Mental Health and Psychosocial Support
&
the World Humanitarian Summit

IASC Presentation
3 June 2015

Presentations

Pillar 1: Humanitarian Effectiveness *Margriet Blaauw*

Pillar 2: Reducing vulnerability and managing risk *Guglielmo Schininà*

Pillar 3: Transformation through innovation *Mark van Ommeren*

Pillar 4: Serving the Needs of People in Conflict *Sabine Rakotomalala*

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Pillar 1: Humanitarian Effectiveness

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Introduction

- What are the issues that we face?

- What has been coming out of the WHS consultations?

- How can we collectively improve humanitarian effectiveness?

What are the issues that we face?

- Emergencies cause emotional and psychological suffering, for individuals, families and communities

- The majority of people will experience psychological stress

- It is estimated that the number of people with common mental disorders increases from a baseline to 15-20 %.

- People with severe and chronic mental and neurological conditions are especially vulnerable

- Emergencies damage or destroy the social supports and material resources needed for coping and recovery

- Affected people and local actors need to rebuild society in fragile and disorganized settings

"Being able to take proper decisions, to adapt to changing situations and to provide for yourself and your children is of utmost importance for survival in emergencies. Mental Health can be a matter of life and death."

Dr. Rabih El Chammay, Head of the National Mental Health Programme, Ministry of Public Health Lebanon

What are the issues that we face?

Guidelines and effective recommended interventions exist, but:

- Needs in emergency settings routinely greatly exceed the response capacity

- Staff and volunteers in direct contact with the affected are often not prepared to deal with people in distress; they often are members of the affected population

- Difficult coordination when more sectors are involved

- Cross-cutting fatigue

What has been coming out of WHS consultations?

Emerging Recommendations on Humanitarian Effectiveness

- Creating a more inclusive, diverse and effective humanitarian system, capable of responding rapidly to what the future may hold:

  - Adapting the humanitarian system to new contexts, actors and challenges

  - Ensuring affected people, particularly women, have a stronger voice and influence over humanitarian action

  - Creating an enabling environment for investment in innovation

How can we enhance humanitarian effectiveness?

1: Ensure inclusion of Mental Health and Psychosocial Support to increase effectiveness of all aspects of the response

- Systematic inclusion across sectors; information sharing and dissemination of best practices in response to a crisis

- Aimed at individual and collective recovery

- Strengthen capacity of local Mental Health and Psychosocial Support coordination mechanisms to provide technical guidance in line with the IASC Guidelines.

- Identifying, supporting and including local best practices to address mental health and psychosocial support

- Establishment of surge capacity on Mental Health and Psychosocial Support to facilitate coordination from the early onset of a disaster.

How can we enhance humanitarian effectiveness?

2: Engage local actors and build their capacity for sustained Mental Health and Psychosocial Support systems and supports

- Assessing needs as well as local capacities and resources when planning programming

- Support capacity development of local agencies and organizations

- Provide support to staff and volunteers by enabling them to recognize, deal and cope with stress and the psycho social consequences deriving from the specific humanitarian context

- Engagement of affected populations, families and communities, women and men, older persons, children and young people, and people with disabilities, in promotion of psychosocial well-being and self-care

- Engagement of local actors in coordination platforms and the cluster system

"The core principles of a Mental Health and Psychosocial Approach do not necessarily advocate for humanitarian actors to do different things; rather they advocate for humanitarian actors to do things differently."

Sarah Harrison, former Co chair IASC RG MHPSS
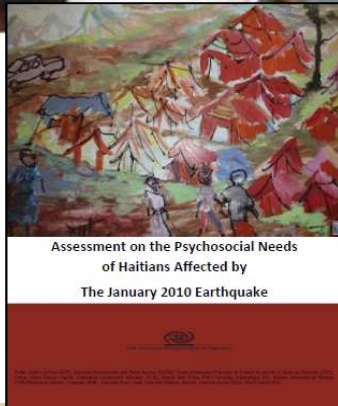
Pillar 2: Reducing Vulnerability and Managing Risk

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Reducing Vulnerability and Managing Risk

Preparedness: be prepared to get it right in conflicts.
(WHS Second Meeting, Point i)

Activity: **Map existing MHPSS services, systems, supports and capacities before an emergency to facilitate the activation of resources and referral of people with mental health and psychosocial problems.**

Example: **Haiti: how we did not get it right in psychiatric institutions**

MHPSS as new pathway to resilience

Recreational activities in the center and distributions in the Moltakana Center in Tripoli, May 2015

