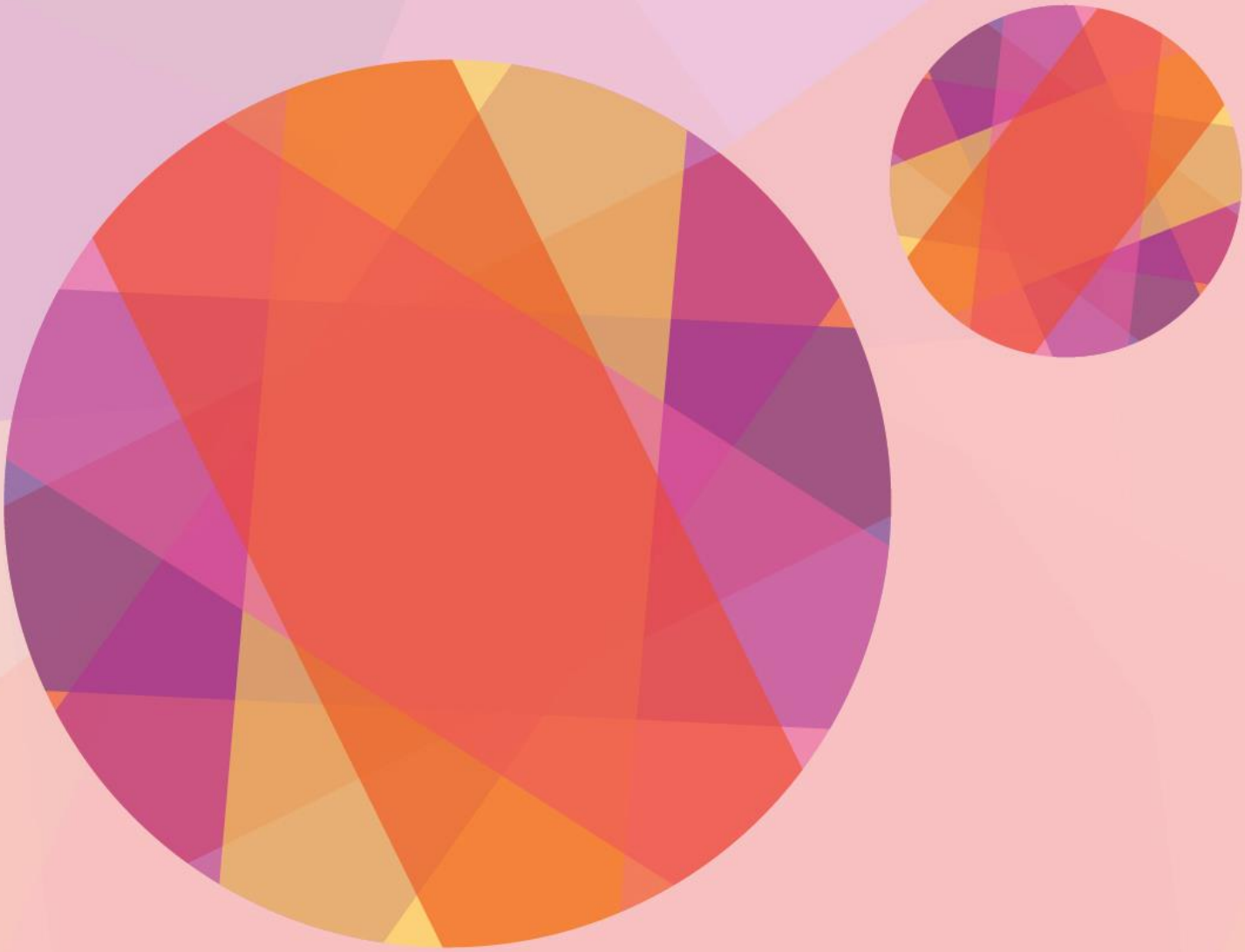

KIT ROYAL TROPICAL INSTITUTE - REPORT

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

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"There is no health without mental health. I think we know, through a large body of evidence, that mental health and physical health interact with each other in very diverse and intimate ways. Therefore, any attempt that we make to improve the mental health of individuals and populations will inevitably have a positive impact on the physical health of those individuals and populations. Therefore, investing in global mental health is, ultimately, an investment in global health."

(Vikram Patel)

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Introduction

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, and these occur in low-, middle- and high-income countries. Especially the prevalence of mental among people affected by conflict is high and stands at 22,1 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 belong to the groups that are most stigmatised. Moreover, there are strong myths about mental health conditions, and there are hardly any specific services available for these groups. Persons with mental health conditions and psychosocial disabilities, especially children and adolescents, are among the most vulnerable groups experiencing marginalisation and human rights violations. They are not well represented in the disability movement, so their voice is often not heard by policymakers and often do not receive treatment and care, especially in low- and middle-income countries.

1. Setting the scene

About this report

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 contribute to sustainable development. In this report, 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. Central in this report is the importance of cultural adaptation of interventions to ensure that interventions are meaningful and useful for culturally diverse groups. We will support this with presenting several case studies from the field and present an overview of useful tools and resources for assessments, program implementation and adaptation.

With this report, we aim to increase the overall understanding of issues and practical tools related to mental health and psychosocial support for Sida and Embassy staff working in and with mental health and psychosocial support (MHPSS) contributions in humanitarian and/or development settings.

