



Department
for International
Development



An Approach and Theory of Change to Mental Health and Psychosocial Support for global development actors



Photo credit: Anna Dubuis /DFID. Inside a UNICEF child friendly space, supported by UK aid, at Batukhali refugee camp in Bangladesh, art therapy and counselling help Rohingya children recover from the trauma they have experienced.

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The Challenge

Mental health is a fundamental part of being human, covering a full continuum including everyday well-being, psychological distress, mental health conditions and psychosocial disabilities.

One in four people will develop a mental health condition in their lifetime. Together, mental health, neurological and substance use (MNS) conditions are the number one cause of years lived with disability (YLDs) worldwide and are the basis for an estimated 10-13% of all disability-adjusted life years (DALYs)^{1,2}. The number of people with MNS conditions is expected to increase dramatically as population sizes and life expectancies rise in low and middle-income countries (LMICs)³.

People with mental health conditions and psychosocial disabilities face major challenges in having their rights recognised. The Human Rights Council states mental health systems and policies around the world are “in crisis”, with evidence of violations of economic, social and other rights – and practices like chaining and shackling all too common-place in mental health services⁴.

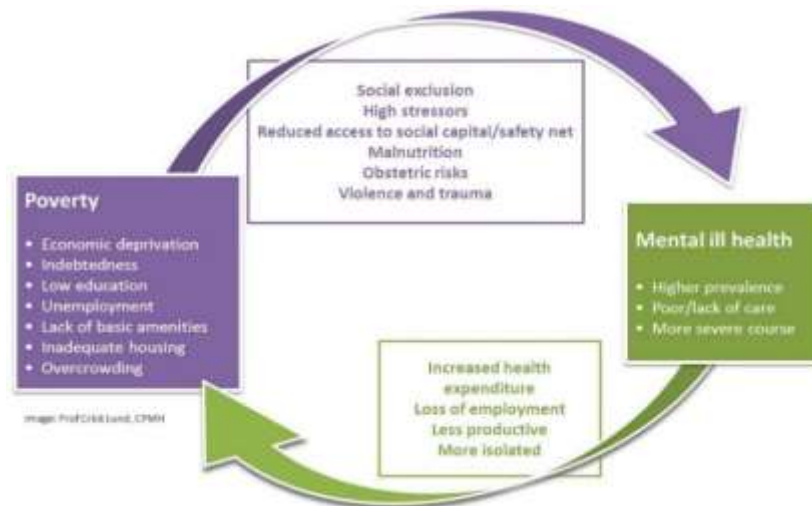
Mental health continues to be one of the most neglected and underfunded development issues of our time⁵. Many people in LMICs will never access essential mental health or social care services in their lifetime, and for those who do, the quality of services is often poor. Public expenditure in these contexts is extremely low and often inequitably and inefficiently allocated^{6,7}. Over 80% of LMICs’ limited mental health spend goes towards running inpatient psychiatric institutions rather than being distributed across a more balanced model of care with services closer to the community^{8,9}. Mental health workers are scarce, for example, Liberia and Sierra Leone each have only one psychiatrist currently practising¹⁰. Organisations led by service users and people with psychosocial disabilities, including those advocating for rights, are largely under-supported.

There is a strong association between poverty, inequalities and poor mental health. This relationship occurs through “multidirectional pathways” that can start early in the life course and produce a cycle of disadvantage¹¹. This relationship is also the product of intersecting social, political and economic determinants that produce both poverty and ill health (see Figure 1).

There is also a strong association with physical health and preventable deaths including maternal suicide, now classified as a direct cause of maternal mortality and a leading contributor to deaths in pregnancy and the postnatal period¹².

It is also important to address the mental health needs of particular populations and vulnerable groups. WHO estimates a 22% prevalence of mental health conditions (depression, anxiety, post-traumatic stress disorder, bipolar disorder, and schizophrenia) at any point in time in conflict-affected populations¹³. Globally, attention to prevalence by age is also important as children and young people in vulnerable circumstances are at increased risk¹⁴. Suicide is the second leading cause of death among those aged 15-29 globally¹⁵. There are significant gender disparities in mental health and social risk factors are highly gendered¹⁶.