Integration of MHPSS considerations in relief and reconstruction

- includes the meaningful participation of affected people in devise the intervention,
- can promote resilience, recovery and functionality of individuals, families and communities

Example: Libya: *Psychosocial Assistance for Crisis-Affected Children and Youth and T... Families in Libya*
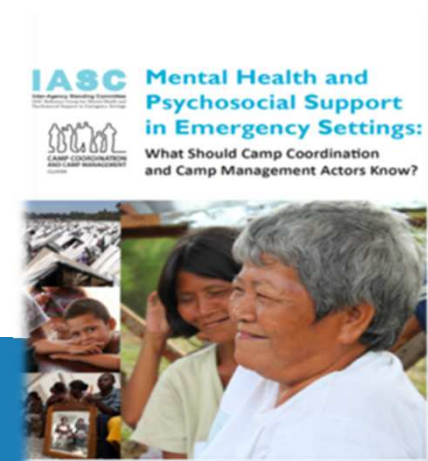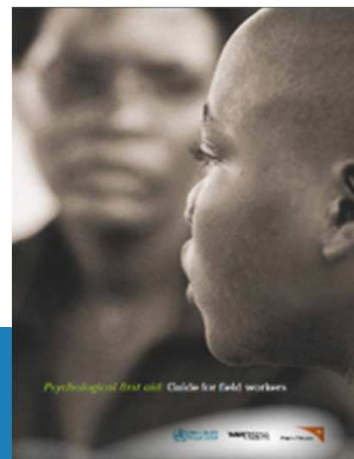
Capacity building

Training for shelter managers

Training in PFA, supportive communication and MHPSS mainstreaming for staff in direct contact with the affected population.

Activity: **MHPSS training for CCCM actors**

Examples: **Haiti, South Sudan, Syria**

Cities in Crisis:
adapting to an urban world

Caveat: **not everyone lives in camps. The challenges in cities in crisis bring to the necessity to adapt tools to an urban world**

(WHS Second Meeting, Cross-cutting issues)

More recommendations for reducing vulnerability and managing risk:

- **Build Mental Health and Psychosocial Support capacities as part of general health care and social services and Community Based Organizations (CBOs).**
- **Facilitate including a mental health plan for emergencies as part of the national mental health plan in order to ensure cohesiveness between the emergency plan and the country's mental health system.**

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Pillar 3:Transformation through innovation

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Low-intensity Psychological interventions

Mark van Ommeren (WHO)

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The problem

- Most adults and children with severe, chronic disabling distress receive no care
  - 2-way association with violence and social exclusion

- In emergencies: no resources to deliver evidence-based psychological care at scale

IASC Guidelines - page 10

3. Do no harm

Humanitarian aid is an important means of helping people affected by emergencies, but aid can also cause unintentional harm (Anderson, 1999). Work on mental health and psychosocial support has the potential to cause harm because it deals with highly sensitive issues. Also, this work lacks the extensive scientific evidence that is available for some other disciplines. Humanitarian actors may reduce the risk of harm in various ways, such as:

- Participating in coordination groups to learn from others and to minimise duplication and gaps in response;

- Designing interventions on the basis of sufficient information (see Action Sheet 2.1);

- Committing to evaluation, openness to scrutiny and external review;

- Developing cultural sensitivity and competence in the areas in which they intervene/work;

- Staying updated on the evidence base regarding effective practices; and

- Developing an understanding of, and consistently reflecting on, universal human rights, power relations between outsiders and emergency-affected people, and the value of participatory approaches.

IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

Staying updated on the evidence base

- Rapidly growing evidence base for psychological interventions from an increasing range of contexts
  - Before 2003, no LAMIC trials
  - Now : 30+ trials from LAMIC that suggest generalizability of many previous findings
    - E.g. CBT also appears to work outside West
    - Increasing evidence for low-intensity interventions

- **Research increasingly suggests that psychological interventions can be effectively delivered by non-specialists, using limited resources**

Towards low resource-intensity psychological interventions

Conventional high intensity interventions

- By specialists

- One manual per problem

- Often many sessions

Innovative low intensity interventions

- Reduced reliance on specialists (rather: lay people, IT, self-help guides etc)

- One manual for multiple problems (where possible)

- Fewer sessions

- Explicit focus on skills for self-management

Implementation: our values

- High quality, feasible and cost effective interventions.

- High quality empirical research to investigate efficacy and effectiveness.

