MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

ICRC

IN BRIEF

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INTRODUCTION

Mental health and psychosocial support (MHPSS) has received increasing attention from public health actors in the past 15 years. Current data indicate that 450 million people worldwide are suffering from mental health or behavioural disorders.

In recent years, the public health focus has been on the burden caused by the disease rather than on the total number of people affected. Mental health, neurological and substance abuse disorders account for around 10-15% of the global burden of disease. According to the World Health Organization's *Mental Health Atlas 2011*, the proportion of mental health disorders left untreated ranges from 35% to 50% in high-income countries and from 76% to 85% in low-to-middle income countries. Over 800,000 deaths per year are the result of suicide, making this the second leading cause of death among 15-29-year-old people. Of the 20 main causes associated with the indicator "years lived with disability", nine are related to mental, neurological or substance-abuse disorders.

This document provides an overview of the needs that the ICRC's MHPSS programmes respond to. It is designed to give the reader insight into MHPSS programmes in situations of armed conflict and other situations of violence.

MHPSS describes a wide range of activities carried out by the ICRC to address the psychological and psychosocial problems caused or exacerbated by armed conflict and other situations of violence.

MHPSS support aims to protect and promote psychosocial well-being, prevent mental health disorders and treat such disorders when they occur.


N. Shrestha/ICRC

MHPSS SUPPORT FOR FAMILIES OF MISSING PERSONS

Not knowing whether a loved one is dead or alive defies emotional comprehension (Boss, 2002). It is an agonizing experience that can paralyze the families of missing persons and leave them susceptible to a variety of mental health and psychosocial difficulties.

Families commonly experience a desperate need not to forget their loved ones. They actively struggle to keep their memory alive despite the psychological and psychosocial difficulties that may result. Psychosocial and relational problems may also arise within families of missing persons or within their community. When this happens within a community, the families are often left completely isolated.

MHPSS needs:

- Symptoms associated with depression and anxiety
- Physical complaints with no known medical condition
- Feelings of desperation
- Living in a state of paralysed decision-making, coping and grieving as families remain in "waiting" mode
- Relationship conflicts within families

The "accompaniment approach", which is described in the *Accompanying Families of Missing Persons* handbook, was developed to respond in a holistic and multidisciplinary manner to the needs of families of missing persons. The handbook was prepared by the Health Unit in consultation with the Restoring Family Links (RFL) and Missing Persons Unit in the Central Tracing Agency and Protection Division. Invaluable assistance was provided by the International Law and Cooperation Department, the Forensic Services and Economic Security Units in the Assistance Division, and the Department of Communication and Information Management.

The MHPSS response:

- Psychosocial support groups (sharing experiences with other families of missing persons)
- Group sessions to share information and develop life skills
- Community sensitization activities


O. Shadman/ICRC

MHPSS is a fundamental component of the accompaniment approach because many families experience critical mental health and psychosocial difficulties when loved ones go missing. The inherent objective of MHPSS is not to "fix" the families' problems but to help them resume more functional lives. In order to achieve this, the programmes are designed to provide the support that families need in order to cope with the ambiguity and uncertainty of their situation.

MHPSS support aims at helping families find some meaning in their distressingly ambiguous experiences and reducing isolation within families and communities. Psychosocial activities are crucial in this process.

The ICRC's approach takes into account the observation that many families of missing persons experience psychological difficulties.

MHPSS monitoring mechanisms are put in place in these programmes in order to measure changes in symptoms associated with depression, anxiety, psychosomatic pain and distressing memories and to assess aspects related to daily functioning. Available data shows lasting improvements in mental health in all regions where MHPSS is provided. While the accompaniment approach provides a general framework, the MHPSS component is adapted to the specific situation and the culture.

The MHPSS response:

- Individual activities that address the families' mental well-being
- Family visits and support for individuals who are more psychologically or geographically isolated
- Referrals to local service providers for more specialized psychological support

P. Yazdi/ICRC

MHPSS SUPPORT FOR VICTIMS OF VIOLENCE

In armed conflicts and other situations of violence, whole populations may experience severe physical and psychological trauma as a result of violence.

MHPSS interventions address the severe needs that arise in response to the trauma of violence. Although MHPSS programmes are designed to help anyone affected by violence, there is a particular focus, in some situations, on victims of sexual violence, unaccompanied children and children associated with armed forces or armed groups.

