L.H. (2003). This Couldn't Happen to Me: Boundary Problems and Sexual Misconduct in the Psychotherapy Relationship. *Psychiatric Services*, 54(4), 517-522. <https://doi.org/10.1176/appi.ps.54.4.517>

<sup>59</sup> Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R., & Chisholm, R. R. (2009). Using client feedback in psychotherapy training: An analysis of its influence on supervision and counselor self-efficacy. *Training and Education in Professional Psychology*, 3(3), 157-168. <http://dx.doi.org/10.1037/a0015673>

and reduction of burnout in helpers<sup>60</sup>; indicating its links to staff care and well-being; and might also be viewed as an organisation's duty of care to MHPSS helpers and an occupational health and safety obligation. Beyond this, there is evidence that supervision is associated with effectiveness of client care and outcomes<sup>61</sup>. Despite the known benefits of supervision, it is commonly perceived as costly, a 'nice to have' and is frequently the first cut in a budget. However, supervision is a 'must have' for all MHPSS programmes. It should be always available whenever or wherever MHPSS services are provided.

Financially supporting immediate and long term MHPSS workforce needs – Global guidelines recommend: a) that community awareness about MHPSS is promoted (which is essential for work by a MHPSS workforce to be accepted in the community); and that b) all humanitarian staff receive training on international protection standards, codes of conduct and ways to integrate psychosocial support into an emergency response. It is further recommended that all staff learn to provide humane psychosocial support (e.g., psychological first aid). In the immediate aftermath of crises (and at regular intervals in protracted crises) response staff must be funded and facilitated to attend trainings, receive appropriate supervision and provide services. Short-term funding (i.e., < 6-months) is important to meet this need. However, to expand the pool and quality of available MHPSS workers and thus meet increased MHPSS service demands, extended and sustained funding is a condition to develop and maintain the MHPSS workforce.

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<sup>60</sup> Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Juggessur, T., Fothergil, A., & Coyle, D. (2006). Clinical supervision and burnout: the influence of clinical supervision for community mental health nurses. *Journal of Clinical Nursing*, 15(8), 1007-1015. <https://doi.org/10.1111/j.1365-2702.2006.01370.x>

<sup>61</sup> Snowdon, D.A., Leggat, S.G., & Taylor, N.F. (2017). Does clinical supervision of healthcare professionals improve effectiveness of care and patient experience? A systematic review. *Biomed Central (BMC) Health Services Research*, 17:786. DOI: 10.1186/s12913-017-2739-5

While it is often essential to conduct rapid training and supervision in MHPSS in the midst of emergencies<sup>62</sup>, refinement of MHPSS skills is a longer process. Beyond delivery of training, sufficient funding, for more than 1 year, is necessary to: realise competency-based MHPSS workforce development; support workforce development across the levels of the mental health system; and provide continuous advancement of capacity through months of supervised practice and implementation of services. This is especially important for programmes assisting individuals with chronic mental health conditions or vulnerabilities (e.g., disabilities, family separation, history of torture or sexual violence). With sustained, flexible and predictable funding, MHPSS and treatment provided by skilled and consistent staff will yield better outcomes, minimise staff turnover and

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<sup>62</sup> Sphere Association. *The Sphere Handbook: humanitarian Charter and Minimum Standards in Humanitarian Response*, fourth edition, Geneva, Switzerland, 2018. [www.spherestandards.org/handbook](http://www.spherestandards.org/handbook)

enable greater overall quality of MHPSS services. Should the intention for sustainability of the workforce be prioritised, MHPSS programmes, staff and services may only fully cross the emergency-recovery-development nexus with comprehensive funding cycles of 3 to 5 years.

Donors, governments, organisations and leadership need to highly value the effectiveness of MHPSS programmes, not just numbers of individuals reached. To be effective, programmes must have quality, which can be measured based on the competency of the workforce providing services, client satisfaction, or various people and service-oriented MHPSS indicators<sup>63</sup>. The majority of funds for any quality MHPSS programme will, and should be, invested in the MHPSS workforce in the short, intermediate and long-term.