Figure 1: The vicious cycle of poverty and mental ill-health



Source: *Mental Health and Poverty Project/The Lancet*¹⁷

The purpose of this document is to shine a spotlight on the role development can play to improve mental health and wellbeing for all, and in turn, how improved mental health can play a role in attaining key developmental outcomes. As such it recognises that there cannot be full development or healthy lives without addressing mental health. It sets out for the first time how development actors can maximise aid portfolios to strengthen their contribution to mental health and wellbeing in some of the world's poorest countries. It aims to inform policies and programmes by providing a conceptual framework with clear pathways for change. In doing so, this paper also touches on how integrated and quality mental health interventions can positively impact wider development outcomes.

This Theory of Change is the result of a consultative process between development and humanitarian practitioners and an external working group of critical friends, including groups representing people with mental health conditions and psychosocial disabilities. We want to thank the external group for sharing their learning and know how and for challenging this approach through a series of workshops between December 2018 and July 2019.

The Opportunity is Now

Mental health is more than a health issue, it's an issue for wider human rights, development and humanitarian actors. The SDGs provide a 'historic opportunity' to reframe and broaden the global mental health agenda, recognising mental health as an accelerator for wider development goals like learning, early childhood development and maternal health¹¹. This requires a paradigm shift, moving away from a narrow medicalised focus on closing the treatment gap, to also address the quality of services and underlying social determinants across the full continuum of mental health and wellbeing. This was a focus in the UK co-hosted [Global Ministerial Mental Health Summit](#) that sought to galvanise global action and sharing of good practice.

Important policy shifts across the international system attest to this change in thinking. The WHO Comprehensive Mental Health Action Plan 2013–2020¹⁸ (now extended to 2030) includes the promotion of mental health through action on social determinants as one of its five key objectives. The Human Rights Council 2019¹⁹ emphasises the need for a combined focus on social determinants and rights, recognising States' obligations to create and sustain specific conditions that promote a life of dignity and wellbeing for all. The [Lancet Commission on Global Mental Health and Sustainable Development](#) in 2018 recognises the SDGs as an opportunity to reframe global mental health as: i) a global public good ii) a continuum iii) the unique product of social and environmental influences and iv) a fundamental human right. In 2019, the Political Declaration on Universal Health Coverage attested to a renewed global commitment from heads of governments to “implement measures to promote and improve mental health and well-being as an essential component of universal health coverage” with specific mention to addressing social determinants and fully respecting human rights²⁰.

Guiding Vision and Principles

A common, overarching vision was identified through this consultative process, one where: **“All people enjoy the highest attainable standard of mental health and wellbeing and all people with mental health conditions and psychosocial disabilities can exercise their full rights on an equal basis to others.”**

The Vision is integral to meeting the commitments set out in:

- The [UN Sustainable Development Goals](#) (SDGs) that emphasise promotion of wellbeing and healthy lives
- The [UN Convention on the Rights of Persons with Disabilities](#) (CPRD) on legal protection of rights and dignity of people with psychosocial disabilities

- [WHO's Mental Health Action Plan 2013-2020 \(extended to 2030\)](#); on the development of policies and plans in line with international and regional human rights instruments.

The following principles were identified to guide development practitioners:

- **Participation.** Participation is a core principle and requisite of a human rights-based approach. This means putting people at the centre of decision making on their own health and lives - as well in policy, research, and services.
- **Human Rights and dignity.** A rights-based approach offers an alternative to narrow and individualised disease-oriented approaches. It encompasses individual rights and capacity building as well as systems level change²¹.
- **Comprehensive, integrated and responsive services:** Supporting the long-term process of deinstitutionalisation and the reorientation of quality services closer to communities; implementing people-centred, recovery-oriented approaches; and monitoring and protecting human rights using standards.
- **Quality:** Adopting evidence-informed practices to support comprehensive interventions, services and continuity of care. In order to achieve this “healthcare must be safe, effective, timely, efficient, equitable and people centred.”²²
- **Collaboration and partnerships within and across sectors.** Comprehensive approaches require collaboration within and between a wide range of sectors and civil society²³.
- **Equity.** This means promoting equitable and accessible interventions for all. This includes the different experiences and needs across the lifecourse and of excluded groups including women and girls, children and adolescents, people with disabilities, LGBT people, survivors of VAWG, and people living with HIV. Interventions should also seek to address geographical inequities and disparities in accessing services.
- **Do no harm:** Assess the potential negative impacts that interventions may have on wellbeing (including violence and human rights abuses against people with mental health conditions and psychosocial disabilities); and put in place measures to avert and respond to this risk.
- **Context is critical:** Interventions should be tailored and based on rigorous analysis of the particular forms, prevalence, determinants and lived experiences in a specific context, including barriers to inclusion.
- **Data, monitoring, evaluating and learning** to assess the mental health and wellbeing impacts of interventions on individuals and families, better capture the reach of wider interventions on people with mental health conditions and psychosocial disabilities, and inform effective action on mental health.

Theory of Change Diagram

The Theory of Change sets out five outcome areas that are essential for delivering the vision for mental health and well being for all. The full and meaningful participation of people with mental health conditions and psychological disabilities in decision-making, the first outcome, is central across all the pathways of change.



VISION	All people* enjoy the highest attainable standard of mental health and wellbeing and all people with mental health conditions and psychosocial disabilities can exercise their full rights on an equal basis to others			
OUTCOMES	2) People with mental health conditions and psychosocial disabilities are included and enjoy and exercise their full human rights	3) Leadership and governance advanced for mental health at all levels and across sectors	4) Promotion of wellbeing for all and quality services and community interventions for <u>people with mental health conditions and psychosocial disabilities across the lifecourse.</u>	5) Mental health and psychosocial support (MHPSS) is prioritized in preparedness, response and recovery in emergencies and fragile and conflict-affected situations (FCAS)
1) People with mental health conditions and psychosocial disabilities are empowered to advocate and meaningfully participate in decision-making and in the design and implementation and monitoring of legislation, policies, strategies and services for mental health				

OUTPUTS	<ul style="list-style-type: none"> • Mental health policies, strategies and laws developed and operationalized based on international human rights standards; • Mental health systems implementing community-based and recovery-oriented approaches; and • Operationalised strategies that address stigma and human rights violations of persons with mental health and psychosocial disabilities, including in humanitarian settings. 	<ul style="list-style-type: none"> • Political will for mental health at all levels; decision makers responsive and held to account. • Capacity, leadership and advocacy of champions, self-advocates, civil society, and representative groups strengthened and inclusive; • Sustainable financial and human resources in line with needs and extended financial protection. 	<ul style="list-style-type: none"> • Increase quality and access to mental health and social care, from the family and community levels and across the healthcare system • An integrated approach to mental health and social care across services. Including integration into health systems, maternal health, education, early childhood development, youth services and gender-based violence services. • Improving mental health and well-being for all through interventions to address social determinants of mental health, including education; urban design and housing; air quality; social policies; and working conditions. 	<ul style="list-style-type: none"> • Crisis affected populations are safe, protected and human rights violations are addressed. • Crisis affected populations access culturally appropriate, integrated and coordinated MHPSS care in line with minimum standards and guidelines. • MHPSS addresses the mental health needs of particular population and vulnerable groups including survivors of VAWG, children and young people and survivors of torture • Humanitarian organisations have staff and volunteer well-being policies, strategies and SOPs in place. • Sustainable national and community-level human and financial resources to address MHPSS in disaster preparedness, response and FCAS and bridging the response-recovery-development nexus.
	<ul style="list-style-type: none"> • People with mental health conditions and psychosocial disabilities are empowered to participate in decision making. 	<ul style="list-style-type: none"> • Participation and representation in civil society and the wider disability movement 	<ul style="list-style-type: none"> • Meaningful dialogue between user groups and decision-making bodies and service providers. Including health, education, judiciary, social sectors, rights and disability bodies. 	<ul style="list-style-type: none"> • Community engagement and accountability to ensure responsive and adaptive services.
BARRIERS	<ul style="list-style-type: none"> • Stigma and structural discrimination • Lack of (and access to) health care and services and skilled workforce • Poor quality of limited services • Lack of data and information • Human rights violations, violence, abuse, coercion in formal and informal institutions • Lack of sustainable resources and political will • Scale of social determinants: poverty, inequalities, (gender based) violence, childhood adversity • Lack of coordinated emergency response • Poor integration of physical and mental healthcare and comorbidities 			