All ICRC interventions responding to the needs of victims of violence are built around mental health and psychosocial factors. The focus is on preventing further harm, supporting the victims and addressing the challenges that emerge when victims seek help. Identifying victims and detecting broader behaviour patterns and attitudes remain major challenges. For victims to feel comfortable seeking care, a number of steps must be taken to ensure safety and confidentiality. Interventions targeting victims of violence must respond directly to the victims' needs and concerns in a way that is culturally appropriate and sensitive to the specific situation.

Victims of violence may experience symptoms indicative of depression and anxiety, as well as other stress and trauma related difficulties.
They are frequently stigmatized and rejected by their communities and even by their own families due to the nature of the violence experienced or resulting mental health difficulties.

PEOPLE AFFECTED BY VIOLENCE

In some situations, the ICRC addresses the MHPSS needs of victims of violence through primary health care (PHC) facilities. This is a strategic choice. Because people routinely go to PHC facilities to seek physical health-care services, the likelihood of identifying civilian victims of violence is high. PHC facilities are very common, which means they are never far from victims and are even accessible for people living in isolated areas.

The integration of MHPSS support in PHC ensures a holistic health approach and continuum of patient care that responds to people's needs. In some situations, the Health Unit builds the capacities of PHC practitioners by providing training, coaching and supervision in basic psychological support that helps them identify people with MHPSS issues and provide them with appropriate support and referrals. Through the training, the PHC practitioners learn how to identify more severe cases and how to record and refer cases appropriately.

MHPSS needs:

- Somatization (medically unexplained bodily symptoms such as headaches, backaches and abdominal pain), and psychosomatic problems that are triggered by psychological difficulties
- Anxiety

The MHPSS response:

- Individual consultations
- Outreach, information and sensitization in the community about both mental and physical health topics
- Home visits for severe cases
- Increased awareness and understanding of the consequences of violence-related MHPSS issues (through PHC staff and community health workers)


W. Lembryk/ICRC

VICTIMS OF SEXUAL VIOLENCE

Sexual violence is an important documented correlate and consequence of conflict. Sexual violence can have multiple health and social effects on victims/survivors, their social networks and their communities.

Community-based initiatives, in which communities learn how to respond to sexual violence, make it easier to identify victims and care for them. Psychological initiatives ensure that victims' mental health needs are addressed.

MHPSS needs:

- Guilt, shame and severe stigma surrounding sexual violence
- Anxiety
- Suicidal tendencies
- Fear, alarm, disorientation, anger
- Fears of coming forward after an attack

The MHPSS response:

- Outreach activities
- Sensitization and information sessions for whole communities to address the stigma surrounding sexual violence
- Awareness-raising about available services and the importance of using them immediately after an attack
- Intensive training and coaching of key community actors (who are trusted by the victims and easily accessible) so they can provide basic psychosocial and psychological support and, when necessary, refer to mental health professionals


P. Yazdi/ICRC

CHILDREN AFFECTED BY VIOLENCE

Children separated from their primary caregiver as a result of armed conflict, other situations of violence, natural disaster or migration become more vulnerable to hunger, disease, violence and sexual assault. Unaccompanied minors are thus subject to a range of MHPSS issues. Mental health and psychosocial problems are more likely after prolonged separation, when children are reunited with distant relatives or when the family is in dire circumstances. It is also likely when children return after a period of separation and bring back small children of their own. They may also not want to go back to their family because of painful memories of separation, anger at having been abandoned, or the fear of having to live with people with whom they are unfamiliar, such as when the parents remarry.

MHPSS problems are also common in cases where children have been separated from families as a result of joining the armed forces or an armed group, whether by force or by choice. They may have traumatic experiences that will haunt them for many years after returning to civilian life. And the reason for which children may have chosen to join the armed forces or an armed group – lack of work, violence at home, no caregiver, or a desire for revenge – may still apply.

MHPSS needs:

- Aggression
- Insomnia
- Sleepwalking (and trying to escape even when they are safe)
- Constantly reliving what they witnessed or were forced to do
- Rejection by families and communities
- Problems of social reintegration

For more information on the MHPSS response to children, please refer to the section on helpers: specific service providers.

M. Chernov/ICRC

MHPSS needs:

- Acute stress
- Vicarious trauma
- Secondary traumatization
- Cumulative stress reactions
- Insufficient information, guidance and support

MHPSS SUPPORT FOR HELPERS

Helpers are people who are active in a service-oriented front-line position. They may work in on-site recovery or emergency response or in education, health training, community mobilization, advocacy or social services. Because helpers are part of the community affected by violence, they are often going through the same difficulties as their community (death of friends and family, and loss of their home and public services) at the same time as they are providing help every day to others. This daily exposure to stressful and distressing situations means that first-aiders, first responders and other groups bear a double burden. As a result, they are often beset by mental health and psychosocial difficulties of their own.

