ANNEX B: MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

UNHCR GLOBAL STRATEGY FOR PUBLIC HEALTH

2021-2025

ANNEX 2: PROGRAMMATIC GUIDANCE

B) TECHNICAL SHEET: MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS)

ACRONYMS

CBST	Community-based Sociotherapy
CETA	Common Elements Treatment Approach
GBV	Gender-based Violence
HIS	Health Information System
IASC	Inter-Agency Standing Committee
IAT	Integrated Adapt Therapy
IPT	Interpersonal Therapy for Depression
IPV	Intimate Partner Violence
iRHIS	integrated Refugee Health Information System
mhGAP	Mental Health Gap Action Programme
mhGAP-HIG	Mental Health Gap Action Programme Humanitarian Intervention Guide
MHPSS	Mental Health and Psychosocial Support
MNS disorders	Mental, neurological and substance use disorders
PM+	Problem Management Plus
POC	Persons of Concern
PTSD	Post-traumatic stress disorder
SDG	Sustainable Development Goals
SH+	Self Help Plus
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office for Drugs and Crime
WHO	World Health Organization

1. INTRODUCTION

MHPSS

Mental health is an inseparable part of health that must be addressed in an integrated way throughout the public health programmes of UNHCR and partners. Within humanitarian assistance, the broader term 'mental health and psychosocial support' (MHPSS) is commonly used to refer to 'any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental disorders'. This technical sheet will mainly focus on what health actors in refugee setting should do with regards to MHPSS and how to coordinate around MHPSS with other sectors. However, MHPSS is not restricted to the health sector and requires multisectoral action with interventions in programmes for protection (community-based protection, child protection and GBV) and education. Coordination with other sectors is therefore essential. For more guidance on MHPSS outside the health sector consult the following documents:

- Operational guidance, mental health & psychosocial support programming for refugee operations
- Strengthening Mental Health and Psychosocial Support in 2021

Terminology

Within UNHCR, we use the term 'mental disorders' when referring to a therapeutic context (for example the number of consultations for mental disorders in the HIS). We use the term 'MHPSS problems/ conditions' when referring to a broader spectrum of issues including social problems, emotional distress, common mental disorders (such as depression and post-traumatic stress disorder), severe mental disorders (such as psychosis), alcohol and substance abuse, and intellectual or developmental disabilities. For historical and pragmatic reasons, epilepsy and dementia are included in MHPSS work. Some actors use other terms such as 'mental, neurological and substance use (MNS) disorders'[1] or 'psychosocial disability'.[2]

Prevalence

Around 22% of adults in conflict settings have mental health disorders. This is much more than in non-conflict settings. Reasons for the increased prevalence of mental health conditions include adverse experiences in country of origin, on the way and in refugee settings and lack of supportive social systems. Many more are distressed, but there are no global data.

The mental health and psychosocial well-being of displaced communities is determined by

- events in the past that lead to their displacement or on the way to safety
- current conditions including the adequacy of the assistance and protection in place
- how refugees perceive their future: solutions and real prospects to get a better life.

Multifactorial aetiology

Without good mental health, people feel unable or less able to carry out activities of daily living, including self-care, education, employment and participation in social life. There is a bidirectional relation between mental health and poverty, loss of livelihoods: (1) People who drift into poverty, marginalization, who lost their livelihoods and future, have more mental health issues; (2) Pervasive states of depression, hopelessness, being overwhelmed by memories of the past and being full of negative thoughts, hinders people to use their potential to find solutions.

Sustainable Development Goals

Mental health is explicitly mentioned in the Sustainable Development Goals.

- SDG 3.4: 'By 2030, reduce by one third premature mortality from non-communicable disease through prevention and treatment and promote mental health and well-being'.
- SDG 3.5 'Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol'.

MHPSS is also relevant for other goals such as SDG 16 on Justice, Peace and Stronger Institutions.