Theory of Change Narrative

The following section provides **illustrative entry points for change**. A more comprehensive mapping of evidence, assumptions and examples can be found in the four [Disability Inclusion Helpdesk Rapid Evidence Maps](#). This document can be read alongside the new [DFID K4D Topic Guide to Mental Health for Development Professionals](#) – an introductory guide for development and humanitarian practitioners.

The Theory of Change is structured around five critical pathways for change. The reality, of course, is much more complicated. The process of change is multi-directional, with cross over between pathways, and always highly context specific. The intention here is to provide a starting point for development actors to interrogate how they improve policies, programme design and impact and to develop their own plans adapted to the context they are working in – rather than prescriptive guidance.

Outcome 1: PARTICIPATION: *People with mental health conditions and psychosocial disabilities are empowered to advocate and meaningfully participate in decision-making and in the design and implementation and monitoring of legislation, policies, strategies and services*

Participation is both an outcome in itself and a guiding principle. “People have a right to participate in decisions that affect their lives, including those concerning their rights”²⁴. Evidence highlights the long-standing exclusion of people with mental health conditions and psychosocial disabilities from civic space, including from some disabled people’s organisations. The importance of full and meaningful participation is now being more widely recognised and enacted²⁵. There are also increasing calls for more participation in research and knowledge production about mental health²⁶.

The following entry points are critical to ensuring participation across all the pathways of change.

- Supporting the establishment and sustainability of **representative organisations** which are sensitive in respect of gender, ethnicity, disability, mental health condition, sexual orientation and age. The evidence on what work to promote service user leadership in LMICs is still relatively limited but there are examples of success²⁷. Effective representative initiatives often involved governance structures and management decisions led by service users and survivors, where the organisation is guided by clearly defined values.²⁸
- Enabling **meaningful inclusion and decision-making** in the development and implementation of legislation and policies.

- Supporting the **meaningful participation of, and user-involvement in, system strengthening** is emphasised in much of the global literature including in efforts to address quality of services. A systematic review from 2016 posited that consultations with mental health service users in policy formulation processes increased the likelihood of improved mental health services and outcomes²⁹. The review highlights an example from Romania, where local organisations and people with psychosocial disabilities formed coalitions to promote mental health services at the community level. The coalitions were successful in influencing government officials to visit mental health institutions and increased the government's stated commitment to mental health reform³⁰.

Case Study 1: Placing people with mental health conditions and psychosocial disabilities at the heart of inclusive development

DFID's new Disability Inclusion Strategy and **disability inclusion standards** set out an ambitious framework for mainstreaming disability inclusion across the organisation. The standards place engaging and empowering people with disabilities and their representative groups at the centre. One of the five standards set out an explicit requirement where: '*each business unit in DFID should carry out consultation in a way that builds capacity and involves groups that are sometimes excluded such as people with psychosocial or intellectual disabilities*'.

Outcome 2: RIGHTS: *People with mental health conditions and psychosocial disabilities are included and enjoy and exercise their full human rights.*

There is widespread evidence of human rights abuses of people with mental health conditions and psychosocial disabilities both within and outside of health care facilities³¹. The CRPD has been key in the recognition of human rights, including equal legal capacity and free and informed consent of persons with disabilities. A rights-based approach broadens the focus to addressing structural issues, attitudes and root causes, and to ensuring that people with mental health conditions and psychosocial disabilities are at the centre of decision making³².

