Mental Health and Psychosocial Support

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Photo: Julien Harneis

Introduction

Over 10 per cent of the world's population live with a mental health condition (Whiteford et al. 2013), causing 7 per cent of the global burden of disease, and 19 per cent of all the years lived with disability globally (Rehm and Shield 2019). The prevalence of mental health conditions is especially high among people affected by conflict, standing at 22 per cent. Persons with long-term mental health conditions or psycho-social impairments are also part of the group of 1 billion people with disabilities. Within the group of persons with disabilities, persons with mental health conditions, especially children and adolescents, experience the most stigmatisation, marginalisation and human rights violations. Moreover, there are strong myths about mental health conditions, and there are hardly any specific services available for these groups. They are not well represented in the disability movement, so their voice is often not heard by policymakers, and they often do not receive treatment and care, especially in low- and middle-income countries.

About this brief

Promoting mental health and well-being and treating mental, neurologic and substance use conditions has a positive impact on individuals and societies and is essential to ensure good health and well-being and to contribute towards sustainable development. In this brief, we will elaborate upon key concepts in relation to mental health and psychosocial support, the global priorities on mental health, and provide guidance on what works in different settings including examples with evidence for effective interventions. A key consideration of this brief is the importance of the cultural adaptation of interventions to ensure they are meaningful and useful for culturally diverse groups. We will support this by presenting several case studies from the field and presenting an overview of useful tools and resources for assessments, program implementation and adaptation.

With this brief, we aim to increase the overall understanding of the issues and provide an overview of practical tools related to mental health and psychosocial support for Sida and Embassy staff contributing to mental health and psychosocial support (MHPSS) in humanitarian and/or development settings.

The importance of addressing mental health

Global attention for mental health remains urgent as the burden of mental conditions continues to grow with significant impacts on health and major social, human rights and economic consequences. In low- and middle-income countries (LMIC) mental health conditions account for 11.1 per cent of the total disease burden (Patel 2007). These figures are likely underestimated, as collecting and reporting on data for mental health is affected by several challenges, including under-reporting, lack of access and under- or misdiagnosis (Vigo, Thornicroft, and Atun 2016). Globally, these conditions include a range of categories of mental disorders such as depression, anxiety, acute and post-traumatic stress disorder (PTSD), schizophrenia, bipolar disorders and eating disorders. Despite the widespread prevalence of mental disorders, a large proportion of affected people do not receive treatment and care, especially in low- and middle-income countries, where 7 to 85 per cent of people with severe mental health conditions do not have access to the necessary mental health treatment (WHO 2013b), and where government spending on mental health is less than 2 per cent of government health expenditure (WHO 2018).

There is an urgent need to address the mental health of displaced people and those in humanitarian settings (Morina et al. 2018). Disasters and other emergency situations lead to an array of mental health problems, ranging from short-term stress reactions, through to anxiety and depressive disorders and psychosis (Tol et al. 2013). The prevalence of mental disorders (including depression, anxiety, PTSD or schizophrenia) at any point in time among people affected by conflict is 22 per cent (Charlson et al. 2019). Globally, there are over 70.8 million forcibly displaced people (UNHCR 2020). People with pre-existing mental health conditions are often neglected in humanitarian responses, and during crises the health system may be disrupted, affecting the care they receive, and at the same time, crises can cause or worsen mental health conditions, and expose people with mental health conditions to violence and abuse (Ventevogel et al. 2015).

Mental Health and well-being

An internationally accepted definition of mental health is: *"The capacity of thought, emotion, and behaviour that enables every individual to realise their own potential in relation to their developmental stage, to cope with the normal stresses of life, to study or work productively and fruitfully, and to contribute to their community"* (Lancet 2018:p.1562).

Mental health is understood as a continuum, from good mental well-being at one end, to mild, time-limited distress, and progressive and severe suffering and disabling conditions at the other (see figure below). Therefore, the global health agenda focuses on actively promoting mental health in addition to prevention, treatment and rehabilitation. Moreover, mental health is framed in terms of a state of well-being by the World Health Organization: *"Mental health is a state of well-being..."* (WHO 2004). Well-being is defined as *"a subjective positive evaluation of life satisfaction,"* and therefore serious mental conditions are not per se incompatible with a degree of mental well-being (Lancet 2018; Galderisi et al. 2015).