The specific objectives are to provide the staff with:

- An overview of Sida's priorities on MHPSS
- A basic understanding of mental health and psychosocial support and the difference between mental health and psychosocial support.
- An understanding of the definition of disability and the distinction and relationship between disability and MHPSS.
- Guidance on which tools and evidence for effective interventions, mainstreaming and multisectoral system approaches exist and should be followed by actors in humanitarian, development and nexus setting.
- An overview of the tools available to make basic assessments and evaluate MHPSS in humanitarian and development settings.

To answer the objectives, a desk study was done using databases (VU library, Pub-Med) and search engines (Google, google scholar) searching for peer-reviewed literature using keywords (Mental health, Psychosocial support, disability, humanitarian, development, nexus, health system). The websites of the WHO, UNHCR and other key international players in global mental health were reviewed. The draft document was presented to experts in the field of global mental health and health systems strengthening, to get their expert opinion and feedback on the report. In addition, KIT's internal quality assurance mechanism was applied, which entails peer-review at various stages of the development of the report. In addition to a general overview of the current state of the art in global mental health, a range of case studies showcasing specific interventions to address a variety of mental health issues have been included.

Key concepts and definitions

There is no common understanding of the concept of mental health, and it is perceived differently in different cultures and by different academic disciplines. Moreover, the inclusion of mental health in the SDGs has fostered discussions on the need to reframe global mental health adopting a broader dimensional approach that leaves behind the binary perspective of current classifications, reconciling evidence from different fields (e.g. social and biological determinants of mental health) and recognising mental health as a human right (Lancet 2018).

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, through mild, time-limited distress, and to progressive and severe suffering and disabling conditions at the other end (see figure 1). 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)

Figure 1: The continuum of mental health (Heads-Up 2020)

Mental health, neurological and substance use conditions

Various mental health-related terms are being used in the global discourse on mental health, and it is sometimes unclear what the nuances and the differences are between these terms.

Mental, neurological and substance use conditions (MNS) is an increasingly used term that refers 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 like dementia or epilepsy or substance abuse conditions (e.g. alcohol or drug dependence).

'Mental disorders' 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 disorders' is therefore 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 skills to address risks, mediators or consequences of mental health conditions and enable circumstances for recovery. The term MHPSS was coined by the Inter-Agency Standing Committee in 2007 to point out the complementarity between mental health and psychosocial interventions and to facilitate a more integrated approach and multi-sectoral collaboration in humanitarian responses (IASC 2007). Social and psychological processes are two types of interrelated effects of conflict and displacement (UNHCR 2013). The term is now widely and increasingly used by all type of actors, especially fragile settings and in conflict and disaster-affected environments (UNHCR 2013).

What are the interlinkages between mental health and disabilities?

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, therefore, 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 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 disabilities' 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).

2. The urgency of prioritising mental health

The burden of mental health, neurological and substance abuse conditions

Global action on mental health is urgent. The burden of mental conditions continues to grow bringing a significant impact on health and serious social, human rights and economic consequences. Over 10 per cent of the world's population (792 million people) live with a mental health condition (Whiteford et al. 2013), causing 7 per cent of all global burden of disease, and 19 per cent of all years lived with disability (Rehm and Shield 2019). Mental health conditions are common everywhere, in low-, middle-

and high-income countries, however, in LMIC mental health conditions account for 11 per cent of the total disease burden (Patel 2007). These figures are likely much underestimated, as collecting and reporting on data for mental health is affected by several challenges, including underreporting, lack of access and under- or wrongly diagnosing (Vigo, Thornicroft, and Atun 2016).

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 76 to 85 per cent of people with severe mental health conditions do not have access to needed mental health treatment (WHO 2013b).

There is an urgent need to address the mental health of people in humanitarian settings and in displacement (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). Exposure to stressful events, impoverishment, and other daily stressors can trigger or worsen mental health problems, whilst often the mental health infrastructure is weakened (IASC 2007). The prevalence of mental disorders (including depression, anxiety, PTSD or schizophrenia) at any point in time among people affected by conflict is 22,1 per cent (Charlson et al. 2019). Globally there are over 70.8 million people forcibly displaced (UNHCR 2020). People with pre-existing mental health conditions are often neglected in humanitarian responses, whilst the health system may be disrupted, affecting the care they received, and at the same time, the crisis can worsen their mental health condition. Furthermore, they are more exposed to violence and abuse (Ventevogel et al. 2015).

Mental health and Covid-19

The current Covid-19 pandemic is expected to cause an increased level of psychological stress and social suffering, increasing the need for appropriate interventions (IASC 2020). The Covid-19 crisis has a severe impact on mental health, and it is foreseen that it will cause a long-term mental health crisis. Many factors influence this, uncertainty about the evolvement of the virus in the future, distress due to consequences of isolation and loneliness, fear of getting 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 the restrictions continue for more than 6 months (UNFPA 2020). Health care workers at the frontline, older people and people with pre-existing health conditions are at higher risk of experiencing the mental health consequences of the crisis (UN 2020). This pandemic 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.

Determinants of mental health, neurological and substance use conditions

Determinants of mental health not only lie at the individual level (ability to manage thoughts, emotion and behaviour), but cultural, social, economic, political and environmental factors are also important determinants (WHO 2013b). Poor mental health is consistently associated with unemployment, less education, low-income or material standard of living, in addition to poor physical health and adverse life events. Poverty, low education, low socioeconomic status, stress, and limited access to resources can also increase the risk of mental conditions (Patel et al. 2018).