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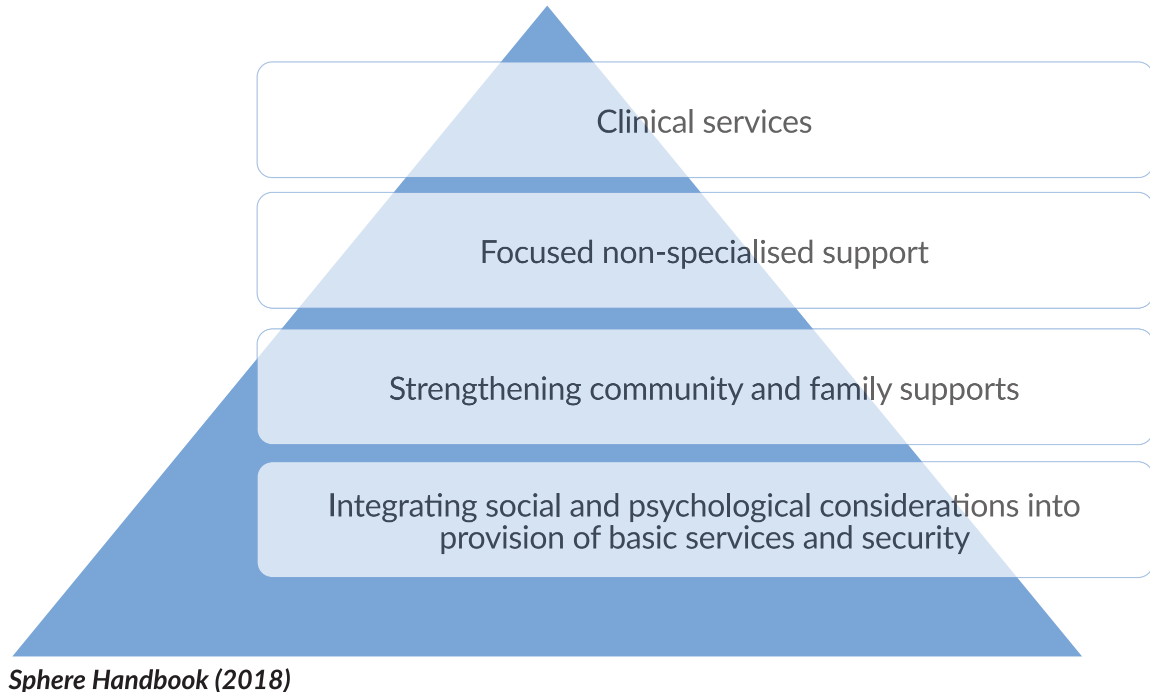
Lebanon. Ten years into Syria crisis, refugee family struggling with poverty and mental health issues

[1] The World Health Organization uses the term 'Mental, neurological and substance use (MNS) disorders' to refer to mental disorders, alcohol/substance use disorders, epilepsy and dementia.

[2] Disability advocates use the term 'psychosocial disability' to refer to forms of disability related to people who have received a mental health related diagnosis (or who self-identify with this term) and who experience participation restrictions due to social and environmental barriers, often related to discrimination and exclusion. The term captures the notion of disability as being the result of physical and social barriers preventing a person with an impairment from participating equally in community and social life.

Figure 1: Multi-layered MHPSS services and supports



Sphere Handbook (2018)

2. GUIDING FRAMEWORKS FOR MHPSS

IASC Guidelines on MHPSS in Emergencies (2007)
This interagency guidance provides a consensus framework for MHPSS in humanitarian settings that forms the basis of agency-specific guidance including that of UNHCR. Key notions in the guidance are (1) that MHPSS is not something that can only be done by mental health specialists, (2) that a multisectoral approach is needed and (3) that services and supports can best be seen as a multi-layered system (see figure 1).

Layer 4: Clinical mental health and psychosocial services for those with severe symptoms or whose intolerable suffering rendering them unable to carry out basic daily functions. Such interventions are usually led by mental health professionals but can also be done by trained and supervised general health workers.

Layer 3: Provision of focused psychosocial support through individual, family or group interventions to provide emotional and practical support to those who find it difficult to cope within their own support network. Non-specialised workers in health, education, community-based protection or child protection usually deliver such support, after training and with ongoing supervision.

Layer 2: Strengthening community and family support. This is not so much about 'outsiders' delivering 'interventions', but about enabling people to preserve and promote their psychosocial well-being through activities that foster social cohesion and through enabling communities to restore or develop mechanisms to protect and support themselves.