- Visible partnerships with
  - Governments
  - Top researchers
  - Foundations and NGOs.

- Research and intervention manuals available in the public domain to aid dissemination and scaling up.

Objectives

- Develop and test a range of different interventions with focus on increasing access to effective care

- All tested through partnerships (2 RCTs per intervention)

- WHO Press as publisher to put manuals in public domain (serving dissemination and quality control of any translation)

- Work with national governments and civil society towards implementation and scaling up of interventions

Five phase model for intervention testing

- Phase 1: Cultural adaptation of psychological intervention (qualitative research)

- Phase 2: Implementation of intervention in test sites to explore feasibility, safety and delivery of the intervention through exploratory randomised pilot trials (RTCs)

- Phase 3: Process evaluation of administering the intervention (qualitative research)

- Phase 4: Definitive randomised controlled trial (RTC)

- Phase 5: Process evaluation of administering the intervention (qualitative research) to prepare for scaling up

Project 1: PM+

Project 1: PM+

- **What**
  - Transdiagnostic (stress, depression, anxiety)
  - Problem-solving counselling combined with behavioural strategies
  - 5 sessions, individual or group format

- **Status**
  - 3 pilot RCTs (2 in Pakistan, 1 in Kenya) (2 completed – 1 ongoing)
  - 2 definitive RCTs ongoing (Pakistan, Kenya), 3rd starting (Pakistan)
  - Funders: USAID OFDA (3x), R2HC ELHRA DFID/Wellcome Trust (1x), GCC (1x)
  - Fundraising for one RCT on PM+ group ongoing

Project 2: Self Help+ (SH+)

Project 2: Self Help +

- **What**
  - Guided self-help package based on acceptance and commitment therapy (ACT; BT combining mindfulness skills with values-based action)
  - Transdiagnostic (stress, depression, anxiety)
  - Elements
    - 4 session pre-recorded psycho-educational program
    - Picture-based self-help book (possibly to be converted into IT version)

- **Status**
  - Pilot and definitive study funded for Uganda (UN Action Trust Fund, R2HC ELHRA DFID/Wellcome Trust)
  - Fundraising for a further RCT

Project 3: IPT-8G

- **What**
  - Group interpersonal therapy (IPT) by lay helper
  - Focus on depression
  - Elements
    - 8 sessions group version to be published by WHO
    - (Based on 16 session group version cf Bolton studies)

- **Status**
  - 8 session group version currently being drafted by Dr Verdeli
  - Evaluation: to be determined
  - Seeking funds & partners

Project 4: E-mental health

Project 4: E-mental health

- **What**
  - Computer based self-help
  - Transdiagnostic (stress, depression, anxiety), possibly based on PM+
  - Elements
    - Short, e-mental health computerised CBT program
    - Follows the story of person being treated for their mental health problem

- **Status**
  - Negotiations in advanced stage to get unrestricted license to use, test and disseminate an established intervention
  - Fundraising for implementing in Lebanon

# Project 5: Low Intensity Intervention for children

- **What**
  - Transdiagnostic
  - Likely start with 10-14 year olds but possibility of adaptation for other ages
  - Elements
    - Few session intervention with between session application
    - Likely adopt child-friendly narrative approach

- **Status**
  - Developing concept using a range of expert inputs
  - Consultation in progress
  - Seeking funds / partners

Resulting work with have relevance to

- Humanitarian emergencies

- Other settings affected by adversity (eg urban violence)

- Development (ie part of mhGAP program)
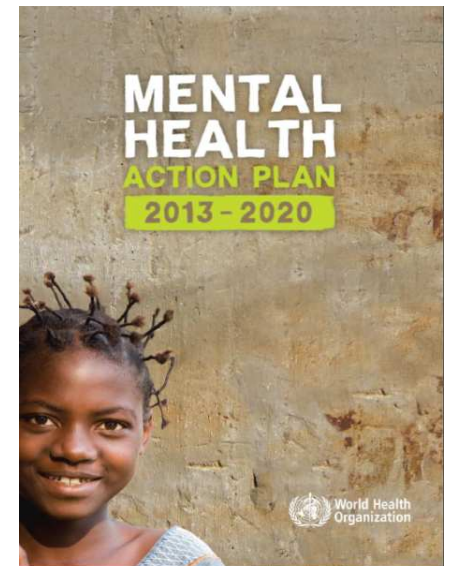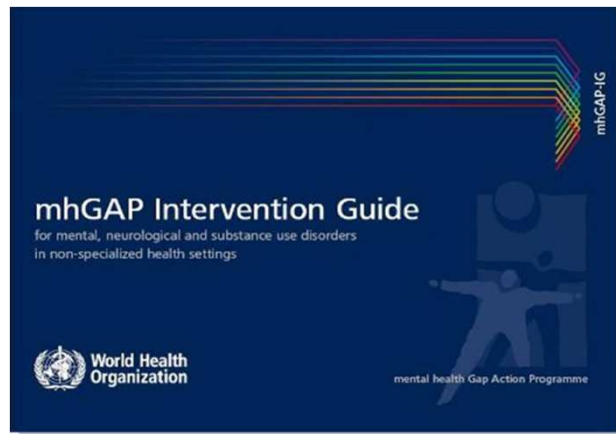
Pillar 4: Serving the Needs of People in Conflict