Gender plays a large role in the prevalence of mental health conditions, with women reporting higher rates of mood disorders, depression, and anxiety compared to men (Astbury 2001). On average, women report 1.5–2 times higher rates of such conditions, however, men have a higher risk of substance use disorders (Ferrari et al. 2014). This skewed gender distribution of mental conditions has far-reaching implications, including, for example, the fact that mothers may have a reduced ability to care for their children. Furthermore, survivors of gender-based violence are more likely to develop mental health conditions, and persons with mental health conditions are more at risk of gender-based violence (García-Moreno et al. 2013).

An important group that is highly affected by mental health all over the globe, is children and adolescents; 10-20 per cent of whom suffer from a mental health or behavioural problem, and suicide is the second leading cause of mortality among youth[1] (WHO 2014, 2020b) . Other vulnerable groups, such as people living with HIV, also have high rates of mental health conditions, in particular depression and Post Traumatic Stress Disorder (PTSD) (Remien et al. 2019).

A brief history

In 1946, the constitution of the World Health Organization (WHO) already explicitly included mental health as part of the health definition; *"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."*(WHO 1946). The notion that "without mental health, there can be no true physical health" was also highlighted by the first Director-General of the WHO back in 1951 (Chrisholm 1951). Nevertheless, mental health only received limited attention in policy and programmes over the following decades. There has been increased emphasis on mental health and human rights in the past 10-15 years, for example, with the adoption of the *Convention on the Rights of Persons with Disabilities (CRPD)* which entered into force on 3rd of May, 2008 (UN 2008). This constituted a key turning point in the human rights framework, responding to the lived experience[2] of people with disabilities, emphasising equality, non-discrimination and social inclusion (Spivakovsky, Seear, and Carter 2018) Driven by the importance of human rights in addressing mental health, and the need for services, legislation, plans, strategies, and programmes to protect, promote, and respect the rights of persons with psychosocial disabilities as one of the steps to address the widespread stigma and discrimination against people with psychosocial disabilities WHO launched the *Mental Health Action Plan for 2013–2020* (WHO 2013b). In 2018, the Political Declaration of the third UN high-level meeting, *"Time to deliver: accelerating our response to address Non-Communicable Diseases (NCDs) for the health and well-being of present and future generations"* for the first time acknowledged the burden of mental health and called upon governments to improve mental health (UN 2018). Furthermore the realisation that mental health is key for development is globally rising, and current leaders in global mental health are now shifting the focus from *"no health without mental health" towards "No sustainable development without mental health"* (Patel et al. 2018). Although development assistance for mental health was steadily increasing since 2007, in 2013 it remained below 1 per cent of global development assistance for health, and for child and adolescent mental health, this remained at only 0.1 per cent, despite this being the most crucial phase in life for mental health prevention (Lund et al. 2011; Ritchie and Roser 2020). As a consequence of this low investment, between 2010 and 2030 the global economy is expected to lose an estimated 16 trillion

[1] Suicide data is highly affected by the reliability of suicide certification and reporting

[2] Lived experience is defined as "the experiences of people on whom a social issue or combination of issues has had a direct impact."(Sandhu 2017).

USD due to mental conditions, linked to loss of productivity throughout the life course (Patel et al. 2018; Barbui et al. 2020).

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 cannot 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 achieving mental health, in turn, contributes to achieving several 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.

3. Mental Health Conditions

The WHO has selected a number of MNS conditions as priority conditions, based upon the burden of disease (in terms of morbidity, disability and mortality) attributed to these conditions, as well as the high economic cost and the association with human rights violations. The conditions include depression, self-harm and suicide, psychoses, bipolar disorders, epilepsy, dementia, substance use disorders, child and adolescent mental and behavioural disorders (Dua et al. 2011). In this chapter, these conditions, and how they contribute to the global burden of disease, are briefly described.

Depression

Depression is common, affecting 3.4 per cent of the global population in 2017, with the prevalence of population with depression ranging between 2 and 6 per cent between countries (Roser 2018). It is a major cause of disability and contributes largely to the global burden of disease (James et al. 2018). Depression affects women more than men (WHO 2016a). Symptoms can range in severity and can include a persistent depressed mood, and a loss of interest and pleasure. It is often combined with other MNS and physical conditions such as anxiety and medically unexplained somatic symptoms. Depression can cause the affected person to suffer greatly and to function poorly at work, in school and in the family, it limits participation in the social environment, and can lead to suicide (WHO 2016b) (WHO 2016a).

Self-harm and suicide

"Suicide is the act of deliberately killing oneself. Self-harm refers to intentional self-inflicted poisoning or injury, which may or may not have a fatal intent or outcome."(WHO 2016b):p73). Every year, close to 800,000 people die due to suicide. In 2016, suicide accounted for 1.4 per cent of all deaths worldwide (WHO 2020g), and among 15-29-year-olds suicide is the second leading cause of death (WHO 2020g). Suicide and self-harm are closely linked with mental health conditions, however, not all suicides (or suicide attempts) are related to mental health, which adds to the challenges of monitoring

and categorising suicide. The risk of dying as a result of suicide for a person with depression is 20 times higher compared to a person without depression (Ferrari et al. 2014). Ninety-per cent of suicide deaths in high-income countries result from underlying mental and substance use disorders (Ferrari et al. 2014; Ritchie and Roser 2020).