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<sup>63</sup> Refer to the IASC Common Monitoring and Evaluation Framework for MHPSS in Emergency Settings for a range of impact and process indicators that can assess programme quality. [https://www.who.int/mental\\_health/emergencies/IASC\\_MHPSS\\_M\\_E\\_30.03.2017.pdf](https://www.who.int/mental_health/emergencies/IASC_MHPSS_M_E_30.03.2017.pdf)



Credit: Unicef

**Protection and  
Promotion of Mental  
Health and Wellbeing  
of Staff and  
Volunteers in the  
Face of Trauma,  
Hostile Environments  
and Chronic Stress**



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## Introduction

Staff and volunteers who respond to humanitarian needs work in difficult, complex and sometimes dangerous environments. They face a triple burden:

- 1) they are often exposed to traumatic events as they provide life-saving assistance and emotional support to affected populations;
- 2) they are often members of affected communities themselves and may, therefore, experience the same losses and stressors as the people they are supporting; and
- 3) they work long hours under extremely challenging conditions, often with inadequate resources or limited training. All these factors combine to create cumulative to chronic stress and are well documented.<sup>64 65 66 67 68</sup>

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<sup>64</sup> Ager, A., Pasha, E., Yu, G., Duke, T., Eriksson, C. & Lopes Cardozo, B. "[Stress, mental health, and burnout in national humanitarian aid workers in Gulu, northern Uganda.](#)" *Journal of Traumatic Stress*. 2012, 713-720.

<sup>65</sup> Brooks, S. K., Dunn, R., Amlôt, R., Greenberg, N., & Rubin, G. J. (2016). Social and occupational factors associated with psychological distress and disorder among disaster responders: a systematic review. *BMC Psychology*, 4(1), 18. doi:10.1186/s40359-016-0120

<sup>66</sup> Cardozo, B.L., Crawford, C.G., Eriksson, C., Zhu, J., Sabin, M., Ager, A., Foy, D., Snider, L., Scholte, W., Kaiser, R., Olf, M., Rijnen, B. & Simon, W. "[Psychological Distress, Depression, Anxiety, and Burnout among International Humanitarian Aid Workers: A Longitudinal Study](#)" *Public Library of Science One*, September 2012, 7(9).

<sup>67</sup> Connorton, E., Perry, M. J., Hemenway, D., & Miller, M. (2012). Humanitarian relief workers and trauma-related mental illness. *Epidemiologic Reviews*, 34(1), 145-155. doi:10.1093/epirev/mxr026

<sup>68</sup> Strohmeier, H. & Scholte, W. F. (2015) "[Trauma-related mental health problems among national humanitarian staff: a systematic review of the literature.](#)" *European Journal of Psychotraumatology* 6

Employers have an organisational duty of care for their staff and volunteers, especially when they work in high-risk situations, with ongoing stressors related to protracted conflict or crisis. Failing to address the mental health and psychosocial needs of staff and volunteers in an organisation where the workforce regularly experiences high levels of stress may cause an increase in sickness levels, problems with work performance, risk-taking behaviour and security incidents due to impaired judgement.

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## Best Practice Approaches

Although there is no one size fits all approach, best-practice approaches for staff and volunteer care<sup>69</sup> are founded on proactive, integrated, systematic approaches that address organisational and structural issues, create a supportive and protective organisational culture and include the provision of basic psychosocial support to staff and volunteers. Recognising that the needs of various staff and volunteers are likely to be different, it is essential that cultural and contextual factors are considered and that the specific mental health and psychosocial needs following critical events are addressed. This includes providing explicit guidelines on reporting critical or potentially stressful incidents and ensuring that all managers and supervisors are trained in appropriate front-line responses to critical incidents or other situations that have led to acute stress.

During and after potentially traumatic incidents, staff with training in psychological first aid should be made available and arrangements should be in place with specialists to provide culturally relevant mental health and wellbeing assistance as required.