The continuum of mental health (Heads-Up 2020)

Mental health, neurological and substance use conditions

Mental, neurological and substance use conditions (MNS) is an increasingly used to refer to a wider range of the mental health continuum. MNS conditions refer to mental health conditions such as depression or schizophrenia, as well as neurological conditions such as dementia or epilepsy or substance abuse conditions (e.g. alcohol or drug dependence). 'Mental disorder' has traditionally been one of the most commonly used terms, it is generally linked to international clinical classifications, and defined as *"Disturbances of thought, emotion, behaviour,*

and relationships with others that lead to substantial suffering and functional impairment in one or more major life activities" (Lancet 2018:p.10). 'Mental disorder' is thus a more specific term than MNS conditions that is used to refer to more severe MNS conditions that limit a person's social and occupational functioning.

Mental health and psychosocial support

Mental health and psychosocial support (MHPSS) refers to any type of support that aims to protect or promote psychosocial well-being and/or prevent or treat mental conditions (IASC 2007). The term 'psychosocial' refers to the close connection between psychological and social processes. MHPSS aims to equip people with the skills to address risks, mediators or consequences of mental health conditions and enable the circumstances needed for recovery.

Mental health and disability

Disability is not a health condition. Disability arises from the interaction between a person´s health and body with multiple factors influencing the environment a person lives in. Disabilities is thus an umbrella term that refers to impairments, activity limitations and participation restrictions (WHO 2002). Disability associated with mental, neurological and substance use conditions is a major contributor to the global burden of disease and among the leading causes of disability worldwide. More specifically, MNS conditions account for an estimated 9.5 per cent of disability-adjusted life years (DALYs) and 28.4 per cent of years lived with disability (WHO 2018; mhGAP Operations Manual). Mental and substance use conditions among children and youth are the sixth leading cause of DALYs and the leading cause of disability in terms of years lost due to disability (Lancet 2018). 'Psychosocial disability' is the term used to refer to impairments related to MNS conditions that limit people´s ability to participate fully in social community life (Lancet 2018).

Photo: UN Women/Allison Joyce

Mental health and Covid-19

The current Covid-19 pandemic is expected to cause an increased level of psychological stress and social suffering and it is foreseen that it will cause a long-term mental health crisis, increasing the need for appropriate interventions (IASC 2020). Many factors influence this: Uncertainty about the evolution of the virus in the future, distress due to consequences of isolation and loneliness, fear of falling ill, dying or losing someone due to the disease, and loss of income and livelihood causing an economic burden for individuals, families and societies. The circumstances have a huge impact on families, and there is a rise in domestic violence. Women are disproportionately affected, and it is expected that there will be 31 million additional cases of gender-based violence if social-distancing continues for more than six months (UNFPA 2020). Health care workers on the frontline, older people and people with pre-existing health conditions are at higher risk of experiencing mental health consequences of the crisis (UN 2020). This crisis makes it even more urgent to address MHPSS as an essential, integrated component of health action, support community action and to use the momentum of interest for mental health reforms.

Mental health and the sustainable development agenda

The Sustainable Development Goals (SDGs) envision a broad conceptualisation of mental health and substance use and includes specific targets under SDG 3: Good health and Well-being (Patel et al. 2018). Target 3.4 aims to "By 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being." And target 3.5 aims to "Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol." (UN 2015). The central SDG principle to leave no one behind can't be seen separately from the right of every person to mental health, and good mental health facilitates good health and well-being, and sustainable development. Furthermore, many SDGs address relevant social determinants of mental health. Therefore, policies/interventions aimed at achieving these SDGs contribute to mental health and reduce inequities in the global burden of mental health, whilst reducing the suffering due to mental health, in turn, contributes to achieving various SDGs (Patel et al. 2018). The links between the social determinants of mental health (demographic, economic, neighbourhood, environmental and social-cultural) and the SDGs are essential in reframing and mainstreaming mental health as an integrated part of global development at large.

What works in different settings: Key Approaches

In order to allow health systems to reinforce MHPSS interventions, there is a need for universal health coverage, which requires the strengthening of the health systems enhancing multi-sectoral collaboration. In addition, there is a need for coordination to bridge the divide between humanitarian and development programs and actors, to ensure the sustainability of effective interventions. Furthermore, because of the complexity of mental health, its different components, and underlying factors of influence, interventions can only be effective when the underlying factors are understood, and the interventions are contextualised and culturally appropriate. Although more research is needed to better understand which MHPSS interventions work, for whom and in which contexts, studies have shown that several cross-cutting principles and approaches should always be taken into account (Patel et al. 2018). These include adopting a rights-based approach, maintaining a life course approach, and empowering people with lived experience.