Psychosis and bipolar disorders

The WHO Mental Health Gap Action Programme (mhGAP) aiming at scaling up services for mental, neurological and substance use disorders describes psychosis and bipolar disorders as severe mental health conditions, linked with a high risk of human rights violations, stigma and discrimination. 3 out of 100 people will experience psychosis in their life, and it often starts at a young age (Ochoa et al. 2012). People suffering from psychosis may have hallucinations (seeing, hearing, smelling, tasting or feeling things that don't exist outside a person's mind), delusions (thought disorders) and severe abnormalities of behaviour, or disturbances of emotion (WHO 2016b). Schizophrenia is a chronic psychotic disorder which is associated with considerable disability and can affect educational and occupational performance (Ochoa et al. 2012) Although it is less common as many other MNS conditions, it affects 0.3 per cent of the global population (ranging from 0.2 to 0.4 per cent between countries) (Roser 2018), and affects men more than women (WHO 2020e).

The global prevalence of bipolar disorder is 0.6 per cent and ranges from 0.3 to 1.2 per cent between countries and accounted for nearly 10 million DALYs in 2013 (Ferrari et al. 2016; Roser 2018). People with a bipolar disorder experience *episodes in which the person's mood and activity levels are significantly disturbed*, ranging from mania, with high energy and activity and elevation of mood, to depression, with low mood, energy and activity (WHO 2016b). These symptoms can affect the quality of life, as they have implications for a person's physical, emotional and social functioning (Vornik and Hirschfeld 2005).

Epilepsy

Epilepsy is a common chronic neurological disorder, causing recurrent unprovoked seizures. It is an important cause of disability and mortality, affecting at any given time, between 4 and 10 per 1,000 people of all ages. Nearly 80% of them living in LMIC, of whom 75% do not access treatment, whilst treatment can be very effective. If treated well, 70% of the people living with epilepsy could live symptom-free (WHO 2020d). In high-income Countries, epilepsy is usually treated by a neurologist, but in the absence of neurological services in LMIC, the treatment is often taken care of by mental health workers. Causes are not always identified but can be genetic or due to trauma or infections of the brain. In some people, no cause may be identified. Non-convulsive epilepsy is characterised by a change in mental status, and convulsive epilepsy can cause sudden abnormal movements, such as body stiffening and shaking. People with convulsive epilepsy are often exposed to huge stigma and higher morbidity and mortality (Beghi et al. 2019; WHO 2016b).

Dementia

Dementia is a neurological condition common in older people but can start at any age. It is a chronic syndrome caused by changes in the brain, leading to memory loss and changes in behaviour and personality. Alzheimer's is the most common of the many forms of dementia (60-70% of all cases). It is a significant cause of disability among older people, and impacts on caretakers, families and societies at large (WHO 2016b). Globally, it is estimated that 5-8 per cent of the population aged 60 years and above live with dementia at any point in time, nearly 60% of them living in LMIC, with nearly 10 million new cases each year. It is projected that in 2030, 82 million people will have dementia, rising to 152

million in 2050. Much of this increase is attributable to the rising numbers of people with dementia in LMIC (WHO 2020c).

Substance use disorders

The mhGAP considers substance use disorders to include drug and alcohol use disorders, intoxication, overdose and withdrawal. A pattern of substance uses that damages physical or mental health is considered harmful use. There is often an association with social problems. It is often associated with social consequences, e.g. family or work problems and risky behaviour (e.g. unsafe sex, the spread of HIV, and domestic violence). The share of the global population with alcohol use disorder is 1.4 per cent (ranging between 0.5-5 per cent between countries), and that of drug use disorder is 0.9 per cent (ranging between 0.4 and 3.5 per cent) (Roser 2018). Yearly, 3.3 million people die due to alcohol use and about 31 million people have a drug use disorder (WHO 2020f). Dependence is characterised by a strong craving to use the substance and losing control over its use (WHO 2016b).

Mental and behavioural conditions in children and adolescents

It is estimated that 43 per cent of children in LMIC below the age of five are at risk of poor development (Black et al. 2017). Furthermore, 16 per cent of the global burden of disease in adolescents is attributed to mental health conditions, and half of mental health conditions start at the age of 14 (WHO 2020a). The mhGAP distinguishes developmental, behavioural and emotional conditions among children and adolescents. Developmental conditions usually start in childhood and include intellectual disability and autism spectrum disorders. Behavioural conditions include Attention Deficit Hyperactivity Disorder (ADHD) and conduct disorders. Emotional disorders are among the most common mental health causes of the global burden of disease in young people and include increased anxiety, depression, fear, and somatic symptoms. These conditions, and the symptoms children and adolescents present, often overlap (WHO 2016b).

Post-traumatic stress disorder

In addition to the defined priority conditions, Post Traumatic Stress Disorder (PTSD) is one of the most prevalent mental health conditions in humanitarian settings. PTSD can develop in response to exposure to extremely stressful or traumatic events, or an exceptionally threatening situation. Examples include rape, violent attack, severe accidents, sudden destruction of home or community, or harm to close relatives or friends. PTSD is characterised by re-experiencing the event in nightmares, flashbacks, or physical sensations, avoidance and emotional numbing, panic attacks, sleep disturbance and poor concentration. People experiencing PTSD may also be at higher risk of depression, difficulties managing anger, and misuse drugs or alcohol.