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## Best Practice Example for Staff and Volunteer MHPSS Care

One example of a systemic, efficient approach is the Colombian Red Cross psychosocial programme, which targets both Red Cross volunteers and paid staff. It provides psychosocial support in emergencies and disasters, and in programme areas, including 'Mental Health to Red Cross.' Within the programme, there are three levels of training; 1) is very basic, and focuses on introduction and orientation, identifying risk factors related to mental health, referral to professionals and awareness-raising campaigns; 2) focuses on community-based counselling, psychosocial workshops and psychological first aid; and 3) is about professional support.

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<sup>69</sup> Antares Foundation. (2012). *Managing stress in humanitarian workers – Guidelines for good practice*. Third edition. Retrieved from: <https://www.antaresfoundation.org/>



## Resources must be dedicated and integrated into all programme budgets to sustainably support mental health and psychosocial wellbeing of staff and volunteers across all sectors

It is widely recognised globally that protecting and promoting the mental health and psychosocial wellbeing of staff and volunteers across all sectors is not only important, but a prerequisite for efficient and sustainable humanitarian impact. Ensuring the wellbeing of the workforce yields higher-quality programmes and leads to better outcomes for affected populations. Too often, appropriate support and care systems for staff and volunteers are not in place on the ground due to various barriers, including limited understanding of the issue, lack of acknowledgement from management, organisational and structural barriers and a lack of funding or effort dedicated to staff and volunteer wellbeing.

### Best Practice Examples: Staff Care Policies and Dedicated Funding

In response to the Syrian crisis in 2016, the urgent need to develop a staff care policy and to build capacity to address the needs of humanitarian workers in the region was recognised. A cooperation between **WHO and Antares Foundation** resulted in:

- Design of a generic policy on staff wellbeing for humanitarian NGOs in the region (45 NGOs were involved).
- Capacity building within the organisations: In 2017 and 2018, 60 trainers received a one week Train the Trainers on Self-Care/Staff Care training in the region.
- Development of a Self-Care Trainers Manual.
- Over 100 Self Care trainings in South West Turkey and 15 in North West Syria have been rolled out so far. This is coordinated by WHO and funded by WHO and European Civil Protection and Humanitarian Aid Operations (ECHO)

As a result of the build-up of capacity, self-care and staff care modules can now be incorporated into relevant mental health programmes and trainings in South West Turkey and North West Syria.

The **Icelandic Red Cross** ensures it dedicates funding to staff and volunteer care within its international programmes. One example is within the Integrated Community Health and Epidemic Readiness Program in Uganda, which is a consortium between the Ugandan, Canadian and Icelandic Red Cross. Funding support is provided for:

- Ongoing training of staff and volunteers to deliver psychosocial support and care.
- Individual staff and volunteer emotional support sessions, including monthly stress management sessions, retreats to conduct team building and self-care sessions, continuous coaching and mentorship to psychosocial volunteers.
- Physical support structures for psychosocial staff and volunteers including protective equipment and visibility materials, bicycles for staff and volunteers to implement the project, and tents for psychosocial volunteers.
- A working group on staff and volunteer care.

## Key Recommendations

- Systemic approaches should address both routine sources of stress and unexpected stressful situations, while not interfering with the natural recovery processes that most staff and volunteers will experience.
- Organisations should equip staff and volunteers with the necessary skills to cope with stressful situations and encouraged to take responsibility towards their own wellbeing and the wellbeing of others.
- A mental health professional should contact all surviving staff/volunteers one to three months following the incident. The professional should assess how the survivor is feeling and functioning and make referrals for clinical treatment for those with substantial mental health issues, such depression or alcohol use that are not improving over time.<sup>70</sup>
- Policy makers and donors have a vital and active role to play in minimizing and addressing the barriers and thus in supporting more efficient, sustainable and higher-quality programmes. This role can actively be played out through: 1) advocacy for the inclusion of staff and volunteer mental health and wellbeing programs and initiatives; 2) establishment of funding preconditions that require the inclusion of budget lines and/or activities in projects and programs that promote staff and volunteer mental health and wellbeing; and 3) support for quality research into the effectiveness of these initiatives and interventions. Published research is urgently needed to support both activities on the ground and to promote wider advocacy efforts to raise awareness and put this on the agenda for managers, organisations, stakeholders, and other donors and policy makers.