Entry points for development actors include:

- **Supporting national policies, legislation and research in line with international human rights standards:** This includes both: i) developing *standalone* national mental health policy and action plans to protect the rights of people with mental health conditions and ii) *reviewing and removing discriminatory provisions in laws and policies* related to health, social welfare, employment, education and criminal justice and incorporating new provisions in order to protect

rights. There are emerging examples of comprehensive approaches to mental health policy and law – including Peru’s reform of its civil code.

- **Investing in innovative practices to prevent and end coercion and support the long term process of de-institutionalisation from all kinds of institutions.** The [WHO's Quality Rights Initiative](#)²⁶ aims to help drive policy and legal reform in line with international human rights standards including through training and guidance tools for policy makers and service providers. In doing so it also impacts practice, attitudes and services. The focus is on respecting the right of the individual to make his or her own decisions, providing people with information and choice about treatment options³³.
- **Creating and supporting community-based and recovery-oriented support services that respect and promote human rights, and that are culturally and gender appropriate across the life course.** The Bapu Trust for Research on Mind and Discourse is a mental health organisation co-run with people with mental health conditions and psychosocial disabilities, providing advocacy, community services and carrying out research in India. An evaluation of their *Seher* programme found that the Bapu Trust’s approach of providing support and services to persons with mental health conditions coupled with engaging the community to build a local support network has improved the situation of people with mental health conditions at relatively low cost³⁴.
- **Supporting actions to combat stigma, discrimination and human rights violations and transform attitudes.** One example is Time to Change, a UK national anti-stigma campaign that has used public relations and social contact events, together with social marketing campaign materials. Its evaluation suggests a “positive relationship between social contact and a reduction in prejudice”³⁵. The evaluation, however, found that it was harder to address negative attitudes of health professionals and recommends further testing of the social contact model.

Case Study 2: Scaling up rights-based approaches across Ghana

The UK has been a proud supporter of mental health in Ghana, bringing quality services to the community level and eroding the stigma around mental health. This investment has seen mental health provision expanded to all 260 districts compared to 32 just six years ago. In partnership with WHO and the Government of Ghana, DFID Ghana is going further still – supporting improvements in the quality of care provided in mental health facilities across the whole country. In 2019, we launched the largest ever national roll out of QualityRights – an initiative that is delivering training to health and non-health professionals to improve quality of care and respect for human rights of people with mental health conditions.

Outcome 3: LEADERSHIP AND GOVERNANCE: *Leadership and governance advanced for mental health at all levels and across sectors.*

Strengthened governance, leadership and accountability is required across all sectors and at all levels – from communities to national political leaders to global leadership. This is essential to addressing the lack of investment. Incorporating and integrating mental health into the health sector is critical to increasing access, while integrating mental health across wider sectors such as education, employment and social welfare helps address social determinants of mental health and ensures a comprehensive and holistic approach.

Entry points for development actors include:

- **Supporting integration of mental health into global and national frameworks and sectors – including SDG national plans** to address social determinants of mental health and provide a comprehensive strategy to promote mental health.
- **Supporting integration of mental health into national action plans to achieve Universal Health Coverage.** This is important if actors are to realise the commitment set out in the Political Declaration on Universal Health Coverage to “promote and improve mental health and well-being as an essential component of universal health coverage”. Integrating mental health into health policy and plans helps makes services more accessible¹⁸. There are calls for cost-effective mental health services and products to be included in interventions publicly subsidised under Universal Health Care schemes. There are examples of growing service coverage through benefits plans in countries such as Uganda and Ghana³⁶.
- **Dedicated and comprehensive mental health policies** to provide detailed guidance for mental health systems. A growing, but still limited evidence base, further highlights the need for (i) capacity building of mental health policymakers and planners across governance levels to bridge the gap between mental health policy and implementation³⁷ and (ii) capacity building and supporting leadership opportunities for service users and service users’ organisations for holding governments accountable³⁸.