Acute and posttraumatic stress disorders are included in the mhGAP intervention guide for humanitarian settings. There has been some debate about the cross-cultural validity of this diagnosis, which should also be kept in mind with the classification of other disorders (e.g. schizophrenia, depression etc.).

4. 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 (UHC), which requires strengthening of health systems and enhancing multi-sectoral

collaboration. There is also 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.

4.1 Universal Health Coverage for Mental Health

The principle of 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. These will enable them to achieve recovery and the highest attainable standard of health, including mental health, without financial hardship.

The global health agenda is calling upon the inclusion of mental health as an essential component of UHC, that is that 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 to have a comprehensive approach, and it means shifting away from institution-based mental health care towards community based mental health care (WHO 2018a). The principles of UHC in relation to mental health implies appropriate attention to the access of people with MNS conditions and psychosocial disabilities to quality services, expanding the role of mental health specialists and enhancing mental health competencies among other health care providers. One of the means to progress 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).

UCH for mental health: contribution through health system strengthening

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 improving the 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 achieving UCH.

Strengthening primary care level

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 primary health care (PHC) level. Moreover, a shift is required from addressing severe conditions only to include early interventions for emerging mental health problems. A community-based focus is not only relevant 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 2). This doesn't 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). 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 health-care systems (Fu et al. 2020).

Figure 2: WHO service organisation pyramid (Bhugra et al. 2017)

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 health staff, especially in LMICs, a 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 promoting task-sharing with trained non-specialist mental health care providers, and enhancing 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 in many languages, can be culturally adjusted and applied to train midlevel 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 especially 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 will only work if health workers receive sufficient mental health support, coaching, supervision and opportunities for debriefing and peer counselling. Therefore, 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).

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 approach 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, working in partnerships to mobilise, disburse and utilise funds, and providing oversight and accountability (Patel et al. 2018). Furthermore, it is recommended that national health budgets allocate a minimum of 5 per cent 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). 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 SDGs 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 little evidence that cash transfer programs can positively impact mental health outcomes, and can reduce 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). However, (continuous) the availability of a few essential low-cost psychotropic drugs (e.g. 1-2 antidepressants, 2 antipsychotics and 2-3 anti-epileptic drugs can be very cost-effective and has 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).

Strengthening information systems, evidence and research for mental health

Gathering data for mental health is crucial, as this provides a basis for the organisation and evaluation of 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 there is also a problem with other programs not reporting 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 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.

Improving 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 the vertical and horizontal integration of mental health services, coordination and collaboration across levels in the health system, re-allocation of funds (towards mental health at PHC and community level and at specialist level) 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 the 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 in order 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, it is important that a country has a national mental health coordinator and unit within the ministry of health and (develops) 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).

4.2 Effective interventions: from emergency setting 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 due to mental health conditions can be alleviated. Psychosocial support aims to equip people with skills to address risks, mediators or consequences of mental health conditions and to facilitate enabling 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 3)(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 example, 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 focused groups on alcohol and substance abuse, epilepsy support groups, Inter Personal Therapy (IPT) groups and Problem Management Plus (PM+), a transdiagnostic intervention providing individual psychological support for people affected by crisis (Dawson et al. 2015).

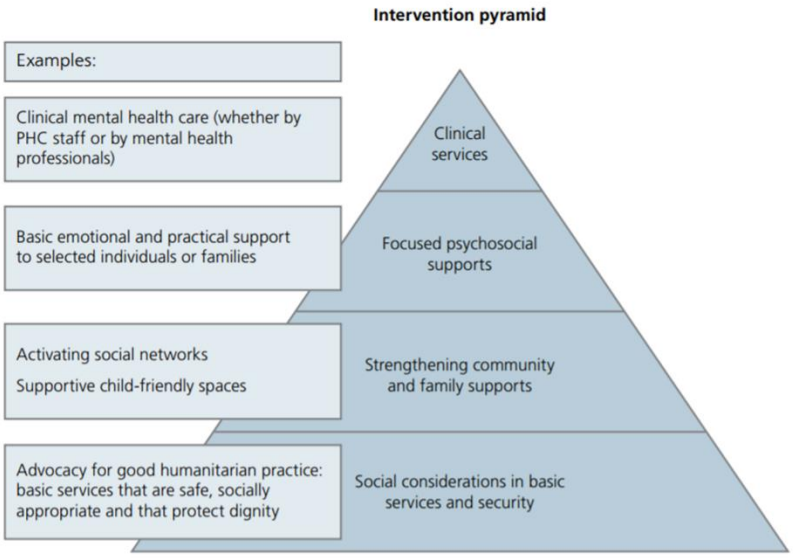

Figure 3: Intervention pyramid during emergencies (Wessells and van Ommeren 2008)

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 mental health conditions and adults with depression in humanitarian settings, but these focus mainly on the 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 by media and governments for the plight of people affected, and their mental health needs, which can generate financial support from various actors, presenting opportunities for sustainable mental 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).*

During the world humanitarian summit in 2016, the importance of addressing the humanitarian-development nexus was stressed, whereby humanitarian action and development are implemented as part of a continuum. This is certainly a necessity for mental health interventions and programs. 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 the

humanitarian and development actors is needed. Furthermore, the continuation of long-running efforts in the 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 will allow the scope of practice of health workers and related competencies at different levels to be defined, and therefore mental health can be integrated into current service delivery models and developing systems for the training and supervision of the health and social workforce, building local capacity. 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 to 5 years. Understanding how MHPSS programs can be best integrated into existing services is key to strengthen the humanitarian-development nexus (Ran 2019).

