



## Key messages for external-high level advocacy on MHPSS

This document sets out key messages and background for use by the ICRC, IFRC, and National Societies in their engagement with authorities and decision-makers which influence political support and resourcing for MHPSS activities. These may include Heads of State, national ministries, donors, and other high-level government decision-makers. Taken as a whole, they constitute the Movement's key messages and asks to states on MHPSS, which can be adapted to particular interlocutors and contexts (where some messages / asks will be more applicable than others), in support of Priority Action Area 6 of the [Movement MHPSS Roadmap 2019](#) (mobilizing political support for MHPSS).

### Key messages

#### *Why mental health cannot wait: The case for action on mental health now*

Mental health cannot wait. There is no health without mental health, since **health is not merely the absence of disease or infirmity, but a state of complete physical, social, and mental well-being** ([WHO Constitution](#)). COVID-19 has illustrated this starkly. It has exposed and exacerbated pre-existing social and economic inequalities, which – as “[social determinants of health](#)” – demonstrate the centrality of MHPSS to overall public health. Mental health is not a ‘COVID phenomenon’, yet the ongoing pandemic represents an opportunity to transform mental health long-term – particularly in settings affected by armed conflict, natural disasters, and other humanitarian crises, where mental health impacts may be highest and means to address them lowest.

Why can't it wait – amidst pandemic pressures and other competing priorities – and why should governments and other service providers act on mental health now?

1. Because acting on mental health is part-and-parcel of states' responsibility to provide for the health of their populations. As with other crises, COVID-19's secondary impacts on livelihoods, education, social bonds, and aspirations are, for some people, worse than its direct health impacts. And they will linger long after the crisis has ended. These secondary impacts, as social determinants of health, have a huge impact on people's mental health – and thus on society's health, wellbeing, and economic productivity. [One in six people](#) will have a mental health condition at some point in their lifetime. This escalates to **one in five for those living in armed conflict** settings. Behind these statistics are people seeking to live their lives with health and dignity.
2. Because it is cost effective. For every [\\$1 invested, there is a \\$4 return](#). And MHPSS interventions have positive multiplier effects in that they benefit not only the individuals concerned – a breadwinner or primary caregiver, for example – but the families and communities they are part of.
3. Because it is an opportunity to build back better and strengthen resilience. Much progress has been made in understanding the parity between physical and mental health, and the links between them. Our pandemic recovery depends not only on vaccination and other public health measures, but also on MHPSS. [Past experience](#) – from Burundi to Kosovo, from Sri Lanka to the West Bank – suggests that failing to protect mental health will prolong the effects of a crisis in health, economic, social, and political terms. Addressing mental health will help societies build back better, healthier, and stronger.

4. Because it may help to prevent further societal tension and decline. Failing to address mental health issues may cause frustration and desperation to find outlets in violence (including domestic violence), conflict, and behaviour which damages social cohesion and solidarity. The full impact of such decline may only be apparent over time, when action may be ‘too much too late’.

### *The way forward*

Governments and donors have the responsibility, resources, and influence to use this historic moment to redouble efforts to strengthen mental health and psychosocial wellbeing, particularly for those living in conflict, disaster, and other humanitarian crises. And the Movement has started playing its part by implementing the International Conference resolution on MHPSS that it jointly committed to with governments.<sup>1</sup> In brief, governments need to deliver on *their* commitments<sup>2</sup> by increasing provision of and access to MHPSS services, and by ensuring integration of these services into national health architectures. We recommend:

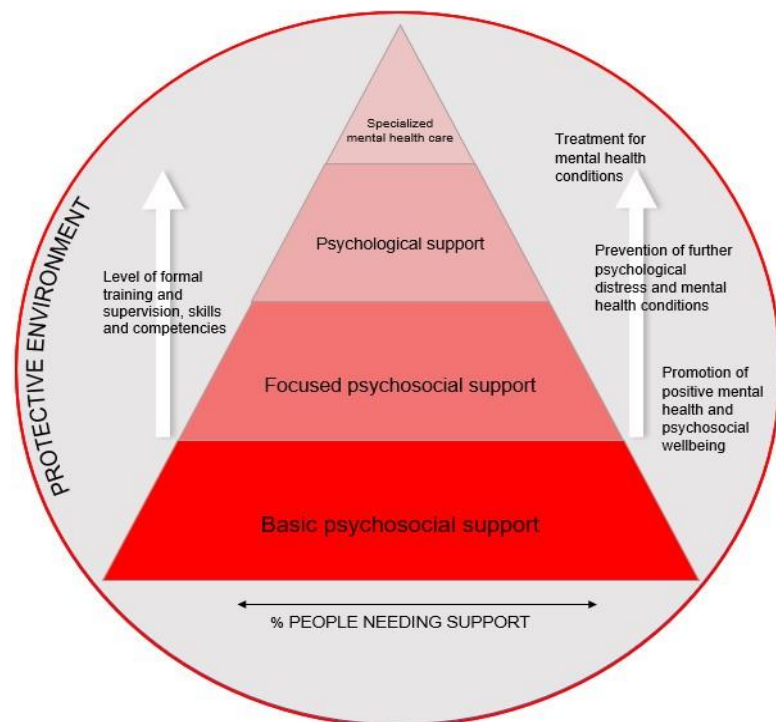
#### **1. Ensure provision of MHPSS services<sup>3</sup>**

The first step is ensuring sufficient human and other resources to **provide** MHPSS services, which means funding them and training skilled staff. They must be provided alongside – indeed as part of – routine ‘physical’ healthcare, welfare, education, and other services, and cover the full range of MHPSS services as part of a continuum of care.