Universal Health Coverage for Mental Health

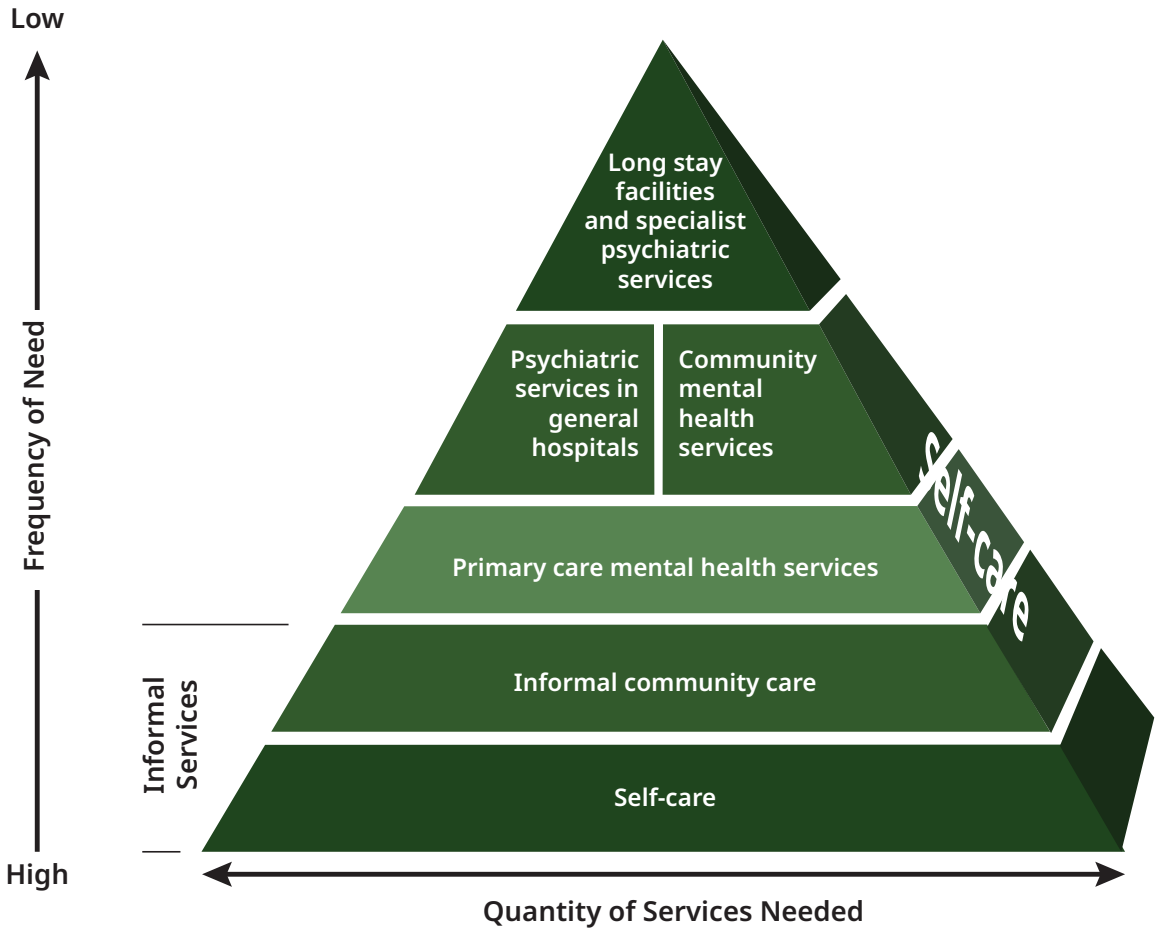
The principle of universal health coverage (UHC) means that every person should be able to access essential health and social services, regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, enabling them to achieve recovery and the highest attainable standard of health, including mental health, without financial hardship.
The global health agenda is calling for the inclusion of mental health as an essential component of

UHC, i.e. mental health should be part of basic health care packages and insurance schemes. The inclusion of mental health services in essential health care packages is to avoid the separation of physical and mental health and approach them as a whole, shifting away from institutions and towards community-based mental health care (WHO 2018a). The principles of UHC in relation to mental health implies ensuring people with MNS conditions and psychosocial disabilities have access to quality services, expanding the role of mental health specialists and enhancing mental health competencies among other health care providers. One of the steps towards UHC is to strengthen the health system, ensuring it is people-centred and to reform services in such a way that quality services are equitable and efficient, and that health systems are resilient and sustainable (Kieny et al. 2017). Strengthening health systems to support the delivery of integrated mental health care along with ensuring that interventions are aligned with existing health system features, are key to improve coverage of services in LMIC (Petersen et al. 2019). For each health system building block we will discuss what can be done to strengthen the health system and to contribute to the achievement of UHC.