4.3 People centred interventions: human rights and life course approach

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 in 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, while at the same time they are at risk to get affected by more stressors and vulnerability for MNS conditions and disorders.

People with MNS conditions as well as people with psychosocial disabilities are among the most vulnerable groups experiencing marginalisation and multiple human rights violations. Worldwide, people living with MNS conditions or psychosocial disabilities are routinely denied access to quality health services, housing, employment, education or legal protection. In addition, stigmatisation and discrimination are barriers to social inclusion and lead to various forms of violence (e.g. physical and sexual violence). Promoting the empowerment, rehabilitation, and participation of people with MNS or psychosocial disabilities in their communities is also an underlying principle related to human rights. This includes meaningful engagement in all stages of an intervention, from the planning phase through to evaluation. People with a lived experience are often represented by professionals who make decisions on their behalf in MHPSS interventions. The Convention on the Rights of Persons with Disabilities states that all people have the inherent legal capacity, and therefore should be at the centre of the decisions affecting their well-being (Articles 12 and 14). A human rights approach also entails having decision-making mechanisms in place that enable people with a lived experience to

exercise their right to decide and make choices that affect their lives (Lancet 2018). The patient should be at the centre of any intervention, and all interventions should involve people with lived experience at all stages, not as a replacement for existing care structures, but strongly embedded in programs supported by experts.

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 justifies the importance of taking a life-course perspective on mental health, and to address in particular the needs of children and adolescents. Even before being born, 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 being particularly receptive to peer and media pressure, which exacerbates the risk of alcohol and drug abuse, which in turn is particularly harmful to the brain development of teenagers. During adulthood, either being unemployed or having a poor work-leisure balance becomes a key determinant of mental health. Finally, in old age, the risk of cognitive decline and dementia come in to play as well as the risk of social isolation (Ritchie and Roser 2020).

5. Case studies from the field

Whilst some approaches have shown to be effective across various settings, for other interventions the strength of the evidence for effectiveness on the outcomes is limited. However, they have been included in this report as they are promising when the approaches described in this report are taken into account. Not surprisingly, all the case studies selected use community/people centred approaches, apply service delivery models which are characterised by a shift towards community-level care and are promising scalable interventions.

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
Evidence	Through routine screening and referral, the PMHP model demonstrates the feasibility and acceptability of a stepped care approach to provision of mental health care at the primary care level

This project developed an intervention allowing the delivery of mental health care in an obstetric setting to women during their perinatal period, 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% of all women attending antenatal care in the maternity clinic were offered mental health screening with 95% uptake. Of those screened, 32% qualified for referral to counselling. The project includes the 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).

Example of integration at Primary health care level, including mental health screening and treatment	
Intervention	**Community based stepped care approach**
Country	India
Mental health focus	Use front-line, non-specialist health workers to identify and treat mental illness at a national level, as a means to counter the large treatment gap in low-income countries
Target group	General population
Evidence	Strong cost effective model. Found to have population benefit and helps to reduce stigma

A community-based stepped-care model is a strong cost-effective model to reach people who need mental health services with limited resources. Different NGOs use it as the basis for their programs and it can be used by governments. The approach has a population health benefit, benefitting groups of people rather than just individuals. It helps to reduce stigma, enhancing community understanding mental illness and how it can be addressed. The model is based on having a few trained medical specialists at the top with some health professionals trained in mental health care throughout the national system with a broad base of lay health workers trained to help deliver basic mental health services (including diagnosing, referring and provide basic mental health services). The least intensive intervention that is appropriate for a person is typically provided first (Mackenzie and Caddick 2016).

Example of integration of mental health services at primary health care level	
Intervention	**PRIME (Programme for Improving Mental healthcare)**
Country	Nepal
Mental health focus	Scaling up/Integration/Health system strengthening
Target group	General
Evidence	Effective integration and scaling up of mental health service delivery.

A community-based stepped-care model is a strong cost-effective model to reach people who need mental health services with limited resources. Different NGOs use it as the basis for their programs and it can be used by governments. The approach has a population health benefit, benefitting groups of people rather than just individuals. It helps to reduce stigma, enhancing community understanding mental illness and how it can be addressed. The model is based on having a few trained medical specialists at the top with some health professionals trained in mental health care throughout the national system with a broad base of lay health workers trained to help deliver basic mental health services (including diagnosing, referring and provide basic mental health services). The least intensive intervention that is appropriate for a person is typically provided first (Mackenzie and Caddick 2016).

Example of integration of mental health in general care and decentralisation of care	
Intervention	**mhGAP training implementation**
Country	Pakistan
Mental health focus	Task shifting to primary care
Target group	Displaced populations
Evidence	Despite the challenges of a humanitarian crisis, mhGAP guidelines can be successfully implemented to train primary care physicians in LMIC. However, the dearth of primary care resources can hinder the complete integration of mental health services into primary healthcare.