All helpers are considered to be in equal need of support because they are working on the front line helping others. Programmes aimed at helpers thus have two core components:

1) **Specific support is provided to helpers in terms of managing the stress and personal challenges arising from their particular role.**

2) **Helpers are equipped with resources to help the affected communities and improve their own effectiveness. These resources are always culturally appropriate and adapted to the local situation.**

The MHPSS response

- Setting up focus groups
- Holding individual consultations
- Creating and gathering peer support groups
- Organizing stress management activities
- Working with those who manage helpers to develop logistical/structural rules and schedules to prevent burnout
- Establishing emergency procedures to handle trauma and critical incident care
- Making referrals to external clinical staff for MHPSS follow-up
- Creating awareness-raising materials about detecting and self-monitoring resilience, burnout, vicarious trauma and stress management

HELPERS: FIRST-AIDERS AND FIRST RESPONDERS

One group of helpers is first-aiders. MHPSS programmes work alongside first-aid teams in the field to give them training in basic psychological support and equip them with the skills they need to provide reassurance and emotional support to victims and to better communicate with them. When the ICRC provides first-aid training, psychological aspects are always addressed. And in emergency and front-line situations, the physical and psychological needs of beneficiaries are systematically taken into account.

HELPERS: KEY COMMUNITY ACTORS

In some situations, helpers are community actors. These are people who are already trusted by the beneficiaries. Through training and supervision, they can act as counsellors with the ability to identify and refer more severe cases. Training, coaching and supervision are also provided to enable these actors to carry out sensitization activities within their communities.

HELPERS: SPECIFIC SERVICE PROVIDERS

Specific service providers such as RFL teams are another important group of helpers. Given the beneficiaries' challenging situations, these helpers may be asked to provide emotional support that goes beyond their normal role. In order to make the RFL teams (including tracing delegates, protection field officers and RFL volunteers) most effective, they are provided with special training in mental health and psychosocial issues. In addition to this training, further capacity building in addressing MHPSS issues is provided regularly to RFL field teams. This is particularly important during the selection and preparation of host families, the preparation of children and families for reunification (guidance, counselling, emotional support, etc.) and when there is a need to provide continuous psychological support for children.

G. De Moustier/ICRC

MHPSS SUPPORT FOR HOSPITALIZED/WEAPON-WOUNDED PATIENTS AND PEOPLE WITH PHYSICAL DISABILITIES

For hospitalized/weapon-wounded patients, the physical trauma is often associated with psychological trauma. The ICRC recognizes that the mental health of physically wounded patients has an important influence on the healing process. And a chronic physical disability puts an additional burden on the patients' mental health and psychosocial well-being.

Learning to live with a chronic disability is challenging in many ways. As well as adapting to new physical limitations, the patients may face a range of psychological and psychosocial consequences.

MHPSS needs:

- Problems of self-image
- Lack of independence
- Restricted activities
- Wide range of social challenges (lack of family support, unemployment, discrimination)
- Chronic pain
- Phantom pain

The MHPSS response:

- Providing direct support and training to the mobile and resident medical teams, to sensitize them to better understand patients' MHPSS needs
- Strengthening the teams' capacities in providing psychological and psychosocial support to hospitalized/weapon-wounded patients


G. Tahtah/ICRC

HOSPITALIZED/WEAPON-WOUNDED PATIENTS

The psychological and psychosocial well-being of hospitalized and weapon-wounded patients is linked to their experience of being injured. A range of activities is commonly needed to effectively meet their needs.

PEOPLE WITH PHYSICAL DISABILITIES

People with physical disabilities face a broad array of complications. One aspect of addressing these complications is to help people grasp their situation, which means helping them understand exactly how they can expect their life to change as a result of their injury. This helps people with physical disabilities to better cope with their new circumstances.

The MHPSS response:

- Helping people with physical disabilities adhere to therapy. People sometimes resist treatment (for various reasons), and so helping them understand the different aspects of their treatment often improves adherence. This approach is especially important if mental health problems – such as a lack of energy associated with depression-like symptoms – are among the causes of non-adherence.
- Helping people learn to function despite their disability. There is a specific focus here on supporting social reintegration.