Strengthening the primary care level

In order to improve access to and use of MHPSS services, the focus of service provision should shift from large hospitals to district and community-based services, and from vertical specialised care to the integration of mental health care in existing service delivery models, especially at the primary health care (PHC) level. Moreover, a shift is required from only addressing severe conditions to including early interventions for emerging mental health problems. A community-based focus is relevant not only in humanitarian settings but also in development settings and high-income settings and will enhance the demand for and access to services (Patel et al. 2018). The model envisaged by the WHO suggests a service organisation pyramid that visualises the relatively high need and low cost of informal, community-based services, self-care and services that address basic needs of people to prevent and address the majority of mental health and psychosocial needs, compared to costly specialised psychiatric services (see figure below). This doesn't

WHO service organisation pyramid (Bhugra et al. 2017)



mean that those services are less important, all levels of the pyramid need to be in place in order to offer a comprehensive service package (Bhugra et al. 2017; Wessells and van Ommeren 2008). And if this is to be successful, it also implies that support structures and clear linkages to more specialist services are in place. For the pyramid structure to be effective, a functioning referral and supervision structure between the different layers needs to be in place. The Covid-19 crisis shows the importance of action on mental health and psychosocial support. Moreover, despite the importance of personal contact required to support MNS, Covid-19 also showed that there is an urgent need to incorporate the use of digital technologies for delivering mental health interventions across the continuum of care, to bridge the mental health gap and strengthen local healthcare systems (Fu et al. 2020).

Improving human resources for mental health

A lack of mental health service providers is a key factor influencing access to services. For every 10,000 people globally, there is less than one mental health worker (WHO 2018b). The scarcity of human resources for mental health is influenced by issues such as the overall shortage of human resources, especially in LMIC, lack of training on mental health and MHPSS competencies, stigma linked to working in mental health, and the retention and motivation of staff. An opportunity to improve access is by promoting task-sharing with trained non-specialist mental health care providers, and enhancing the coordination between primary and specialist care (Patel et al. 2018), which also requires a sound supervision structure across the layers of the pyramid. The mhGAP training tools, which are translated into many languages, can be culturally adjusted and applied to train mid-level general health care workers to recognise and manage patients with the most common severe mental health conditions (Faregh et al. 2019).

The mental health of health care workers is another important consideration to take into account. In humanitarian settings, health workers have high rates of depression, anxiety and burnout, as they can be exposed to the crisis and are sometimes even targeted themselves. Hearing the traumatic experiences of patients can also have a ripple effect on the health care provider. Furthermore, as more and more tasks are shifted to lay health workers or community health workers, specific consideration needs to be given to ensure appropriate support for this level of the health workforce. It would only work if health workers receive sufficient mental health support, coaching, supervision and opportunities for debriefing and peer counselling. Hence it is key that there is appropriate support for staff, which will have a positive impact on the quality and retention of staff (Connorton et al. 2012).

Photo: UN Women/Christopher Herwig

Addressing financial resources for mental health

The financial protection of people with mental health conditions is a crucial element in strengthening the mental health system. One of the approaches is to ensure mental health is included in insurance schemes and that insurance schemes are accessible to people with mental health conditions. The Lancet Commission on global mental health emphasises the cost-effectiveness of mental health interventions, and working in partnerships to mobilise, disburse and utilise funds, and provide oversight and accountability (Patel et al. 2018). Furthermore, it is recommended that national health budgets allocate a minimum of 5 to 10 per cent (in LMIC and high-income countries respectively) of the health budget for mental health, according to specific country needs and informed by context-appropriate assessments (Mackenzie and Caddick 2016). In reality, this ranges from an average of 0.5 per cent in low-income countries to 5.1 per cent in high-income countries (Patel 2018). Redistributing funds from the tertiary level to primary and secondary level services and promoting the integration of mental health in existing services will additionally boost the efficiency of the health system (Patel et al. 2018; Petersen et al. 2019). Tracking and reporting on funding for mental health will show progress towards achieving the SGDs and the targets in the WHO mental health action plan, and can demonstrate that mental health is a priority, which in turn can attract more funding (Mackenzie and Caddick 2016).

The Lancet Commission on global mental health and development suggests that the evaluation of the feasibility and impact of innovative finance mechanisms for mental health is one of the priorities for research (Patel et al. 2018). There is scarce evidence that cash transfer programs can positively impact mental health outcomes, and can reduce the barriers to accessing health care (Patel et al. 2018).

Improving supplies

Although the bulk of mental health prevention and response interventions are within the sphere of psychosocial interventions, the availability of psychotropic drugs is an essential component of the mental health system. Compared to medicines for infectious, and non-communicable diseases, the availability of basic psychotropic drugs is notably low (Dharmawardene and Menkes 2014). Yet (continuous) availability of a few essential low-cost psychotropic drugs (e.g. 1-2 antidepressants, 2 anti-psychotics and 2-3 anti-epileptic drugs can be very cost-effective and have the potential to markedly reduce the existing burden of neuropsychiatric disorders for those suffering from severe mental illness or epilepsy (Gureje et al. 2007; WHO 2019).

