Inclusive Futures
Promoting disability inclusion

Disability Inclusion Helpdesk Report

Query	**What works to prioritise mental health and psychosocial support (MHPSS) in emergencies and fragile and conflict affected states (FCAS)? A rapid evidence review**
Authors	**Veronica Ahlenbäck, Emma Haegeman and China Mills**
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Query	What works to prioritise mental health and psychosocial support (MHPSS) in preparedness, response and recovery in emergencies and fragile and conflict affected states (FCAS)? What are examples of effective interventions in this area?

Contents

OVERVIEW

- **Psychological distress, mental health conditions and psychosocial disabilities** are common among emergency-affected populations; most will experience some form of psychological distress and some will develop mental health conditions and psychosocial disabilities as a result of trauma and intersecting social determinants. Conflict and emergencies may also exacerbate pre-existing mental health conditions.
- **WHO's Mental Health Action Plan (2013-2020) calls States to consider mental health in humanitarian emergencies,** and to include MHPSS in emergency preparedness. IASCs guidelines on MHPSS in emergencies give guidance to designing, implementing and assessing MHPSS initiatives.
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- **Emergencies often damage existing systems for mental health and psychosocial support (MHPSS) services,** and States struggle to fulfil their obligation to provide these services in times of emergencies.

Existing guidelines and emerging evidence around MHPSS in emergencies suggest the following key approaches:

- **National emergency preparedness plans must include mental health** to ensure effective response.
- **Multi-sectoral and integrated approaches** are required to address social determinants of mental health and provide MHPSS services to people who have experienced emergency-related psychosocial distress and trauma.
- **Community-level engagement** strengthens delivery and uptake of MHPSS.
- MHPSS services that are **contextually relevant and meaningful** are crucial for MHPSS uptake and outcomes.
- **Group-based MHPSS interventions have several benefits,** including allowing participants to build support networks.
- **Include mental health in recovery plans** and build long-term commitment and strategies for mental health reform.

There are **several limitations in the emerging evidence base** around MHPSS in emergencies, including:

- **Research and evaluations are largely focused on Western-based MHPSS interventions** and ignores locally and contextually adapted approaches, leaving a knowledge-gap around how contextual aspects influence MHPSS uptake.
- A multi-sectoral approach to providing MHPSS is widely promoted by existing guidelines, however, **there is limited documentation and evaluations of multi-sectoral and integrated programmes**.
- IASCs guidelines on MHPSS in emergencies give guidance to designing, implementing and assessing MHPSS initiatives.
- Emergencies can provide a window of opportunity to initiate mental health reform if the increased interest and funding for

Summary[1] of issues and commitments

Mental health is directly and indirectly impacted by humanitarian emergencies and conflict, and is further influenced by ongoing social determinants, such as poor housing and overcrowding (Persaud et al. 2018a). Mental health conditions are common among conflict-affected populations, and almost everyone affected by an emergency will experience some form of psychological distress in response to traumatic events **(**Charlson, van Ommeren, Flaxman, Cornett, Whiteford and Saxena, 2019; WHO, 2019). Psychological distress is a natural reaction to trauma and stress, and for most people affected, this will improve with time (WHO, 2019). However, for some people the psychological response can be severe or prolonged and result in mental health conditions and psychosocial disabilities. Recent prevalence estimates of mental health in conflict settings suggests that 22% conflict-affected populations experience a mental health "disorder" at any point in time (Charlson et al., 2019). The most common forms are mild depression, anxiety and post-traumatic stress disorder (PTSD) (13%), followed by moderate forms of the same conditions (4%). The prevalence of severe forms of depression, anxiety and PTSD, as well as schizophrenia and bipolar disorder is estimated to be 5% (ibid.). People with pre-existing mental health conditions and psychosocial disabilities are particularly vulnerable when a crisis hits (Andrade de Moraes Weintraub et al., 2016). In addition to ongoing challenges such as poverty, discrimination and lack of health care, which may be worsened by disaster or conflict (Persaud et al., 2018a), supply of treatments and medication can become disrupted (WHO, 2019).