Layer 1: Provision of basic services and security in a manner that protects the dignity of all people, including those who are particularly marginalized or isolated and who may face barriers to accessing services and deliver the response in a participatory, rights-based way.
(Adapted from IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings, 2007)

In the Sphere Handbook, MHPSS is mentioned throughout the document, in addition to a specific Mental Health Standard 'People have access to health services that reduce mental health problems and associated impaired functioning' with the following key actions:

1. Coordinate mental health and psychosocial supports across sectors.
2. Develop programmes based on identified needs and resources.
3. Work with community members, including marginalised people, to strengthen community self-help and social support.
4. Orient staff and volunteers on how to offer psychological first aid.
5. Make basic clinical mental health care available at every health care facility.

6. Make psychological interventions available where possible for people impaired by prolonged distress.
7. Protect rights of people with severe mental health conditions in the community, hospitals and institutions.
8. Minimise harm related to alcohol and drugs.
9. Take steps to develop a sustainable mental health system during early recovery planning and protracted crises.

***UNHCR Operational Guidance for MHPSS in Refugee Operations* (2013)**
This document informs the MHPSS response in different sectors. An important concept is the difference between and MHPSS approach and MHPSS interventions:

- Adopting an *MHPSS approach* means providing humanitarian responses in ways that are beneficial to mental health and psychosocial well-being. This is relevant to everyone who assists refugees. Humanitarian actors should not necessarily do different things; rather do things differently. This has become clear within the COVID-19 pandemic.
- *MHPSS interventions* consist of activities with an explicit goal to improve the mental health and psychosocial well-being of refugees, usually implemented by health, protection, education actors.

3. PRIORITY ACTIONS FOR MHPSS WITHIN HEALTH PROGRAMMES

Many refugee hosting countries do not have a functional mental health system to integrate refugees into, while the needs are often extremely high. Therefore, UNHCR uses a twin track approach: (1) support direct service provision through partners and (2) working towards integration through strengthening national services. Below is a list of activities that can be considered, depending on available resources.

a) Integration of mental health into general health care facilities for refugees

Mental health is an intrinsic part of health care. Among patients visiting general health care, a disproportionate number has mental health conditions that can be identified and managed. Therefore, each health facility needs to integrate mental health into its services.

1. Ensure that mental health is part of the Project Partnership Agreement with health providers.
2. Arrange for a routine supply of essential medication for mental disorders to health centres.
   Tools:
   - Psychotropic Medication on UNHCR Essential Medicine list May 2021
   - Calculation tool for quantities of psychotropic medication (in development)

3. Ask partners to regularly organize training for general health staff in identifying and managing mental health conditions. Such trainings usually take 3-5 days and need to be followed by supportive supervision and refresher trainings.

   - Tools: WHO/UNHCR (2015) mhGAP Humanitarian Intervention Guide
   - Tools: WHO/UNHCR (2021 in press): Facilitation Manual mhGAP Humanitarian Intervention Guide

4. Arrange for a mental health professional (dependent on the context this can be a psychiatrist, psychiatric clinical officer, psychiatric nurse or clinical psychologist) to manage people with complex conditions and provide clinical supervision to the general health workers. This can be a part time function. Minimum frequency of visit is once per month to each health centre, but more frequent visits are preferable.

5. Ensure that consultations for mental health conditions are registered in the health information system. In case mental health consultations are done by a separate MHPSS partner they shall be asked to enter their data in iRHIS.

   - Tool: MNS Categories in the iRHIS.
     See also here.

b) Integration of MHPSS into community health work

The community health workers are a bridge between communities and the health facilities. Mental health needs to be a part of their training curriculum and they should be regularly supervised on mental health issues. In some operations more specialized community MHPSS volunteers are trained to do more focussed work.

1. Train community health workers in identification and follow up of people with severe or complex mental health conditions.

2. Train community health workers in Psychological First Aid and Basic Psychosocial Skills.

3. Consider using community workers in facilitating of support groups for refugees with mental health conditions.
Tools
   - Psychological First Aid: Guide for field workers
   - Basic Psychosocial skills: A Guide for COVID-19 Responders
   - Sample curriculum for MHPSS training for Community volunteers (in development)
   - mhGAP community toolkit

c) Provision of evidence-based brief psychological therapies

Mild and moderate mental health conditions can be effectively addressed through brief scalable psychological interventions (5-8 sessions) that can be delivered by non-specialized staff after a brief training and with supportive clinical supervision by a mental health professional. There are several of such methods.