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Introduction

- What are the issues that we face?

- What has been coming out of the WHS consultations?

- How can we collectively serve the needs of people in conflict?

What are the issues that we face?

	SOCIAL PROBLEMS	PSYCHOLOGICAL/ PSYCHIATRIC PROBLEMS
Pre-existing	e.g. Discrimination	e.g. Psychosis, severe alcohol use
Emergency-induced	e.g. Family separation, loss of jobs, protection threats	e.g. Normal fear, depression
Humanitarian aid-induced	e.g. Conflict between Internal displaced people and local communities	e.g. Anxiety about lack of information

What are the issues that we face?

- Most people have personal and social resources (personal resilience, helpers, shared belief systems, family, friends) that can be supportive and a very effective way of helping them is to problem-solve, cope in adversity and enjoy life via social support networks (e.g. parents/teachers, churches etc.

What are the issues that we face?

	BEFORE DISASTER: 12-month prevalence	AFTER DISASTER: 12-month prevalence
Severe disorder (e.g., psychosis, severe depression, severely disabling form of anxiety disorder)	2-3%	3-4%
Mild or moderate mental disorder (e.g., mild and moderate forms of diagnostic depression and anxiety disorders)	10%	20% **(reduces to 15% with natural recovery)**
Moderate or severe psychological / social distress (no diagnosable disorder)	No estimate	Large percentage **(reduces to unknown extent due to natural recovery)**
None or mild psychological / social distress, which usually resolve over time	No estimate	Small percentage (increases over time due to natural recovery)

Size of the problem: Summary Table of Generic WHO (2005) Projections

What has been coming out of WHS consultations?

Regional consultation – Budapest :

More participatory needs assessment would allow humanitarian actors to address this failure, and may also prevent social fragmentation.

Participant in an online discussion :

"We know that education programs addressing children's holistic well-being can save and sustain lives, address the urgent and specific psychosocial needs of children and create stronger, healthier communities."

Online consultation report – MENA:

The capacity-building of community institutions must be enhanced to provide guidance to youth on income-generating activities, and technical support should be given to community health facilities to enable them to provide better psychosocial support to returnees and their families.

What has been coming out of WHS consultations?

Online consultation report - West and Central Africa:

The discussions indicated that psycho-social and cultural considerations may easily be overlooked in the planning and execution of humanitarian action. This consideration is critical to building a people-centred approach that reduces psychological dependency on aid.

Regional consultation - Middle East and North Africa:

The psychosocial impact of violent conflict and protracted displacement was recognized and targeted support needed to be integrated in the response, in particular for women, the elderly and children.

Online consultation report – Europe :

Child psychology is a critical area requiring greater focus by the region. Highlighting the impact of traumatic experiences of war and displacement, it requires addressing more than immediate basic needs in order to address emotional and psychological wounds. For children this means looking at mental health services and innovatively addressing concerns regarding their futures.

How can we serve the needs of people in conflict?

Most people have personal and social resources (personal resilience, helpers, shared belief systems, family, friends) that can be supportive and a very effective way of helping them is to problem-solve, cope in adversity and enjoy life via social support networks (e.g. parents/teachers, churches etc.

- Suggestion box,   Psychological First Aid

- Child-to-child,   Youth initiatives,   Parents groups,   Pre school activities

- Recreational activities (Tales and riddles, Theatre, Sports, Photo voice)

- Restorative circles   Group counselling

- Individual follow up   Memory work,

How can we serve the needs of people in conflict?

- MHPSS considerations and activities should be part of strategies

- MHPSS should be integrated with conflict mitigation and peace building work

- Knowledge should be consolidated

- Care should be provided to people with severe mental disorders

Questions?