After a humanitarian crisis in a district in Pakistan, the Mental Health Gap Action Programme (mhGAP) training was conducted for physicians and psychosocial staff. Before starting the training, joint consultations with the health authorities in the district were held.
A needs assessment and advocacy were done in the camp, looking at the psychosocial context of the displaced population, the presentations of common mental disorders and the local healthcare system. Based on that, the mhGAP intervention guide was adapted to the local needs and the competence of the local health staff. A major adaptation of the training was to translate it in the local language (Urdu) simplify it, as it was found too complex for the setting (with lots of comprehensive protocols and algorithms). Furthermore the interventions and referral indications were defined with consideration of the healthcare system in the district (Humayun et al. 2017)

Example of community based prevention program with task shifting	
Intervention	**Contact and Safety Planning (CASP) intervention**
Country	Tamil Nadu, South India
Mental health focus	Suicide prevention
Target group	Adults in displaced populations (Sri-Lankan Refugees)
Evidence	Promising outcomes resulting from the study (lower suicide attempts).

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).

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
Evidence	Found effective in reducing PTSD, anxiety, depression symptoms

The Common Elements Treatment Approach (CETA) is a transdiagnostic intervention, addressing mental health problems among survivors of systematic violence. CETA includes 8–12 weekly individual sessions of about an hour. It is provided by non-specialised health workers at the primary health care level. It includes different elements (psychoeducation, relaxation, behavioural activation, cognitive coping and restructuring, imaginal exposure, in vivo exposure, safety). Community Mental Health Workers received a 10 day training on all the elements, as well as on selecting, sequencing, and dosing. In the training the model was culturally adapted to the context. This training was followed by small practice groups, supervised by local psychiatrists, and one pilot. Throughout the program there were weekly group supervisions (by the local supervisors, who were supported by CETA trainers based in the US, through skype). Local supervisors and non-specialised health workers with little prior mental health training or experience were able to implement the model with good results and acceptability, most clients retained in treatment (Weiss et al. 2015; Murray et al. 2014)

Example of a task shifting intervention	
Intervention	**Problem Management Plus (PM+)**
Country	Pakistan
Mental health focus	Common mental health disorders
Target group	Patients receiving specialised mental health care
Evidence	20-weeks after baseline, there was a significant reduction in symptoms of anxiety and depression and improvement in functioning in patients receiving PM+

The WHO PM + intervention uses problem solving and behavioural techniques and is delivered in 5 weekly individual face-to-face sessions of about 90 minutes. The program has a task-shifting approach where non-specialist health workers can deliver the program to adults with psychological distress. It is trans-diagnostic, addressing a range of symptoms for common mental disorders, there is no need for expert diagnosis to qualify treatment. PM + providers received eight days training in PM + by the master trainer followed by fortnightly supervision meetings (Hamdani et al. 2020). (See chapter 7 for more information about PM+)

Example of a vertical program by lay workers	
Intervention	**Friendship Bench**
Country	Zimbabwe
Mental health focus	Common mental health disorders
Target group	Adults
Evidence	Evidence of the feasibility and acceptability of using lay health workers to deliver a psychological intervention for common mental health disorders. And found to result in significant lower symptom scores compared to persons not participating in the program

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).

Example of a horizontal stepped care model and scaling up intervention	
Intervention	**Adult Improving Access to Psychological Therapies program (IAPT)**
Country	United Kingdom
Mental health focus	Talking therapy
Target group	High Income Countries
Evidence	Recovery rates are in excess of 50% and 2 out of 3 people show significant improvement.

The Improving Access to Psychological Therapies (IAPT) programme began in 2008 is a talking therapy programme aiming to help people overcome their depression and anxiety, and better manage their mental health. It includes; Evidenced-based psychological therapies delivered by trained practitioners, matched to the mental health problem, offered integrated with physical healthcare pathways; Routine outcome monitoring, ensuring up-to-date information on an individual's progress (for both the person receiving care and the care provider) through a positive and shared approach. This data is anonymised and published, promoting transparency in service performance encouraging improvement; Outcome focused supervision to continuously support health providers to improve and deliver high quality care. The program uses NICE guidelines in which Cognitive behaviour therapy is most commonly used. IAPT also uses counselling, inter-personal therapy, couples therapy and brief psychodynamic therapy to treat depression. IAPT uses a stepped care model providing low intensity therapies to people with mild symptoms, and if needed, more intensive therapy can be provided. Results are made public (http://content.digital.nhs.uk/iaptreports). IAPT is being scaled up for children and young persons in the UK (Clark 2018).

Example of a prevention intervention with a focus on parenting	
Intervention	**Triple P (Positive Parenting Program)**
Country	Argentina
Mental health focus	Children and adolescents up/parents
Target group	Emotional/social/behavioural issues in children
Evidence	Triple P has been shown to be effective at reducing behavioural and emotional problems in children, improving parental well-being and parenting skills, reducing stress and depression and slowing the rate of child abuse

The Triple P – Positive Parenting Program is implemented in over 25 countries, including in Argentina where it is part of a government project to support families and help them cope with the emotional, social and behavioural issues in children and adolescents. Seminars, one-on-one primary care sessions and group courses are being offered.
The program aims to equip parents with skills to prevent and manage behavioural and emotional problems in children and adolescents (up to 16 years). The program includes a range of interventions of varying intensity tailored to the needs of parents and children (from a tailored communications strategy to one-time assistance to multi-week modular sessions). Modality of delivery also vary from individual face to face, group, telephone assisted and self-directed programs. The program works with an international network of trainers and implementation consultants who support accreditation of practitioners and provide a sustainability framework to guide delivery in different contexts and makes use of the Incredible Years (IY) programs for parents, teachers, and children aiming to reduce challenging behaviours in children under 12. The program addresses overlapping risk factors for developing conduct disorders in children across settings. The programs have been shown to be effective with different ethnic groups, cultures and age (Nowak and Heinrichs 2008).