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<sup>70</sup> Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings (2007)

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Iraq, Credit: Cordaid / Mickael Franci

# Investment in Mental Health and Psychosocial Support: How to Increase Funding for Immediate and Longer-Term Needs?



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## Introduction

This paper addresses three key questions concerning scaled-up investment for Mental Health and Psychosocial Support in Humanitarian Emergencies: 1) why invest; 2) what and how much to invest; and 3) how – and how not – to invest?

## Why invest in Mental Health and Psychosocial Support in Crisis Situations?

Mental health forms an intrinsic part of personal and collective wellbeing; everyone should have the right to enjoy good mental health so that they may flourish as individuals and citizens. From an economic perspective, mental health can also be regarded as an important asset or resource that contributes to the human capital of an individual, family and/or community members. Many evidence-based, good quality and cost-effective interventions are available to promote and protect good mental health.

Crisis situations place enormous, and often unbearable strains, on mental health, thereby jeopardising their wellbeing and substantially increasing the risk of psychological distress and diverse mental health conditions. This in turn impacts the ability of individuals to contribute to the economic wellbeing of their family or community and to be financially independent. It also places a large additional strain on already over-stretched, broken or absent health and social welfare systems.

Even before crises, many resource-constrained countries do not have adequate or appropriate mental health systems in place. Crisis increases the strain on such systems, making it even more difficult to cope with the increased needs. However, crisis can present an important opportunity to build more sustainable mental health systems in line with human rights and universal health coverage principles.

It is the right of all people to have access to appropriate mental health care and support, regardless of circumstances, and it should also, therefore, be a priority in crisis situations. The consequences of not making appropriate investments in MHPSS are plainly apparent, as is demonstrated by current crisis situations. For example, Yemen has been devastated by war and conflict over several decades and is currently the world's worst humanitarian emergency with immense multi-sectoral needs. Yet, the mental health needs of the affected population have been severely neglected. Due to lack of investment and political will there has been little, if any, advocacy or funding to support MHPSS responses. With limited government ability to act and limited MHPSS actors with the capacity and funding to respond, the vast majority of those with emotional distress and mental health conditions have nowhere to turn for support.

## What and how much to invest in Mental Health and Psychosocial Support in Crisis Situations?

Mental health and psychosocial support (MHPSS) provides a vital component of a response to crisis situations; it is concerned not just with direct impacts on traumatic stress and depression, but also with pre-existing mental health conditions and crisis-induced social issues (such as discrimination against certain groups or disruption of livelihoods and social networks). The mental health and psychosocial support needs of affected individuals or populations, therefore, implies and requires both acute and longer-term planning, resource mobilisation and programmatic implementation.

As indicated by the Inter-agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings and other frameworks, such as WHO's Service Organization Pyramid for an Optimal Mix of Services for Mental Health, investment needs to happen at all levels of care, rather than being solely directed towards community psychosocial support or on clinical care for one condition, such as depression or posttraumatic stress disorder (PTSD).

Key elements of both a minimum and a comprehensive MHPSS response have been clearly identified and communicated, but to date there has been insufficient information on the resource requirements and associated costs of such a response. Part of the work on a Minimum Service Package (MSP), funded by the Netherlands and the UK Governments, is to help address this. Estimation of the cost implications of a minimum MHPSS response, including by sector, activity type and phase, can greatly assist local agencies, national authorities and international partners in the appropriate planning, mobilisation and allocation of resources over time.



## How (and how not) to invest in Mental Health and Psychosocial Support in Crisis Situations?

The history of earlier responses to crises is littered with reactive, sector-specific and vertical approaches to financing. Most importantly, there is a fundamental disconnect between the long-term needs for MHPSS support following a crisis (e.g. 10 or more years) and the relatively short-term nature of humanitarian funding cycles (e.g. 3 months to 1 year). MHPSS funding must be anchored in needs-based resource planning, greater resource pooling (e.g. between donors) and phased allocations over time.