Photo: Martine Perret

Strengthened information systems, evidence and research for mental health

Gathering data for mental health is crucial as this gives input to organising and evaluating mental health intervention programs (Patel et al. 2018). The mental health atlas collects global mental health information from WHO member states, but for the 2017 report, 20 per cent of LMIC did not report any mental health data, and very often data from private providers and non-specialised health services are lacking (WHO 2018). There is not only a challenge with a lack of reporting on mental health interventions, but also the challenge that other programs do not report disaggregated data, which could show if people with mental health conditions are accessing these services (keeping in mind that many people with mental health conditions do not access health care at all). Furthermore, programs which actually address psychosocial support are often not recognised as addressing this and do not use indicators for MHPSS, so this is not being reported on, especially in development settings. There is still a need for more evidence on interventions for children and adolescents, in particular in humanitarian settings and for migrants (Barbui et al. 2020).

To better understand if and how MHPSS interventions work (or not), we cannot rely on routine administrative and health systems data alone, more research is required alongside a research agenda. Acknowledging that MHPSS interventions are complex and that they interact with the context in which they are implemented, calls for a research agenda focussing on whether the interventions worked, and also on how these interventions functioned, for who, why and in which contexts.

Improvement of effective leadership and mental health system governance

Integrating mental health care requires a different way of organising the health system, and a rethink of the institutional arrangements around mental health. For instance, it requires adaptations in terms of vertical and horizontal integration of mental health services, coordination and collaboration across different levels in the health system, re-allocation of funds (towards mental health at the PHC, community and specialist levels) and changes in funding arrangements, for example, how mental health services are paid for and by who and addressing the scope of practice among health workers.

Apart from improving service delivery, action should also be taken on the prevention of MNS and protection of vulnerable groups at risk for MNS. Given the wide range of social determinants that influence mental health, a multisectoral approach beyond health should be developed to break the cycle between ill mental health and poverty (Patel et al. 2018). Policies should be put in place to strengthen the collaboration between the relevant sectors (protection, justice, health, education, social welfare, housing etc. depending on the context) and to develop community-level interventions that cut across sectors. In these responses, it is key to combine mainstreaming initiatives with specific mental health interventions (Petersen et al. 2019). Furthermore, a country should have a national mental health coordinator and unit within the ministry of health and (develop) a strategic plan on MHPSS.

Governance for mental health and psychosocial support should also ensure the creation of an enabling environment for people living with mental health and psychosocial conditions and their families, so that they are supported and can access services. This includes considerations to address mental health legislation providing for the protection of the rights of people with MNS conditions (Pathare and Sagade 2013).

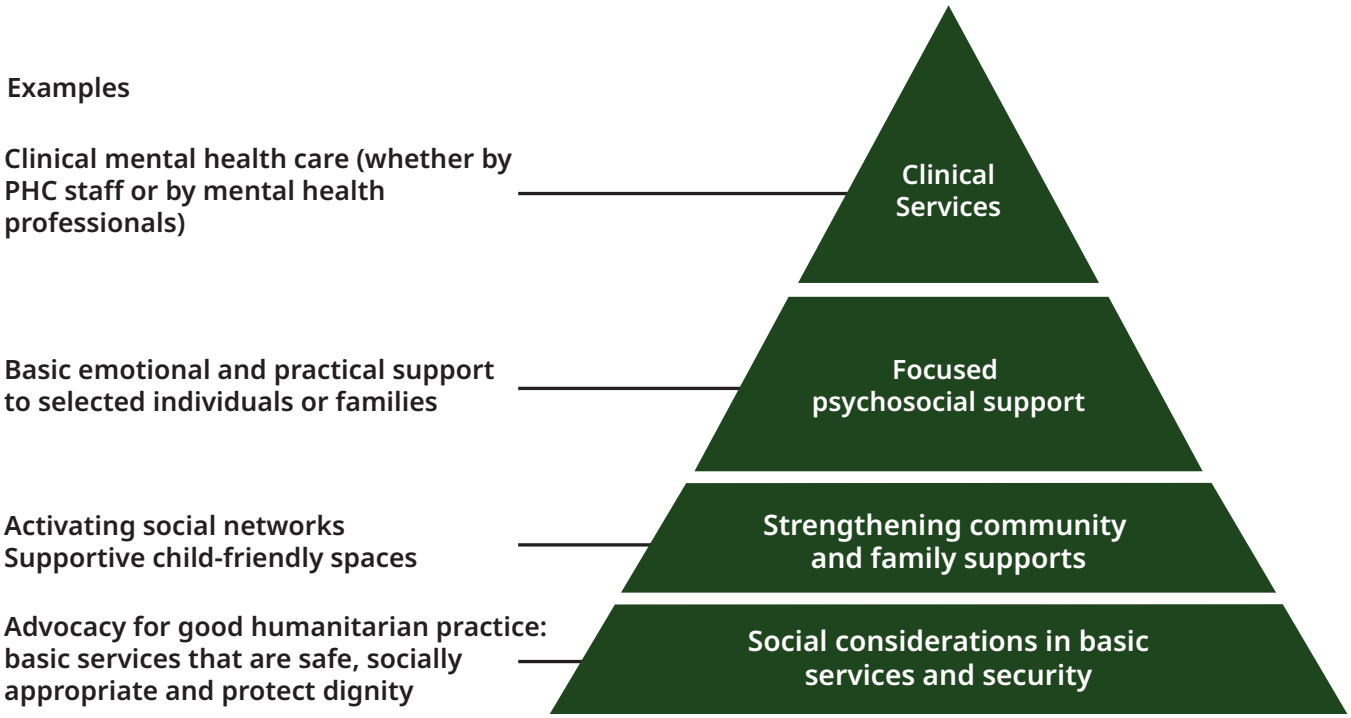
Effective interventions: From emergency settings to development