P. Yazdi/ICRC

MHPSS SUPPORT FOR PEOPLE DEPRIVED OF THEIR FREEDOM

People who have a mental health disorder are more likely to end up in detention because local health-care systems have nowhere else to put them or because their mental health condition may make them more aggressive or prone to commit crimes. And once detained, people with pre-existing mental health difficulties may see their symptoms worsen. The way in which they are treated while in the detention facility, the conditions of the facilities themselves and the increased vulnerability that detention brings can also have lasting psychological and psychosocial consequences on the detainees.

In many cases, detainees with mental health disorders are stigmatized and do not receive continuity of care. They are at greater risk of ill treatment (including torture) than detainees without mental health disorders. And ill treatment can trigger more significant mental health problems.

MHPSS needs:

- Symptoms associated with dissociation
- Depersonalization
- Damaged self-concept
- Sexual dysfunction, psychosis, substance abuse or neuropsychological impairments

The Health Unit seeks to prioritize the needs of detainees with mental health disorders and works with released detainees, addressing the psychological and psychosocial consequences of ill treatment. As with all other MHPSS programmes, the aim is to improve day-to-day functioning, promote healthy coping mechanisms and lower levels of distress and anxiety.


P. Yazdi/ICRC

Once released, detainees who were victims of ill treatment are referred to facilities that can help them overcome a wide range of mental health and psychosocial problems (such as unemployment and relational difficulties with their family or community). It is important that detainees be referred to local facilities: this ensures that support is sustainable over the long term, which is necessary because the difficulties they experience as a result of ill treatment are often longstanding in nature. A further advantage of local facilities is that the care provided is culturally appropriate and sensitive to the detainees' specific experience. The Health Unit provides support to these facilities to ensure released detainees receive high quality care.

The MHPSS response:

- Sensitizing detention and medical staff to the importance of MHPSS needs and services
- If there are mental health professionals involved, the ICRC will attempt to train them and discuss with them the specificities of the detainees and the importance of providing them with comprehensive mental health support
- Other major activities involve efforts to improve the overall general well-being of detainees with mental health disorders by advocating for special conditions according to the disorder, in the sense of positive discrimination (e.g. a person with schizophrenia should not be placed in an overcrowded cell, which is likely to aggravate symptoms)
- The ICRC also strives to ensure that mental health treatment is available, that appropriate protocols are employed and that effective screening procedures are used to identify detainees with mental health difficulties


Al Baba/ICRC

MHPSS SUPPORT FOR PEOPLE AFFECTED BY EMERGENCIES

The term "emergency" is used in this context to describe an unplanned, sudden event resulting in significant consequences for those affected by it. Such events may include situations of intense unexpected violence, natural disasters or pandemics – all of which have serious consequences for the mental health and psychosocial well-being of those affected. Mental health and psychosocial issues have long been neglected in emergency settings owing to the immediate demand to address unmet "basic needs". In recent years, it has been increasingly recognized that emergency situations put a high additional burden on the mental health and psychosocial well-being of all involved. The inclusion of MHPSS support is therefore essential in providing a holistic response.

The horrors, losses, uncertainties and numerous other stressors associated with emergencies increase the risk that people will experience an array of social, behavioural and psychological difficulties.

MHPSS needs:

- Difficulties associated with family separation
- Difficulties associated with discrimination
- Loss of livelihood and the social fabric of everyday life
- Low trust and limited resources
- Grief
- Distress
- Alcohol and substance abuse
- Symptoms of depression and anxiety, including those associated with PTSD

The MHPSS first response assessment includes:

- Psychoeducation (teaching people about mental health issues)
- Normalization (helping people understand that the MHPSS difficulties they are facing are completely normal in relation to their experience)
- Helping the delegation identify those with severe MHPSS problems and where those individuals can be referred

The general approach in emergency or disaster situations is guided by public health considerations such as promoting health, providing psychoeducation and encouraging community awareness and participation. Emergency MHPSS interventions must be tailored to the crisis at hand.

The MHPSS response:

- Providing support for victims through quick needs assessments and innovative activities
- Supporting those involved in coordinating the general response during the crisis
- Building the capacity of resident staff
- Supporting helpers, who are exposed to a wide variety of challenges in emergency situations

E. Schindler/ICRC

The number of MHPSS programmes worldwide has grown rapidly in recent years, rising from 10 in 2010 to 59 in 2015.

ICRC's MHPSS team includes almost 100 mobile and resident mental health professionals around the world.

MISSION

The International Committee of the Red Cross (ICRC) is an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance. The ICRC also endeavours to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles. Established in 1863, the ICRC is at the origin of the Geneva Conventions and the International Red Cross and Red Crescent Movement. It directs and coordinates the international activities conducted by the Movement in armed conflicts and other situations of violence.

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