Despite the impact of humanitarian emergencies on mental health and wellbeing, mental health is often a low priority in the immediate onset/aftermath of a crisis, risking long-lasting effects for affected populations (Persaud et al., 2018b). State capacity and willingness to address mental health is often weak in fragile and conflict affected (FCAS) states and international and non-governmental organisations (NGOs) often play a crucial role in providing support around mental health. The World Health Organisation (WHO) is the international lead in providing mental health support in emergencies and humanitarian crises. The WHO co-chairs the Inter-Agency Standing Committee (IASC) Reference Group on Mental Health and Psychosocial Well-being in Emergency Settings, which was created to bring the United Nations (UN) and NGOs together to provide guidance on working on mental health in emergencies (WHO, 2019). IASC has produced a number of guidelines and tools including the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007) and IASC Reference Group Mental Health and Psychosocial Support Assessment Guide (2012) and the Humanitarian Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialised Health Settings (mhGAP-HIG), published by WHO and UNHCR in 2015 (WHO and UNHCR, 2015). The guide builds upon the general principles set out by IASC but provides more practical advice on assessment and treatment options for the most common psychosocial disabilities experienced by crisis-affected populations.

International commitments and relevant guidance are in place. For example, Article 12 of the UNCRPD states that "State Parties shall take, in accordance with their obligations under international law…all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.' The WHO stresses that humanitarian emergencies, whether caused by conflict or natural disasters, disrupt local systems for support and the needs of the affected population will commonly overwhelm the local system's capacity to provide basic services such as MHPSS (WHO and UNHCR, 2015). The UN's Special Rapporteur on the right to physical and mental health emphasises that the obligation to ensure the right to health for conflict-affected populations primarily lies with States involved in the conflict (UN General Assembly, 2013).

The WHO Mental Health Action Plan 2013-2020 (WHO, 2013a) includes mental health in humanitarian emergencies as a proposed action. It emphasises the importance of working with national emergency committees to include MHPSS in emergency preparedness, ensure access to MHPSS services during and following an emergency, and promoting long-term support for mental health systems after an emergency and the need for MHPSS services for health workers and humanitarian workers (ibid.). Mental health among humanitarian workers themselves has recently gained more attention, however, there is still limited research (Strohmeier and

[1] Please note this short report is based on a light-touch, rapid review of the publicly available evidence, involving 3 person days (2 researcher days, 1 expert day). It is one of four similar reviews examining the evidence on the four outcome areas articulated in DFID's draft theory of change on mental health: rights and participation, leadership and governance, services and community interventions, FCAS and humanitarian contexts. The reviews provide a snapshot of some of the key issues and focus on summarising findings from systematic reviews, evidence syntheses and key global thematic reports, including frameworks and guidance.

Scholte, 2015) and most studies focus on international workers, although the majority of people working in humanitarian response are national staff (ibid.). The research on volunteers is also limited, though evidence indicates volunteers reporting higher levels of mental health complaints than employed staff (Overseas Development Institute, 2018). This points towards the importance of making sure that MHPSS services for humanitarian workers are accessible to both international and national staff as well as volunteer workers.

Providing mental health and psychosocial support (MHPSS) alongside addressing social determinants of distress is seen as an essential part of emergency response and humanitarian aid (IASC, 2010). IASC defines mental health and psychosocial[2] support (MHPSS) as "any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder" (IASC, 2010, p. 1). IASC urges humanitarian actors working in the field of mental health to encourage actors in other sectors to use the IASC Guidelines, as engagement across sectors is crucial, particularly in order to address social risk factors on mental health and wellbeing (IASC, 2010). IASC has pinpointed "establish coordination of intersectoral mental health and psychosocial support" as a core component in establishing response to mental health issues in emergencies (IASC, 2010, p. 5).

What works

There is limited evidence of what works to prioritise MHPSS in emergencies and conflict. While most humanitarian emergencies take place in Low-and Middle-Income Countries (LMICs), most research and evaluations are based on methods developed in high-income, non-emergency settings (Dickson and Bangpan, 2018). There is thus a lack of evidence that looks at the full range of MHPSS interventions. This section will first focus on available, though limited, evidence of effective MHPSS interventions in humanitarian settings. Secondly, it will outline the principles and approaches set out in the guidelines on MHPSS in humanitarian settings. These appear to be widely agreed upon as good practices, however, there is limited documentation and evaluation of implementation.

Evidence from LMICs shows interventions can positively affect mental health and related outcomes. A 2017 DFID-funded systematic review found evidence that MHPSS interventions can reduce functional impairments and emotional problems in children, and PTSD, depression, anger and partner violence in adults (Bangpan et al., 2017).

Community-level engagement strengthens delivery and uptake of MHPSS. Studies found engagement with local communities are a key ingredient for implementation of MHPSS programmes and effective uptake in humanitarian contexts (Bangpan et al., 2017; Dickson and Bangpan, 2018). The 2017 systematic review found that community awareness raising, can be a vital initial step to overcome barriers such as stigma and silence (ibid). A programme to rehabilitate and reintegrate former child soldiers into communities in Mozambique found community members first needed to understand the impact that being a child soldier has on children, in order to accept their reintegration into the community (ibid.). Targeting children and youth and building trust and engagement with parents has been identified as an essential component for children's uptake of services (Bangpan et al., 2017; Dickson and Bangpan, 2018).