Coordination of plans and financing can be greatly facilitated by the formation of a MHPSS Technical Working Group, to be prioritised as part of the immediate humanitarian response (not some months later). To improve programmatic efficiency, multi-level, multi-sectoral and multi-partner investment should be encouraged and leveraged via common planning and integration or mainstreaming of MHPSS within the core agendas of relevant clusters or sectors, especially health, protection and education. It is vital this work be done wherever possible in conjunction with national authorities to ensure a sustainable response that builds back a better MHPSS system for the future. In short, the goal of sustainable financing is the development of community-based MHPSS services that affirm the rights of users to have access to economic and social opportunities and to be integrated into host societies wherever migration has occurred.

Practical mechanisms for enabling more sustained and sustainable MHPSS financing require improvements in the links or transition between Humanitarian and Development actors, processes and funding from the outset of a crisis. Specific measures that can help to strengthen these links include: taking greater account of the duration of crises when designing programmes and therefore funding cycles using humanitarian and development aid (i.e. anticipating and planning for 5-10 years, not 6 months); engaging all relevant clusters in funding MHPSS (e.g. protection and education); improving the links between MH and PSS; strengthening national systems (through institutional funding, legislation and policies in line with international frameworks e.g. WHO comprehensive mental health plan 2013-2030, and through sustainable service provision including ongoing training and supervision); and avoiding the construction of parallel systems. In Lebanon for example, the government has seen an opportunity within the humanitarian crisis (with the influx of refugees equivalent to a third of the Lebanese population) to strengthen the national mental health system and bridge humanitarian and development funding to develop services accessible to both the host and the refugee populations.

In the absence of sufficient domestic funding, and particularly at times of humanitarian crisis, conflict or other emergencies, external donor funding is a necessity. There is currently no dedicated mental health fund or financing mechanism. Potential options to enhance the flow of needed funds include: 1) leveraging existing financing mechanisms/funding, with the aim of improving efficiency as well as the better integration of mental health emergency and longer-term development requirements (e.g. by updating criteria for emergency and development pooled funds); 2) exploring the development of a Trust Fund (or Foreign Investment Fund if the size of funds raised is likely to

be very substantial) to enable a dedicated pooled fund for MHPSS; 3) incentivising nongovernmental funding for MHPSS in emergencies through matched funding or a Giving Pledge; and 4) improving longer-term funding through a new financing mechanism, such as an international financing facility such as a Mental Health Capital Account or Mental Health Guarantee Facility.

## Key recommendations

- Place MHPSS financing on a more secure foundation via a) resource needs estimation and budgetary planning (e.g. as developed for a Minimum Initial Service Package) by those participating in a MHPSS response; b) return on investment analyses to better establish and monitor funding requirements plus returns over time; c) longer or extended funding duration (using both humanitarian and development sources); d) alignment of proposals with cluster-level needs overviews and response planning as well as existing guidelines (e.g. IASC) and international human rights norms and standards; and e) coordination with MHPSS national coordination mechanisms and alignment with national plans where available.
- Dedicate funding and include budget code tracking for MHPSS within large budget requests in a) humanitarian response plans and needs overviews; b) central emergency response funding requests; and c) budgets of operational agencies and organisations (e.g. UN agencies).
- Consider making use of existing trust funds that could be directed towards mental health; and develop for discussion terms of reference for a new trust fund and /or matched funding initiatives to encourage greater government and nongovernmental (non-profit) funding.

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Liberia, Credit: World Bank / Dominic Chavez

# Delivering MHPSS in Public Health Emergencies: Specific Needs & Requirements



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## Introduction

An outbreak of a highly infectious disease, such as Ebola Virus Outbreaks, requires programmes to be developed in order to address the mental health needs of the survivors and their families, the communities affected and the responders themselves (both local and international). There are typically high levels of stigma directed towards all responders (international and national) and in particular intensely experienced by survivors and their families. MHPSS programmes should be integrated into services offered by health and other core sectors. MHPSS is also relevant to public health information campaigns and community engagement, as well as informed by anthropological research. MHPSS programmes need to provide support before, during and after an outbreak response.