Key messages and recommendations

Key messages

Regarding the urgency of prioritising mental health:

- Over 10 percent of the world's population live 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. The prevalence of mental health condition is especially high among people affected by conflict, standing at 22,1 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.
- Children and adolescents are an important group that is highly affected by mental health.
- 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
- At the same time, 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, through mild and time-limited distress, and to progressive and sever 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 need 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 approach 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 sustainability of these services.
- Preventive interventions are more effective when a multisectoral approach is in place
- There is a need for more (disaggregated) mental health data and research on what works and how with respect to MHPSS interventions.

Recommendations

Regarding availability and accessibility of services

- To achieve UHC, mental health needs to be an integrated part of the work Sida supports, by explicitly formulating goals for mental health and including criteria for addressing mental health for 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, multisectoral response to mental health by supporting national governments in the development of mental health policies and plans.

Regarding 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, stimulating and strengthening interventions adopting a life course approach and a rights-based approach.

Regarding prevention, equity and inclusiveness

- Addressing 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 in intervention development, implementation and monitoring and evaluation as partners.
- 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 a focus is place on the particular on the needs and empowerment of people with a lived experience and ensure sensitisation about their human rights violations.

Regarding research and data

- As the research gap for mental health across various settings remains a barrier for the 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 people with lived experience in particular. 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

Resource	*Description*	*Applicable context*	*Available from*
Mental health action plan 2013 – 2020	Adopted by the Member states during the 66th World Health Assembly, the action plan recognises the essential role of mental health in achieving health for all people. It is based on a life-course approach, aims to achieve equity through universal health coverage and stresses the importance of prevention	All settings	https://www.who.int/mental_health/action_plan_2013/en/
mhGAP intervention guide	The mhGAP Intervention Guide (mhGAP-IG) for mental, neurological and substance use disorders for non-specialist health settings, is a technical tool developed by WHO to assist in implementation of mhGAP. It presents integrated management of priority conditions using protocols for clinical decision-making. The mhGAP-IG is a model guide and has been developed for use by health-care providers working in non-specialised health-care settings after adaptation for national and local needs.	All settings	https://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/
mhGAP Humanitarian intervention guide	The mhGAP Humanitarian Intervention Guide contains first-line management recommendations for mental, neurological and substance use conditions for non-specialist health-care providers in humanitarian emergencies where access to specialists and treatment options is limited. It is a simple, practical tool that aims to support general health facilities in areas affected by humanitarian emergencies in assessing and managing mental health conditions. It includes a complete package of how to implement training (in different languages)	Humanitarian settings	https://www.who.int/mental_health/publications/mhgap_hig/en/
IASC guidelines	The Inter-agency standing committee (IASC) Guidelines enable humanitarian actors to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergency.	Humanitarian settings	https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf
Assessing mental health and psychosocial needs and resources	The WHO-UNHCR publication Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings was developed because of frequent requests from the field to advise on assessment. Although a range of assessment tools exist, what has been missing is an overall approach that clarifies when to use which tool for what purpose. This document offers an approach that should help assessors review information that is already	Humanitarian settings	https://www.who.int/mental_health/resources/toolkit_mh_emergencies/en/

	available and only collect new data that will be of practical use.		
Caring for volunteers, A psychosocial Support Toolkit	The toolkit assists National Societies of the Red Cross in preparing and supporting volunteers for their work during and after disasters, conflicts and other crisis events. It contains practical tools and information on preparing for crises, communication and Psychological First Aid (PFA), peer support and monitoring and evaluation.	During and after disasters, conflicts and other crisis events	https://pscentre.org/?resource=caring-for-volunteers-a-psychosocial-support-toolkit-english
Building Back Better	Although not a guideline as such, this WHO publication shows how in 10 diverse emergency-affected areas the emergencies, in spite of their tragic nature and adverse effects on mental health, were used as unparalleled opportunities to build better mental health systems for all people in need.	Post disaster/post conflict	https://www.who.int/mental_health/emergencies/building_back_better/en/
Mental Health Atlas	The Mental Health Atlas series is considered the most comprehensive resource on global information on mental health and an important tool for developing and planning mental health services within countries and regions. The Mental Health Atlas 2017 acquires new importance as it includes information and data on the progress towards the achievement of objectives and targets of the Comprehensive Mental Health Action Plan 2013–2020.	All settings	https://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/
The Sphere Handbook	Handbook providing guidance on humanitarian charter and minimum standards in humanitarian response. Provides standards on mental health care as part of health. *"People of all ages have access to healthcare that addresses mental health conditions and associated impaired functioning"*	Humanitarian settings	https://spherestandards.org/wp-content/uploads/Sphere-Handbook-2018-EN.pdf
Problem Management Plus (PM+)	The manual describes a scalable psychological intervention called Problem Management Plus (PM+) for adults impaired by distress in communities who are exposed to adversity. Aspects of Cognitive Behavioural Therapy (CBT) have been changed to make them feasible in communities that do not have many specialists.	Settings where people are exposed to adversity	https://www.who.int/mental_health/emergencies/problem_management_plus/en/
Useful websites	• World Health Organization • WHO Mental health & Covid-19 • Psychosocial support centre (IFRC) • Mental Health Innovation Network • Movement for Global Mental Health • Our world in data		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

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