Culturally appropriate and relevant MHPSS activities. A2017 systematic review highlights the importance of tailoring MHPSS activities to the local context and culture to maximise uptake of the services (Bangpan et al., 2017). This means that interventions must be meaningful according to local understandings of wellbeing, including identifying cultural and social barriers to the uptake of MHPSS services in design. A programme in Mozambique, helped reintegrate former child soldiers into communities, using traditional 'cleansing ceremonies', recognised as a culturally meaningful method to rebuild trust between children and community members (ibid.). Studies have found that when MHPSS programmes are based on Western-based approaches without appropriate consideration of local context and culture, they risk having limited impact (Dickson and Bangpan, 2018). A post-conflict programme in Sierra Leone, found training materials based on counselling techniques from Western contexts were not suited to the local culture, and had to be adapted by service providers (ibid.).

[2] The term 'psychosocial' brings attention to the close interconnectedness between psychological and social processes and how the two processes are at a constant interplay with each other (IASC, 2010).

Group-based MHPSS programmes. Studies across different emergency settings have highlighted the benefits of providing group-based MHPSS to emergency- and conflict- affected populations (Bangpan et al., 2017). These allow participants to build support networks with peers, facilitate social cohesion, and provide spaces for experience sharing in a safe environment (ibid.). Evaluations of group-based programmes targeting women in post-genocide Rwanda found participants valued sharing their stories with others who had been through similar experiences and highlighted the importance of space to do this outside the community (ibid.).

It is important to note that MHPSS programmes have varied outcomes on different mental health conditions psychosocial disabilities among different affected populations, and outcomes can vary between types intervention. The systematic review by Bangpan et al. (2017) found that MHPSS programmes that targeted children and youth had most impact on functional impairment, slightly reduced PTSD, psychological distress, conduct problems and somatic complaints, and may reduce emotional problems, but had little or no impact on anxiety and depression (Bangpan et al., 2017). Programmes that targeted adults were found to be likely to reduce PTSD, depression and anger, may improve anxiety, common mental health problems, fear and avoidance, grief and emotional problems, but have little or no impact on social support (ibid.). Though most studies focused on short-term impact and that the strength of evidence was inconsistent. Bangpan et al. (2017) stresses that need to further explore longer term outcomes and impacts by gender and age group. A recent systematic review looking at impact on different groups of children in humanitarian settings (Purgato et al., 2018) found that MHPSS interventions can be effective across age, gender and displacement status, but that children aged 15-18, not living in displacement and those from smaller households tend to benefit more (ibid.).

The following are practices and approaches promoted by existing guidelines on MHPSS in humanitarian settings, but with limited empirical evidence currently available.

Include mental health in national preparedness plans. Comprehensive preparedness plans help countries initiate effective response and progress on the path towards recovery faster when an emergency strikes (UNISDR, 2015). According to The Sendai Framework for Disaster Risk Reduction 2015-2030, a key component in preparedness is to ensure necessary capacities for response are in place at all levels and be ready to take early action at the first signs of an emergency (Aitsi-Selmi and Virginia Murray, 2015). The document emphasises that response and recovery must be planned for in advance, and that psychosocial support and mental health services is a crucial component of effective response and recovery (UNISDR, 2015). For example, WHO is providing support to countries in the Caribbean to prepare for how to provide MHPSS in events of disasters (WHO, 2019).

Multi-sectoral and integrated approaches to MHPSS in emergency response. The guidelines on mental health in emergency promote the need for different sectors to provide MHPSS services in a complementary manner. Including health, education, protection, and livelihood programmes (IASC 2010; IASC 2007; Overseas Development Institute, 2018). IASC advise that interventions should be as integrated as possible, at the systems level in order to reach more people (IASC, 2007). However, there has been little systematic documentation and evaluation of implementation of integrated approaches (Overseas Development Institute, 2018). A study on MHPSS in the Syrian refugee response noted that the everyday stresses of living in displacement contributes to psychological distress, however, this is often interpreted as conflict-related PTSD (ibid.). The study argues that this risks a focus on clinical interventions, when targeting the sources of everyday stress in refugee camps, might be more effective (ibid). Case 2 under 'effective interventions' provide an example of a multi-sectoral and integrated approach in Syria.