The choice is dependent on what the programme wants to achieve, costs, availability of trained staff and versions that are contextually and linguistically adapted. Important is to choose a method that is evidence-based. The most widely used methods are Problem Management Plus (PM+) which has been developed by the World Health Organization and group Interpersonal Therapy for Depression (IPT) which has been developed by Columbia University New York and was published by the World Health Organization. Table 1 contains an overview of scalable psychological interventions.

Table 1: Overview of scalable psychological interventions

Intervention (+ link)	*Description*	*For whom?*	*Where has it been used?*
Problem Management Plus (PM+) Individual version Group version	Based on Cognitive Behavioural Therapy. Participants learn to use four techniques: stress management, problem solving, behavioural activation and strengthening support. Basic training 7 days + regular supervision. • Individual version: 5 sessions of 90 min. • Group version (6-8 participants): 5 sessions Researched through RCTs in Pakistan, Kenya (non-refugees) and with Syrian and Venezuelan refugees	For adults with depression, anxiety and stress, including people who do not have a diagnosis.	Widely translated and used by UNHCR partners in • Middle East and North Africa: (Iraq, Jordan, Lebanon, Syria) • East and Horn of Africa and Great Lakes: (Ethiopia, Kenya, Uganda) • West and Central Africa (Chad, CAR) • Asia (Bangladesh) • Europe (Greece, Turkey, Switzerland, Netherlands) • Americas (Colombia, Equador, Panama)
Interpersonal Therapy for Depression (IPT) Group version Individual version (in development)	Aims to reduce depression by improving interpersonal skills to address: 1) loss, 2) role transitions. 3)interpersonal conflicts and 4) social isolation. Basic training 4-7 days + refresher and weekly clinical supervision. • Group version: 8 sessions • Individual version: 8-12 sessions • 'Interpersonal Counselling': Brief 3 session version as first line treatment by community workers	For adults with mild, moderate or severe depression. Can be effective for other conditions such as PSTD.	• Implemented through UNHCR in Bangladesh, Tanzania and Peru. • Used by partners in Lebanon, Syria.

Intervention (+ link)	*Description*	*For whom?*	*Where has it been used?*
Self Help Plus (SH+) Group version	Guided self-help for emotional distress using a self-help book and audios in 5 weekly sessions for groups up to 30 people. Research with South Sudanese refugee women showed small and transient effects. Research among refugees in Turkey and Europe showed a preventive effect on the development of mental health problems.	For adults with distress or mild-moderate depression anxiety	• South Sudanese women in Uganda (Juba Arabic version) • Refugees and migrants in Europe (Farsi, Arabic and English)
Integrated Adapt Therapy (IAT) Not yet in public domain	6 session model (individual or group), using elements of Cognitive Behavioural Therapy, that are 'packaged' specifically for refugees with attention to how the refugee experience is connected to psychological symptoms. Research with refugees in Malaysia and Bangladesh showed satisfactory results.	For refugee adults	• Myanmar refugees in Malaysia and Bangladesh • Refugees in Australia
Community-based Sociotherapy (CBST) Not yet in public domain.	15 group sessions of 2-3 hours with 8-12 persons from the same community ('area- based approach' facilitated by two facilitators from the same community. Participation in the group is based on social issues (marginalization, mistrust) not only on psychopathology. Goal is strengthening social connectedness, interpersonal support and mutual trust. Research in Rwanda shows improvements in mental health and civic participation.	Adults	• Conflict-affected populations in Rwanda, Burundi, DRC, Ethiopia and Liberia • Currently research with Congolese refugees in Rwanda and Uganda
Common Elements Treatment Approach (CETA) Not yet in public domain.	8-12 individual one-hour sessions based on Cognitive Behavioural Therapy with a modular approach for treatment of depression, anxiety, substance use and trauma and stress related disorders. Briefer versions and group versions are possible. More information here	Adults and Adolescents	• IDP in Iraq and Ukraine • Refugees in Thailand • Refugees in Ethiopia • Nationals in Zambia and Myanmar
Thinking Healthy Group version	15 group sessions for with perinatal mental health issues. Published by WHO	Women with perinatal depression	• Pakistan/India (non-refugees) • Yemen (non-refugees)
Friendship Bench Not yet in public domain	Individual Therapy (3 or more sessions) for people with mild/ moderate mental based on Problem Solving Therapy, activity scheduling followed by peer led group support. More info here.	Adults	• Zimbabwe

d) Promote access to mental health professionals for people with complex problems

With the steps above, access to essential MHPSS services can be greatly increased. But the emphasis on integrated treatment by non-specialists does of course not make the role of mental health professionals such as psychiatrists, psychiatric nurses and clinical psychologists redundant. They are especially important for training/ supervision and to help people with more complex problems. In many low- and middle-income countries it can be challenging to find specialist care or referral facilities that are of acceptable quality. A brief assessment should take place before considering a facility adequate for referral with a particular view on the use of evidence base treatments and respect for human rights.