When people exposed to stress in humanitarian settings have access to preventive and protective measures, such as community and family support, the risk of, or the suffering from mental health conditions can be alleviated. Psychosocial support aims to equip people with skills needed to address risks, mediators or consequences of mental health conditions and to enable the social circumstances for recovery. Therefore, psychosocial support is an important focus of humanitarian action in addition to mental health care (IASC 2007). In line with the WHO service level pyramid, the Inter-Agency Standing Committee (IASC) guidelines on MHPSS illustrate the focus on social considerations in basic services, and strengthening community and family support as the basis of MHPSS in humanitarian settings (See figure below)(IASC 2007). The lowest level of the pyramid is about safety (e.g. where do girls shower or collect wood, can sleeping rooms be locked from the inside), information from authorities, food, housing, and family tracing. Psychological First Aid (PFA) for teachers is an example of an intervention that fits here (listening, recognising and referral). The second level involves, for instance, income-generating activities, playgrounds for children, women groups and other support groups that help to address psychosocial problems. Research on sociotherapy groups in Rwanda showed how these can restore the social fabric of war-torn communities (Scholte et al. 2011). In Liberia, during the Ebola crises, so-called "Community Healing Dialogues" served a similar purpose (Morelli et al. 2019). Examples of interventions in the third level are focus groups on alcohol and substance abuse, epilepsy support groups, Inter-Personal Therapy (IPT) groups and Problem Management Plus (PM+), a trans-diagnostic intervention providing individual psychological support for people affected by crisis (Dawson et al. 2015).

Most patients prefer psychological interventions over pharmacological interventions (Patel et al. 2018), and there is robust evidence for the efficacy of psychosocial interventions in adults with common MHC and adults with depression in humanitarian settings, but these focus mainly on specialist and non-specialist support and less on the interventions in the lower layers of the pyramid.

After a crisis, there is often much more attention paid by media and governments to the plight and mental health needs of those affected, which can generate financial support from various actors, presenting opportunities for sustainable mental

Intervention pyramid during emergencies (Wessells and van Ommeren 2008)



health interventions. At the beginning of a crisis, a base for long-term mental health reform can be laid. Therefore, humanitarian emergencies can be seen as opportunities for health systems and humanitarian, as well as development actors and governments, to "build back better" (WHO 2013a).

To ensure that quality MHPSS services with long-term impact are available across the humanitarian-development nexus and that people's resilience is strengthened, coordination between humanitarian and development actors is needed. Furthermore, the continuation of long-running efforts in humanitarian and development fields (the nexus), requires different service delivery models (across the WHO pyramid) within the health sector, including the integration of care, coordination and collaboration across levels (and sectors). This should then allow for defining the scope of practice of health workers and related competencies at different levels and thus integrating mental health in current service delivery models, the development systems for the training and supervision of the health and social workforce, and building local capacity, to fit this model. To enable this, financing should support both direct and long-term programs. Sustainability of the workforce will require a strategic plan and funding cycles of 3- 5 years. Understanding how MHPSS programs can be best integrated into existing services is key to strengthening the humanitarian-development nexus (Ran 2019).