Include mental health in recovery plans. The UN's Special Rapporteur on the right of everyone to physical and mental health, highlights the need for State recovery plans to prioritise mental health, and develop detailed, time-bound plans that focus on reconstruction of infrastructure and health systems, with a roadmap for making mental health services available and accessible (UN General Assembly, 2013). The Special Rapporteur stresses the importance of participation of affected communities in the development of such plans to increase transparency and promote accountability (ibid.). In a report about post-emergency recovery, WHO (2013) identifies common practices in cases where countries have managed to prioritise mental health in their recovery from emergencies (WHO, 2013b). These practices include:

- Long-term commitment for mental health reform;
- Adopting a broad focus on mental health needs rather than establishing services that only target certain mental health conditions;
- National and local professionals take leadership in the reform;

- Coordination across international organisations and government agencies;
- Recognising and training health workers to respond to mental health needs (ibid.)

The report recognises the importance of strengthening national governments' capacity to provide MHPSS in the long-term, for instance by supporting policy processes for mental health reform and support for human resources and expertise (WHO, 2013b). Another common factor for maintaining mental health as a priority was advocacy for mental health reform, by a range of actors including government officials, NGOs, health workers and mental health service users (ibid.).

Effective interventions

Example 1: Development of community mental health services in post-conflict Bosnia and Herzegovina. Post-conflict Bosnia and Herzegovina has seen a rapid increase in mental health needs in the 20 years following the conflict in the Balkans (Placella, 2018). The conflict has had a multigenerational impact, on those that experienced conflict firsthand and the younger generations experiencing mental health difficulties, as a result of transgenerational trauma (ibid.). The most common mental health conditions are depression, anxiety and stress-related concerns, with growing substance and alcohol use among young people. Exacerbated by high levels of domestic violence, unemployment and poverty (ibid.). Emergency mental health care were provided during the conflict, but the post-conflict period required a major reform of the mental health system to meet the needs of the conflict-affected population (De Vries and Klazinga, 2006). Reform was initiated in 1995 with funding and technical support from bilateral and multilateral donors. This allowed a shift from institutionalisation to community-based mental health. This came with changes in the organisation of healthcare, often based on funders models of healthcare financing and administration. The deinstitutionalisation required a reorganisation of the mental health workforce, and international organisations trained existing and new staff in community-based mental healthcare (ibid.). The reform has seen the establishment of 73 community-based mental health centres which provide MHPSS to 3.8 million people. And is now moving from the needs in the direct aftermath of the crisis to a broader focus on prevention and promoting wellbeing. The shift to community-based MHPSS has been combined with efforts to tackle social stigma surrounding mental health and subsequent discrimination against people with psychosocial disabilities (Placella, 2018). A large-scale awareness campaign about mental health is seen to have changed public and healthcare provider perceptions alike, and media reporting (ibid.). The reform has been highlighted as a 'good practice' in deinstitutionalisation (see Placella, 2018), though this evidence review was not able to identify an independent evaluation.

Example 2: Sustainable post-emergency scale-up of mental health services in the Philippines. In 2013, a category five typhoon hit the Philippines, killing 6,201 people and displacing 4.1 million people (Andrade de Moraes Weintraub et al., 2016), an estimated 14.1 million were affected by the disaster. The immediate emergency response to the disaster included initiating mental health support services, with WHO providing psychological first aid (WHO, 2014). Service providers saw an increase in people seeking support for mental health conditions after 6 months, in line with experiences from similar disasters that show that most mental health problems start occurring about 6 months after the incident. The joint efforts saw a major upscale of mental health services in the Philippines. As of 2019, every general health care facility in the disaster affected area provide integrated mental health services by trained health care workers, showing that mental health remains prioritised six years after the disaster (WHO, 2019).

Example 3: Increased access to mental health care services in Syria through an integrated approach. WHO estimates that more than half of Syria's population are in need of MHPSS, and one in four children at risk of developing a mental health condition (WHO, 2017). Despite the ongoing conflict, the availability of MHPSS is more extensive than before the conflict as WHO and other humanitarian actors have rolled out support (WHO, 2019). This has meant a shift from institutionalised mental health care largely centred in urban areas to community-based mental health care. MHPSS is now widely provided in primary and secondary health care facilities, as well as by women's centres and community-based organisations (WHO, 2019). With mental health services available in 150 primary and secondary health care facilities in 11 administrative areas, including those worst affected by the conflict (WHO, 2017). WHO's Mental Health Gap Programme has trained 1,000 non-specialist general health practitioners to identify and provide MHPSS services, under the supervision of national specialists (ibid.). WHO has trained more than 60 psychologists to provide specialist care, and about 2,000 health workers to become skilled in mental health first-aid, coupled by an initiative to train teachers and social workers

to identify psychosocial disabilities among children, provide basic care, and refer to specialist mental health care when needed (ibid.). The integration of mental health in primary and secondary health care, community-based organisations and training of specialist and non-specialist mental health workers constitutes an example of an integrated and multisectoral approach to mental health reform, as promoted by IASC's guidelines.