Outcome 4: Promotion of wellbeing for all and quality services and community interventions for people with mental health conditions and psychosocial disabilities across the lifecourse.

Supporting good mental health and promoting wellbeing is relevant and important for everyone. Supportive, inclusive and healthy environments and societies are vital to achieve this.

Factors that contribute towards poor mental health are broad and extend across sectors, organisations and Government departments – not just those pertaining to health. “Mental health is influenced by a broad range of social and economic determinants including: income level, employment status, education level, material standard of living, physical health status, family cohesion, discrimination, violations of human rights and exposure to adverse life events, including sexual violence, child abuse and neglect”¹⁸. All people should be able to exercise their rights and entitlements in these areas, supported by inclusive community organisations and structures and be empowered to improve and support their own health. Any discussion on mental health must recognise the essential importance of these wider determinants and how interventions, initiatives, policies and programmes at these points contribute to maintain good mental health for all.

Access to quality health and care services and community interventions for those people that need them is also paramount. This means that there are appropriate services available across the mental health continuum and in line with WHO definitions of quality of care³⁹. This means that services are based on the best, contextualised evidence available; are respectful, caring and rights-based; are fully integrated into health and social care systems; are appropriately staffed by a trained and capacitated workforce, and affordable and evidence-based medications are accessible. Where possible these services should be community-based and include rehabilitative services and specialist care for specific groups, including children, adolescents and new mothers.

Entry points for development actors include:

- **Improving wellbeing for all and addressing social and environmental determinants.** There are strong links between social disadvantage and poor mental health. Addressing underlying factors is essential to maximising mental health globally. This means taking into account the mental health implications of decisions made in related areas, such as improvements to livelihoods, workplace environments, education, and addressing poverty. This should include, but not be limited to:
 - Antidiscrimination laws and engaging and involving communities to reduce stigma and discrimination;
 - Inclusive education systems that promote life skills; comprehensive sex and relationship education programmes; comprehensive approaches to prevent violence against women and girls; interventions to promote safe, stable and nurturing relationships between children, their parents and carers;
 - Provision of healthy living and working conditions, including work improvements and stress management¹⁸;

- Economic and social protection interventions¹⁷, including cash transfer programmes, have been shown to have a positive effect on mental health conditions by decreasing stress and depression^{40,41}. Family friendly policies such as affordable childcare have a similar effect⁴²;
 - Preventing maternal suicide and poor maternal mental health across the life course including by addressing key risk factors like VAWG and access to Sexual and Reproductive Health and Rights⁴³;
 - Food security interventions - food insecurity is shown to be associated with mental health conditions in low-income and middle-income countries⁴⁴;
 - Improving housing - housing quality and overcrowding, is associated, in adults, with increased risk of mental health conditions⁴⁵;
 - Improving the built environment - neighbourhoods that provide safe opportunities for walking and leisure activities are associated with a reduced prevalence of depression and alcohol-use⁴⁶;
 - Tackling inequality and building cohesion - racial segregation and community instability, are associated with depression⁴⁷;
 - Supporting inclusive growth - macroeconomic decline has been shown to be associated with increased risk of a number of mental health conditions, mainly through impact on employment, income, insecurity, and loss of social networks⁴⁸.
- **Supporting high quality services.** This includes the development of integrated services, championing user co-development, voice and rights and incorporating peer support, with a recovery and rehabilitative focus. This also involves supporting research in LMICs on the best way of delivering these services for these communities⁴⁹. DFID is now supporting Quality Rights Initiative in Ghana, training health and non health practitioners to engage with user voices, improve standards of care and adopt human-rights based approaches. In the UK, the National Involvement Partnership (NIP) project worked with the National Survivor and User Network (NSUN), to co-produce National Standards 2013 in order to improve experiences of services and support across the UK⁵⁰.
 - **Supporting the integration of these quality services into health systems.** This should include coordination with services and sectors outside of healthcare, including education and employment. Mental health care and support should be included in health systems strengthening approaches and be recognised as an essential component of universal health coverage. The Perinatal Mental Health Project (PMHP) in South Africa provided interventions to break the cycle of maternal mental distress by recognising that mental health services should be provided as part of health care at the primary level, not only at the specialist level.