People centred interventions

Human rights based approach

A human rights-based approach is underpinned by a set of key human rights principles, including participation, accountability, non-discrimination and equity, empowerment and legality. The principle of human rights in relation to mental health needs to be considered from two angles: mental health as a universal and basic human right itself and the risks of human rights violations for people living with MNS conditions or at risk of poor mental health (Lancet 2018). A human rights approach is necessary to enable an environment that promotes mental health for all and protects the well-being of people with MNS conditions as well as those at risk of poor mental health. This includes addressing the multiple social, economic or political circumstances that challenge mental health (e.g. poverty, safety).

From an equity and social justice perspective, ensuring the right to mental health requires a particular focus on groups who are at greatest risk of not enjoying their rights. For example, people affected by poverty, violence, conflict, forced migration, displacement or natural disasters, sexual and gender minorities, ethnic minorities, people living in institutions, homeless people or people already living with a disability or MNS conditions (WHO 2004; Lancet 2018). These population groups, particularly those facing multiple forms of inequalities and vulnerabilities, often have poorer access to appropriate care, support, protection and prevention due to economic, legal, language and cultural barriers. They are also at risk of being affected by more stressors and are therefore more vulnerable for MNS conditions and disorders.

Life course approach

Different individual, social and environmental risks to mental health conditions can manifest themselves at various formative stages of life, in particular during the sensitive stages of childhood and adolescence (Patel et al. 2018). This shows the importance of taking a life-course perspective on mental health, and to address in particular the needs of children and adolescents. Even before birth, a person's mental health can already be influenced, for example, by risky behaviour or malnutrition during pregnancy (impacting brain development). Just after birth, the attachment of the new-born to the mother/caretaker can influence social and emotional development. During childhood, playground bullying, or family conflict can be factors influencing a child's cognitive and emotional development. During adolescence, mental health conditions are more likely to manifest. Adolescents are going through a critical stage in their life, moving from childhood to adulthood and are particularly receptive to peer, and media pressure, which exacerbates the risk of alcohol and drug abuse, which, in turn, is particularly harmful to teenage brain development. During adulthood, either being unemployed or having a poor work-leisure balance becomes a key determinant of mental health. Finally, in older age, the risk of cognitive decline and dementia come in to play as well as the risk of social isolation (Ritchie and Roser 2020).

Case Studies

Case study 1: Example of mental health integration into maternal health service

Intervention: Stepped care for maternal mental health

Country: South Africa

Mental health focus: Integrated perinatal mental health

Target group: Women

This project developed an intervention allowing the delivery of mental health care to women during their perinatal period, in an obstetric setting, making use of limited resources available at the primary care level. They used a collaborative and step-wise approach. Through screening and referral, within 3 years, 90 per cent of all women attending antenatal care in the maternity clinic were offered mental health screening with an uptake of 95 per cent. Of those screened, 32 per cent qualified for referral to counselling. The project includes capacity development of general health workers to provide primary mental health care and has a focus on improving access to care for vulnerable clients (Honikman et al. 2012).

Case study 2: Example of community-based mental health program with non-specialised health workers

Intervention: Common Elements Treatment Approach (CETA)

Country: Southern Iraq

Mental health focus: Post Traumatic Stress Disorder

Target group: Survivors of systematic violence

Identification of persons at risk of suicide, connection to care and follow up as a crucial prevention strategy: A combination of WHO's Brief intervention and Contact (this involves a combination of education, advice and long-term follow up contact), and Safety Planning (this involves the development of a plan together with the person at risk of suicide, that supports a person when having suicidal thoughts). This program is delivered by community volunteers who were trained to provide emotional support and assess suicide risk and safety planning. They visit the community on a biweekly basis (Vijayakumar et al. 2017; Fleischmann et al. 2008).

Case study 3: Example of a vertical program by lay workers

Intervention: Friendship Bench

Country: Zimbabwe

Mental health focus: Common mental health disorders

Target group: Adults

The Friendship Bench is a task shifting program that aims to enhance mental well-being and quality of life by creating safe spaces and a sense of belonging in communities. In this program, problem solving therapy is delivered by trained lay health workers The cognitive behaviour therapy (CBT) used in the program emphasises the use of problem solving therapy (PST) for the treatment of common mental health disorders. The intervention consists of six sessions of 30-45 min of structured PST, delivered in a discrete area outside of the clinic building on a bench (The Friendship Bench). (Chibanda et al. 2015; Chibanda et al. 2016).

Key messages and data

Regarding the urgency of prioritising mental health:

- Over 10 per cent of the world's population lives with a mental health condition, causing 7 per cent of all global burden of disease, and 19 per cent of all years lived with disability. In low- and middle-income countries mental health conditions account for 11 per cent of the total disease burden. The prevalence of mental health conditions is especially high among people affected by conflict and stands at 22 per cent.
- Disability associated with mental, neurological and substance use conditions is a major contributor to the global burden of disease and among the leading causes of disability worldwide.
- An important group that is highly affected by mental health are children and adolescents
- Gender plays a large role in the prevalence of mental health conditions, with women reporting higher rates of mood disorders, depression, and anxiety in comparison to men.
- People with MNS conditions as well as people with psychosocial disabilities are among the most vulnerable groups globally experiencing marginalisation and multiple human rights violations
- A large proportion of affected people do not receive treatment and care, especially in low- and middle-income countries.