Risks and enablers: MHPSS in emergencies and FCAS

Lack of resources and continued instability in post-conflict and post-emergency settings put health systems, including mental health systems and MHPSS services, under severe pressure (UN General Assembly, 2013). These circumstances pose significant challenges to providing basic services to the population and rebuilding health systems. Emergency situations can also present opportunities to strengthen mental health systems during and after crisis. The increased attention to mental health, combined with the influx of aid can be used to develop a stronger mental health system (WHO, 2019), although it is crucial that the immediate spike in interest and funding is transformed into long-term strategic efforts in order to be sustainable (WHO, 2013b). For example, in Sri Lanka, WHO supported the government to undergo a mental health reform following the tsunami in 2004. The reform led to a doubling in the number of districts that have mental health infrastructure in place (ibid.).

Pre-existing inequalities and marginalisation experienced by people with psychosocial disabilities is exacerbated in situations of conflict or disaster. Human rights abuses against people with mental health conditions and psychosocial disabilities are common in communities and health care settings. In many countries, people lack access to mental health services all together, or can only access services in institutionalised settings (Persaud et al., 2018a). Discrimination and social exclusion of people with psychosocial disabilities, and sometimes their families, lead to higher levels of poverty among people with mental health conditions (ibid.). Ongoing challenges in accessing basic rights such as housing, food and health care for people with psychosocial disabilities are likely to worsen in times of crisis due to increased economic stresses, displacement and disrupted health systems. Countries that struggle with ensuring basic needs and protecting the human rights of people with psychosocial disabilities (commonly LMICs) are also more vulnerable to conflict and disasters (ibid.). Given pre-existing inequalities and the disproportionate impact conflict and disaster have on individuals with psychosocial disabilities, Persaud et al. (2018) argue that mental health should be a priority and strategic goal of foreign aid in conflict countries and emergencies, instead of an "afterthought" after more "pressing" needs are addressed (Persaud et al., 2018b).

Challenges in engaging government to be part of MHPSS strategies and programmes. There are numerous accounts of failed attempts to engage with government to coordinate and deliver MHPSS programmes in emergencies and FCAS. A systematic review found that unresponsive government authorities is a common barrier faced by MHPSS programme coordinators and providers (Bangpan et al., 2017). This is partly attributed to the fact that mental health remains a stigmatised issue in many contexts, and people within the government lack the will, knowledge and skills to address and prioritise mental health in emergency response and recovery (ibid.).

Lack of trained mental health workers and specialists. The mental health sector is severely underfunded in many LMICs and suffers from a chronic lack of human resources. In Sierra Leone, a study notes that low salaries coupled with stigma led to few medical students specialising in psychiatry (Bangpan et al., 2017). In cases where programmes have been adequately resourced with mental health staff, studies still found concerns on the level of knowledge and skills (ibid.). Findings from Sierra Leone, Haiti and Uganda found providers of mental health care identified weaknesses in their ability to identify and treat mental health issues (ibid.). Retaining staff after training is another barrier (ibid.). There is, however, emerging evidence of better human resourcing improving access. For example, there is growing evidence that trained and supervised community workers can provide brief psychological treatment for depression (WHO and UNHCR, 2015).

The current evidence base on MHPSS initiatives in humanitarian settings largely focuses on approaches to trauma-treatment that have been developed and tested in HICs, and that may not be appropriate in different cultural contexts (Dickson and Bangpan, 2018). An identified barrier to making interventions contextually relevant was the use of pre-defined scales of wellbeing that have been developed in other contexts, rather than exploring what 'well-being' means for people in the local context (Overseas Development Institute, 2018)

Ethical challenges with doing research on mental health in LMICs and emergency settings. Evidence generation on mental health in emergencies needs to pay close attention to ethical considerations, drawing on local knowledge. Chiumento et al. (2016) identify six ethical challenges that researchers on mental health in post-conflict and emergency settings need to navigate, ranging from who conducts the research to how to carry out ethical reviews where ethical review boards are non-existent or lacking capacity. They also emphasise the importance of locally-tuned research approaches, such as using local researchers as they speak local languages and are well placed to navigate cultural norms and safety issues as well as build trust with research participants.

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