Additionally, in a public health emergency such as Ebola or Zika Virus Outbreaks, there are groups at higher risk of MHPSS problems. For Zika Virus Outbreaks these include parents, prospective parents (i.e. reproductive health advice) and children impacted, along with health workers supporting (often) deeply affected families. MHPSS programmes have to be designed and developed to address these needs.

Of special concern, are outbreaks occurring as part of a wider and more complex emergency, such as the current Ebola outbreak in the Democratic Republic of the Congo in the midst of a civil war, hampering efforts to control and end the outbreak and to provide MHPSS.

### What is different about delivering MHPSS in Public Health Emergencies?

Disease outbreaks can lead to significant mental and psychosocial effects in a number of ways:<sup>71</sup>

- Fear of the virus is associated with the experience of intense distress.
- Exposure to any severe stressor is a risk factor for a range of long-term mental and psychosocial problems (including anxiety and mood disorders, as well as acute stress and grief reactions).
- Physical isolation due to virus containment concerns of individuals, families or communities exposed to a virus is a further risk for psychosocial problems.
- Social problems may emerge after a population is exposed to the virus and the disease control response: for example, breakdown of community support systems, social stigma and discrimination associated with the disease.
- There can be a drastic decline of income generation within communities due to travel and work restrictions, loss of family and community members and the collapse of businesses.
- Health services use may go down and, as a result, many people may die from malaria and other communicable diseases, resulting in (further) bereavement for surviving populations

### What MHPSS needs do the affected populations (including responders) have?

Exposure to extreme stressors is risk factor for a broad array of short-term and chronic mental health conditions, and accordingly, the affected population needs access to community mental health services.

For a highly infectious disease such as Ebola Virus Disease, the MHPSS needs of affected populations include reliable, valid and understandable information, to understand how to prevent, detect and treat the virus. This will reduce prevailing anxiety, which must be reduced for an effective public health response, which also requires acceptance of interventions that stop the spread of the disease in a way that may be counter to traditional or local practices.

A second overall need for the affected population is the introduction and practice of highly effective stigma reduction programmes. Such programmes need to include the long-term restoration of communities, and survivors' return to their communities. Stigma reduction applies both narrowly to reducing stigma surrounding mental health and more widely in reducing stigma surrounding a specific disease and its survivors e.g. Ebola Virus Disease. Stigma reduction takes time. This means work on stigma reduction needs to be a long-term investment, over at least 1-year, post-outbreak response. This is particularly important given the viral load of Ebola virus which can remain within the (especially male) victims for many months and therefore, long-term effects on survivors can be considerable (both physical and mental). The use of Community Healing Dialogues (CHD), based on the principles of socio-therapy, was perceived to be effective in overcoming isolation of survivors in the 2014 Ebola response.

While the needs of survivors and their families are perhaps relatively clear, it is also critical to address those of the responders. In the case of the Western African Ebola outbreak in 2014, there are many examples of Community Health Workers (CHWs) who were unable to cope, thereby abandoning their posts and/or who contributed to worsening the epidemic due to their fear-based behaviours.

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<sup>71</sup> IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings (2015). "Mental Health and Psychosocial Support in Ebola Virus Disease Outbreaks: A Guide for Public Health Programme Planners." Geneva.

The effectiveness of the response was reduced because of the consequent reduction in numbers of health workers. Extremely frightened CHWs can risk their own lives and others by not following the health advice provided regarding prevention, detection and treatment themselves.

### Example of Impact of Stress and Lack of MHPSS for Health Workers

In some countries, where public health emergencies occur, the same populations have previously experienced conflict and this can contribute to increasing the mental health needs of the population and responders. For example, in Liberia the Carter Center reported that many of the Community Health Workers reported stories of how, in the face of Ebola, they often experienced their own flashbacks to the war or other situations of acute stress reinforcing the urgent need for their mental health support.

