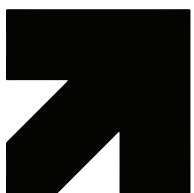# MENTAL HEALTH IN HUMANITARIAN CRISES:
ADDRESSING THE TREATMENT GAP

UNDERSTANDING THE INVISIBLE CRISIS

Nearly 80 million people worldwide are affected by conflict and displacement. At the same time, an estimated 15 million people around the world are living with a mental health condition. This staggering number is likely an underestimate with conditions like suicide, self-harm, chronic & toxic stress, and other psychological distress not counted. Conflict and forced migration have a profoundly negative impact on mental health and wellbeing, and unsurprisingly, mental disorders tend to double in the acute phase of an emergency.

Globally, only 1% of the health workforce are mental health workers. While estimates for access to mental health care and treatment within countries affected by conflict and displacement do not exist, we know conditions are exacerbated in humanitarian settings where people needing mental health and psychosocial support services too often go undiagnosed and untreated.

From improvements in the management of diabetes, to the learning outcomes for children, and engagement in social change there is strong evidence from non-humanitarian contexts of the catalytic nature of investment in mental health and psychosocial support on non-mental health outcomes. At the same time, strong evidence for effective mental health treatment approaches exist within humanitarian settings with links to broader health and social outcomes.

Ignoring mental health can have profound consequences on a person's ability to regain control of their lives after conflict and displacement. The IRC is committed to bringing mental health out of the shadows and making it more visible and supported across humanitarian crises.

We are committed to addressing the mental health treatment gap by integrating mental health into primary health care within all countries where we implement health programs by adopting evidence-based interventions and adapting them to the local context.

ADDRESSING THE MENTAL HEALTH TREATMENT GAP IN HUMANITARIAN SETTINGS

One of the most effective ways of closing the global treatment gap is to integrate mental health care into primary health care across the humanitarian development nexus. The IRC has successfully integrated mental health into primary health care services across ten countries and seen great impact. In 2020, IRC teams supported more than 78,000 consultations for patients with mental health conditions. This includes including providing pharmacological and/ or non-pharmacological care for common and severe conditions ranging from depression and anxiety to psychosis and bipolar disorder. Through primary health care programs, the IRC provides individual and group counselling, psychosocial support groups, and basic psychoeducation through health education sessions.

A commitment to quality

The IRC's approach to mental health is guided by a global mental health evidence base for implementing high-quality, strengths-based programming aimed at improving the mental health and wellbeing of individuals and families while doing no harm. Key interventions include the World Health Organization Mental Health Gap Action Programme (mhGAP), scalable psychological interventions and community-based mental health services and advocacy. Aligned with these approaches, the IRC is deeply committed to increasing access and quality of services along with taking measures to ensure that the delivery of mental health care is adapted to the context, culturally sensitive and responsive to client needs. This includes addressing healthcare provider attitudes and competencies, their adherence to global standards, the cultural appropriateness of interventions, and the use of data to inform and improve decision making. To deliver evidence-based interventions, strong supervision and support systems must be in place. The IRC uses a series of interventions designed to improve quality and supervision through competency checklists, self-assessments, and on-the-job supervision sessions delivered by a multidisciplinary team of mental health practitioners. Remote supervision has also been essential during the COVID-19 pandemic.

Scalable psychological interventions

There are a range of evidence-based, scalable, psychological interventions that can be delivered by non-specialists like midwives, nurses, social workers and community health workers to help people experiencing disabling stress, depression and anxiety. These are modified versions of existing evidence-based psychological treatments that are simplified to be rolled out by providers without formal academic training in mental health and can be used within humanitarian and fragile settings to reach more people, in places where there are not enough clinical staff to meet the growing need. This directly aligns with the IRC's greater vision for strong primary health care delivered directly in the communities where people live.

Destigmatizing mental health

In many humanitarian settings, stigma and discrimination against persons with mental health conditions and their families is pervasive – preventing those in need from seeking support and in some cases resulting in gross violations of human rights. In many settings there is also a lack of basic understanding among the general population of mental health and wellness including signs and symptoms of mental distress, regulation of emotions, and positive coping mechanisms. Increasing knowledge and awareness among conflict-affected populations about mental health concerns and available services is critical for removing stigma and ensuing access to services. Through outreach services the IRC encourages people to actively seek out help when they recognize that they, or members of their family, are unwell. Through household visits, psychoeducation sessions run by community volunteers and discussions of mental health concerns during routine health visits, the IRC works to change the narrative about mental health services and the stigma associated with them.

AN INTEGRATED APPROACH

Mental health is rarely considered a priority within humanitarian and fragile settings. Even when the need is recognized, it can be perceived as too difficult or too expensive to implement. At the IRC, we believe it is a human right and is a critical piece of improving overall health for those affected by conflict.

At the IRC, we are committed to delivering high quality mental health programs that are integrated within all primary health care programs, and that are highly adapted to the specific context where we work based on the health system, health workforce, security challenges, client group, and the cultural and social norms that affect well-being and mental health conditions. The IRC strives to support a catalytic change within the delivery of primary health care within humanitarian and fragile settings, making it the norm to ensure mental distress and mental health disorders receive sufficient attention and are part of a comprehensive package of care for all patients. This requires supporting health care providers across all phases of a conflict to change their practice to address an individual's physical health needs alongside their psychological and psychosocial needs.

We will ensure that Mental Health programs within primary health care are implemented within the overarching IRC MHPSS framework, that aims to provide client centered services across health, protection, education, and economic programming, both addressing the primary drivers of mental distress, and by implementing coordinated programs to address these needs. And across all of this, the IRC will continue investing in research to generate evidence and to accelerate the implementation of integrated mental health interventions that are scalable.

Self-Help Plus in Uganda

Within our IRC Uganda programming, we are implementing a scalable psychological intervention called Self-Help Plus (SH+) which uses audio-recorded sessions and an illustrated self-help book delivered through group workshops facilitated by a trained SH+. The program aims to support people through stress management to reduce psychological distress and improve functioning, within the larger context of conflict, poverty, and interpersonal violence. The project is co-designed with partners HealthRight International and the IRC Health and Protection teams in order to integrate this approach within five zones of Bidibidi Refugee Settlement and delivered through existing community based structures, with strong referral pathways to more specialized mental health services at the primary health care level.

MHPSS Response within COVID-19

In response to the pandemic, the IRC adapted its programs to ensure we could safely and effectively address mental health problems impacting our clients and frontline workers, while continuing to provide the support needed by existing mental health clients. In Kenya, Uganda, and Thailand, IRC teams integrated coping and anti-stigma messaging into general COVID-19 related messages; in Uganda, IRC held weekly staff welfare meetings and WhatsApp groups to share updates and messages to help staff utilize positive coping techniques; in Thailand, teams planned scheduled relaxation breaks for staff; in Tanzania, the IRC adjusted to more individual mental health and psychosocial support and have been transparent with our clients through the process; and in several countries teams categorized existing mental health clients to identify those most at risk in order to proactively plan for ongoing care and the use of hybrid service delivery using remote and in-person approaches. We also rolled out a global MHPSS learning series for all countries so that teams around the world were better able to address the increased demand for mental health services. This is just a snapshot of the MHPSS efforts during the COVID-19 pandemic.