Everyone has different needs so there is no one-size fits all approach; these services must range from the most basic psychosocial support to specialised mental health care. The same person may also need different services at different points in time.

People are resilient, even in crisis. **MHPSS is not passive** (‘received as a victim’); it is **active, respecting people’s agency and strengthening their resilience in the face of adversity.** MHPSS does not seek to “fix” a problem, but allows people to resume functional lives by dealing with uncertainty and hardship.

All the Movement’s MHPSS work is about supporting people in their trials; building them up when their circumstances are trying to tear them down.



<sup>1</sup> <https://www.ifrc.org/article/mental-health-matters-progress-report-mental-health-and-psychosocial-support-activities-within>

<sup>2</sup> For example, in UN General Assembly Resolution [74/2](#) (2019) on Universal Healthcare, World Health Assembly Resolution [73.1](#) (2020) on COVID-19 response, and [Sustainable Development Goal 3](#) of the 2030 Agenda, and [Resolution at the 33<sup>rd</sup> International RCRC Movement Conference \(2019\)](#).

<sup>3</sup> This is especially linked to policy statements 2 and 6 of the Movement MHPSS Policy. [Movement MHPSS Policy\\_Eng\\_single.pdf \(pscentre.org\)](#)



#### Examples:

**Specialized mental health care:** In Mauritania, the Mauritanian Red Crescent, with support from the French Red Cross, has trained health staff in Nouadhibou on mhGAP, a WHO-approved tool consisting of interventions to prevent and manage mental, neurological, and substance use disorders, including in children, meant for contexts where there is lack of trained mental health professionals. The staff can now welcome and provide more adapted support to those in need identified in the communities. Such specialized services are generally run in hospitals' mental health units, and are often unavailable or inaccessible in humanitarian settings due to the lack of qualified staff.

**Psychological support:** In Syria, a decade of conflict has left millions with hidden wounds and limited capacity to heal them. On a daily basis, ICRC teams work with people who have lost a limb, were forced to flee their home (multiple times), witnessed death of a loved one, have missing or detained family members. Even if they acknowledge their own psychological suffering, they find it extremely hard to seek support which, if available is only psychiatric in nature and not standardized or affordable. The ICRC, in close partnership with the Syrian Arab Red Crescent, strives to enhance the capacity of local psychologists to ensure quality mental health care. Since 2019, mental health services have been integrated for people with physical disabilities in Aleppo and Damascus physical rehabilitation centers. The ICRC is working with psychologists and case managers to provide focused psychological support, and referrals for specialized mental health care.

**Focused psychosocial support:** Since the beginning of the COVID-19 pandemic, MHPSS teams of the Americas National Societies have been attending to the growing emotional and psychosocial needs of the population in different ways, especially through hotlines. In so doing, the staff have also been exposed to a great emotional burden. In order to promote and protect their psychological well-being, a regional collaboration strategy named 'Caring for those who care' was promoted by IFRC's Regional Office and implemented together with the National Societies and the #youhavemysupport initiative. With this strategy, National Societies like Costa Rican or Argentine Red Crosses, were able to provide peer support to other National Societies in the region, like Ecuadorian and Bolivian Red Crosses, by organizing virtual emotional ventilation groups sessions that helped the frontliners to cope and deal with difficult feelings and distress.

**Basic psychosocial support:** Due to conflict and social and economic instability, young people in South Sudan face chronic unemployment and poverty, as well as deficient public services and decaying infrastructures. They face challenges in education, building social networks and in gaining social skills, leading to severe psychosocial needs. The South Sudan Red Cross, with support from Danish and Swiss Red Cross, has been implementing activities, like sports, games and other recreational activities, to allow young people to have a space to foster new relationships, ventilate, and express their feelings in a safe and healthy way.