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## Best Practice Example of Providing MHPSS Support in an Health Emergency

One inspiring initiative during the 2016 Zika response was the “AMA – União de mães de anjos”, which is a parenting support/advocacy group model using a holistic community-based approach. It provides assistance to families of infants with microcephaly, victims of the Zika Virus, serving more than 400 families throughout the state of Pernambuco, and with the goal of building a policy of quality care for these babies and their families. “Juntos – programa” was another initiative that encourages carers and families of children with congenital Zika syndrome to better understand the needs of their children, support one another and advocate together for their rights and those of their children. Moreover, caring for parents and children affected by Zika can be emotionally challenging for health workers and they may also need MHPSS programmes targeting their needs.

### What do MHPSS Responders Require to be Effective in a Public Health Emergency?

Of primary concern for MHPSS responders are information, strong coordination and resources to enable an effective response. This means the early establishment of the necessary international and national coordination mechanisms and quick access to resources. A second concern is often the lack of trained personnel. For example, in Liberia there was only one local psychiatrist for the entire country. Yet, the backbone of the MHPSS Ebola response were mental health clinicians (e.g. nurses previously trained in mental health) and available psychosocial workers. MHPSS programmes need the access and resources to train lay workers to provide psychological interventions and to provide refresher training for social workers and any other available professionals trained in mental health.

Another concern is that Public Health Emergencies can stem from a rapidly evolving outbreak where scientific knowledge and medical practice is constantly being updated, especially where there is a sudden rise in cases in a disease that hitherto was only known to affect a very small, relatively isolated population. Therefore, an MHPSS response will need to be able to adapt in short order. Given the complexity of dealing with a rare, highly infectious disease outbreak such as Ebola Virus Disease, or a previously unknown disease such as Zika, in the first instance MHPSS responders require early and ongoing interaction with medical, social and anthropological experts involved. As knowledge regarding the prevention, diagnosis and treatment of the disease evolves over time, they need access to new information as it emerges to inform their own programmes.

Another concern is where there are physical safety issues in the areas in which they are operating, MHPSS personnel, therefore, also need regular updates and reporting on the situation on the ground and adequate security and protection is vital.

A final concern is access to, and regular collaboration with, the local authorities from the onset as a long-term response is required. The psychological welfare of Ebola patients and survivors is a long-term issue, with often years of side effects and/or permanent changes to their physical and mental health. This is alongside high levels of stigma and mistrust from their former friends and colleagues, their families and communities. Similarly, the impact of Zika on the lifetime of children and their parents can be considerable. MHPSS responders need to work to develop both short- and longer-term interventions with the cooperation of not just medical and health personnel, but often family and social welfare organisations. In all public health emergencies there is a need to recognise that there may be persons with mental health conditions whose conditions are exacerbated by the emergency and whose needs must be addressed.

## Key recommendations

- International organisations need to sustain rosters that identify specialised MHPSS personnel, able to deploy at short notice, with relevant technical, language and cultural competence.
- International organisations need to provide funding for the development of MHPSS programmes that should contribute to the prevention, detection and response to the disease, as well as stigma reduction during and after the outbreak.
- It is essential have adequate ongoing psychological support for international and national responders (including pre- and post-tour/outbreak).
- Bilateral and multilateral donors should support countries in integrating MHPSS into the National Emergency Preparedness Plans, as the importance of interventions are often only realised after the crisis; and to promote greater collaboration among agencies responding to the crisis in planning, resources and information sharing.
- All MHPSS actors need to work with national or local governments to: manage stigma reduction from the outset; collaborate in the design and delivery of MHPSS interventions; ensure a whole of government approach to the long-term needs of all affected individuals and communities including long-term mental health impacts and the re-integration of survivors into the community.
- As the emergency begins to wane, funders and programme planners must have recovery strategies that encompass “building back better” mental health services, because the mental health consequences of public health emergencies are long-term.

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“Mental health and psychosocial needs can double in populations affected by conflicts, disasters and other emergencies. If left untreated these invisible wounds have far reaching and longer-term negative impacts for individuals, communities and entire societies. Acting on mental health is simply an expression of our shared humanity.”

Elhaj As Sy, Secretary-General of the International Federation of Red Cross and Red Crescent Societies (IFRC)