Regarding key concepts on mental health and psychosocial support

- Mental health is understood as a continuum, from good mental well-being at one end, to mild, time-limited distress, and progressive and severe suffering and disabling conditions at the other. Therefore, the global health agenda focuses on actively promoting mental health in addition to prevention, treatment and rehabilitation

Regarding mental health priorities

- WHO priority MNS conditions are depression, self-harm and suicide, psychoses, bipolar disorders, epilepsy, dementia, substance use disorders, child and adolescent mental and behavioural disorders.
- The circumstances and cultural aspects influencing MNS conditions and how people express and live/ cope with these conditions will vary in each setting and needs to be framed and contextualised.

Regarding what works in different settings and key approaches

- Interventions are effective when they are contextualised and culturally appropriate and include a rights-based and a life course approach.
- Successful MHPSS interventions include district and community-based services, task-sharing with trained non-specialist mental health care providers, coordination between primary and specialist care, and appropriate support to staff.
- When MHPSS interventions in humanitarian settings are initiated, they should include pathways to longer-term sustainable development and the sustainability of these services.
- Preventive interventions are more effective when a multi-sectoral approach is in place
- There is a need for more (disaggregated) mental health data and research on what works and how with to respect to MHPSS interventions.

Photo: EU/Oleksandr Ratushniak

Recommendations

Regarding availability and accessibility of services

- To achieve UHC, mental health needs to be an integrated part of the work Sida supports, with explicitly formulated goals for mental health and the inclusion of criteria for addressing mental health in programs.
- UHC can only be achieved if there is appropriate planning for long-term sustainable interventions by incorporating sustainable objectives for humanitarian action, strengthening primary mental health care, supporting initiatives to strengthen the mental health workforce, and allocation of financial resources and by enhancing coordination between humanitarian and development programs. Sida can contribute to this by choosing to support longer-term MHPSS programs.
- It is key to enhance a coordinated, multi-sectoral response to mental health by supporting national governments in the development of mental health policies and plans.

Photo: Michael Franci/Cordaid

Regarding the life course approach and rights

- Sida supported projects should stimulate discussions with country-level partners for mental health interventions adapted to the cultural and socio-economic context and stimulate and strengthen interventions adopting a life course approach and a rights-based approach.

Regarding prevention, equity, equality and inclusiveness

- Addressing the mental health and psychosocial well-being of populations requires programs to address the multiple determinants of mental health in promotion and prevention plans, including determinants at the social and economic level. Sida can support this by looking beyond the health sector when addressing MHPSS.
- Sida should prioritise targeted programs that focus on the mental well-being of population groups more at risk of poor mental health and include these groups as partners in intervention development, implementation and monitoring and evaluation.
- People with lived experience should be at the centre of any intervention and play a key role in the assessment, implementation and evaluation of programs. Program managers should ensure sufficient attention is paid to the particular needs of people with a lived experience and their empowerment and ensure they are sensitised about violations to their human rights.

Regarding research and data

- As the research gap for mental health across various settings remains a barrier for implementation of adaptable and scalable interventions, and there is a huge need for evidence-informed advocacy to enhance the availability of quality, accessible, appropriate, and acceptable interventions for prevention and response to mental health, it is recommended that Sida prioritises the support for community-based participatory research (CBPR) involving, in particular, people with lived experience. In addition, it is recommended to design a joint research agenda, focusing on what works in which context whilst simultaneously investing in strengthening (health) information systems.

Key Tools and Resources

Mental health action plan 2013 – 2020
mhGAP intervention guide
mhGAP Humanitarian intervention guide
IASC guidelines
Assessing mental health and psychosocial needs and resources
Caring for volunteers: A psychosocial Support Toolkit
Building Back Better
Mental Health Atlas
The Sphere Handbook
Problem Management Plus (PM+)

Useful Websites

https://www.who.int/mental_health/en/
https://www.who.int/teams/mental-health-and-substance-use/covid-19
https://pscentre.org/
https://www.mhinnovation.net/
http://globalmentalhealth.org/
https://ourworldindata.org/mental-health

For more information and the complete reference list see the full report:
https://www.kit.nl/wp-content/uploads/2020/10/MHPSS_Full_Report_Sida-KIT_2020.pdf

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