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Bangladesh. Mental health project helps Rohingya youths discuss anxieties

e) Take steps to address neglected MHPSS issues such as alcohol and other substance use and suicide prevention

Standard packages for MHPSS do not sufficiently address two problem areas that are explicitly mentioned in the Sustainable Development Goals with an indicator to which all national governments have to report.

- Addiction and misuse of substances such as alcohol, illegal drugs and prescription medication.
  - SDG Indicator 3.5.1: Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders
  - SDG Indicator 3.5.2: Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol
- Suicide and suicidal behaviour
  - SDG Indicator 3.4.2: Suicide mortality rate

UNHCR has commissioned systematic reviews on suicide prevention and alcohol and substance use conditions which make clear that i) there are limited evidence-based interventions that have been tested in humanitarian settings and ii) that these problems can only be tackled through long term multi-sectoral approaches that combine community-based interventions with focused individual interventions.

A package for suicide prevention could consist of
- Improved and consistent data collection
- Review of cases of completed suicide and severe attempts
- Public awareness raising and community engagement, including information how and where to seek help
- Restriction of access to methods
- Training of gate keepers and community support persons in identifying people with increased risk for suicide, and in using emotional crisis management and de-escalation techniques
- Training frontline staff from health and protection partners in brief interventions and safety planning
- Opportunities for staff care after crises have occurred
- Standard Operating Procedures and referral pathways to specialized services (e.g. local mental health providers).

A toolkit for suicide prevention and response in refugee setting is being developed by UNHCR.
A package to address alcohol and substance use problems should consist of

- Awareness raising and access control
- Brief interventions on community level
- Individual psychotherapeutic interventions
- Clinical interventions

In 2021, a toolkit to address substance use in humanitarian settings is expected to be released by UNODC in cooperation with UNHCR.

f) Coordination around MHPSS

This technical sheet focussed on the MHPSS intervention within the health sector. However, MHPSS interventions should also be implemented in programmes for protection (child protection, GBV and community-based protection), education and nutrition.

Therefore, multisectoral coordination within a Technical Working Group (TWG) for MHPSS is important. These groups are ideally linked to both the health and protection sector and are co-chaired by actors from health and protection. MHPSS is not a subsector of health or protection. Given the technical nature of TWG involvement of MHPSS experts of NGO partners and government is advisable.

- Terms of Reference for a Technical Working Group for MHPSS (Sectoral Coordination Toolkit: Public Health in Emergencies Toolkit)
- In emergency settings, requests for short term deployment to support coordination and inter-agency capacity building can be done through mechanisms such as the Dutch Surge Support for MHPSS

A new interagency Minimum Services Package for MHPSS in Emergency Settings is being developed by WHO, UNICEF, UNHCR and UNFPA which is expected to become available in 2022.

4. KEY REFERENCE DOCUMENTS

UNHCR Guidance on Mental Health and Psychosocial Support for Persons of Concern

- UNHCR (2013) Operational Guidance for Mental Health and Psychosocial Support Programming in Refugee Operations
- UNHCR (2021) Strengthening Mental Health and Psychosocial Support in 2021
- UNHCR (2018) Mental health and psychosocial support entry in Emergency Handbook

Technical documents with WHO

- WHO & UNHCR (2015) mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies
- WHO & UNHCR (2013) mhGAP module Assessment Management of Conditions Specifically Related to Stress
- WHO & UNHCR (2012) Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings
- WHO & UNHCR (2021). Training manual for mhGAP-HIG.

Related Protection Documents

- Global Protection Cluster (2020) MHPSS and protection outcomes
- UNHCR (2014) Child protection Issue Brief: Mental health and psychosocial well-being of children
- UNHCR (2017) Community-Based Protection & Mental Health & Psychosocial Support
- UNHCR (2020) UNHCR Policy on the Prevention of, Risk Mitigation and Response to Gender-based Violence.