## 2. Ensure access to MHPSS services<sup>4</sup>

**Access** to these services is a second key element – since there is no point in providing services if the people who need them most cannot access them – which means removing the main barriers to access. The RCRC Movement's experience suggests the main barriers which must be removed include:

- Physical distance from service providers, if they exist at all;
- Lack of awareness about service providers – among health, social welfare/protection, education, and other areas;
- Cost of services, including online counselling;
- Legal status and/or lack of documentation;
- Stigma and cultural norms deterring people from seeking MHPSS e.g. that people needing MHPSS are 'crazy', 'cursed', or 'weak'. Ensuring access to MHPSS services is not just about *accessibility*; community leaders can be key in tackling stigma, discrimination, and exclusion that prevent those suffering from accessing MHPSS;
- Workforce limitations and burnout, resulting in low quality or limited range of services e.g. few qualified staff mean that staff are overstretched and cannot provide the sustained engagement required to grapple with mental health issues;
- Weak coordination among service providers and stakeholders e.g. for the purposes of referrals.

<sup>4</sup> This is especially linked to policy guidance 1, 4, and 5 of the Movement's MHPSS Policy.



### 3. Ensure *integration* of MHPSS services

*Integration* of MHPSS services into national health systems – as well as social welfare/protection, education, and other systems – is a third critical element to ensure provision of and access to MHPSS services, and their long-term sustainability.<sup>5</sup>

Concretely, integration into routine health services means not only that a health system resources sufficient MHPSS professionals, but also that health workers throughout the system adopt a patient-centred approach which includes MHPSS as part of overall healthcare – given its proven importance to individuals’ and societies’ overall health. This means that all healthcare workers have a basic level of MHPSS awareness which they incorporate into their ‘bedside manner’ beyond their technical disciplines, and which allows them to refer to MHPSS professionals where needed.

More broadly, integration also means ensuring that workers in the social welfare/protection, education, and other systems are equipped to recognise how the social determinants of health (e.g. nutritious food, clean water, social role models and mentors) impact a person’s mental health, and thus overall health. This is so they can take action both to promote mental health and to respond to mental health challenges in a holistic manner – whether themselves and/or by referring to appropriate services.

## Background

### *On Movement MHPSS activities*

The Red Cross and Red Crescent Movement works in 192 countries, bringing together humanitarian professionals and 13.1 million volunteers to form the world’s largest humanitarian movement, which provides relief in conflict, disasters, emergencies, and non-emergency settings.

According to the [Movement global MHPSS survey 2021](#), across the world, 155 National Societies, the ICRC, and the IFRC provide some form of MHPSS services. Of these, 79% provide psychological first aid as part of their response (with almost 88,000 individuals trained in the previous two years), 68% provide psychological support, and 46% provide training to community actors on MHPSS. When emergencies strike, 87% of National Societies, the ICRC, and the IFRC ensure provision of MHPSS as part of their emergency response. There is also a high recognition of the importance of taking care of the well-being of staff and volunteers. Therefore 79% of National Societies, the ICRC, and the IFRC have services that aim at caring for their frontline workers.

According to the same report, 50% of the respondents plan to increase their overall provision of MHPSS services in the next few years, attesting that, despite the often-limited resources and funds, Movement components are working to deliver a wide range of MHPSS services and activities in accordance with their respective mandates, commitments and auxiliary roles.

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<sup>5</sup> This is especially linked to policy statements 2 and 3 of the Movement’s MHPSS Policy.



### *On investment in MHPSS globally*

Rates of progress in access to MHPSS services described in the latest edition of [WHO Mental Health Atlas](#) for all targets (except suicide rate) were **not satisfactory**. Progress values for 2020 indicate that the global targets can be reached in 2030 only if there is a collective global commitment over the next 10 years across Member States to **make massive investments and expanded efforts at the country level** relating to mental health policies, laws, programmes, and services. The same concerns are shared in the [WHO World Mental Health Report](#) released in June 2022. Hence the importance of acting on the recommendations in this document.

Some staggering figures are the following:

- In 2019, nearly a billion people – including 14% of the world’s adolescents – were living with a mental disorder.
- Suicide accounted for more than 1 in 100 deaths and 58% of suicides occurred before age 50.
- Mental disorders are the leading cause of disability, causing 1 in 6 years lived with disability.
- People with severe mental health conditions die on average 10 to 20 years earlier than the general population, mostly due to preventable physical diseases.
- Depression and anxiety rose by 25% in the first year of the coronavirus pandemic.
- 71% of those with psychosis worldwide do not receive mental health services.

Despite this harsh reality, what the existing data shows is that:

- Levels of **public expenditure on mental health are low** (a global median of 2.1% of government health expenditure) and particularly scarce in low- and middle-income countries.
- **Less than 1%** of all international health aid **goes to mental health**.
- Globally, the median number of mental health workers is 13 per 100 000 population, with extreme variation globally (from **below two workers per 100 000 population** in low-income countries to over 60 in high-income countries).
- Only **28% of WHO Member States** have MHPSS integrated as a component of disaster preparedness and/or disaster risk reduction.
- Only **25% of WHO Member States** have integrated mental health into primary health care service provision.
- On average, **0.64 community-based mental health facilities exist per 100 000 population**, and 2 out of 3 dollars of government spending on mental health is allocated to stand-alone psychiatric hospitals rather than community-based mental health services, where people are best served.