Women were referred to on-site counsellors who also acted as case managers or to on-site psychiatrists or specialists for secondary care. Over a 3-year period, 90% of all women attending antenatal care in the maternity clinic were offered mental health screening with 95% uptake⁵¹.

Case Study 4: Preventing violence against women and girls as a driver of mental health

Over the last six years, [What Works to Prevent Violence](#), DFID's flagship research and innovation programme, has been investing in primary prevention efforts across Africa and Asia to address the underlying causes of violence against women and girls (VAWG) and understand what are effective interventions to prevent it. Results from 13 countries on what works (and doesn't) to prevent violence have shown that violence against women and girls IS preventable.

But *What Works* has also generated new evidence in a range of settings on the associations between mental health, wellbeing, alcohol and substance use and intimate partner violence (IPV). The evidence found women who experience violence are significantly more likely to experience poor mental health. In three studies with participants who ranged from young women in informal settlements in South Africa and married women in Afghanistan, to married women in the occupied Palestinian Territories (oPT), those who had experienced recent IPV were all much more likely to report clinically relevant symptoms of depression (all studies) and post-traumatic stress symptoms (in the two studies that assessed these).

Our interventions also found that preventing VAWG is important for reducing women's experiences of depression and anxiety. In four *What Works*' studies women reported significantly reduced experiences of Intimate Partner Violence, and they also reported improved mental health. In addition, our interventions found that among children, reducing peer violence is associated with reduced poor mental health.

This work has highlighted the essential importance of addressing VAWG as a determinant of mental health and how VAWG initiatives can contribute to maintain good mental health for all. In 2019, DFID announced a new £67.5million global programme to prevent violence against women and girls that will further build on this work.

Outcome 5: EMERGENCIES AND FRAGILE AND CONFLICT-AFFECTED (FCAS): *Mental Health and Psychosocial Support (MHPSS) is prioritised in preparedness, response and recovery in emergencies and FCAS.*

Mental health is directly and indirectly impacted by humanitarian emergencies and conflict. Prevalence of mental health conditions are greater in conflict-affected populations, and almost everyone affected by an emergency will experience some form of psychological distress in response to traumatic events. This means it is important to consider the needs across a population as well as specific needs of survivors of conflict violence. It is also important to address the needs and specific risks facing people with psychosocial disabilities during crisis. Despite the impact of humanitarian emergencies on mental health and well-being, mental health is often a low priority in the immediate onset and aftermath of a crisis. This can have long-lasting effects⁵². Humanitarian emergencies disrupt local systems and the needs of the affected population and will commonly overwhelm the local system's capacity to provide basic services⁵³. Integrating mental health and psychosocial support across sectors and the life course is critical.

Emergency situations can, however, present opportunities to strengthen mental health systems during and after crisis. The increased attention to mental health, combined with the influx of aid can be used to develop a stronger mental health system⁵⁴, although it is crucial that the immediate spike in interest and funding is transformed into long-term strategic efforts in order to be sustainable⁵³.

Practitioners should follow established best practice.

- **Provision of culturally appropriate, focused mental health and psychosocial support to crisis-affected persons of concern.** Evidence from a systematic review in 2017 highlights the importance of tailoring MHPSS activities to the local context and not being overreliant on evidence from trauma-treatment developed and tested in higher income countries⁵⁵. This evidence also highlighted the benefits of group-based MHPSS to emergency- and conflict- affected populations that allow participants to build support networks with peers and provide safe spaces for experience sharing.
- **Capacity building (training and ongoing supervision) in MHPSS of health, social welfare, protection and education staff & volunteers.** There is a chronic lack of human resources, knowledge and skills and ability to identify and treat mental health issues⁵⁶. Capacity building needs to go beyond one off trainings, focus on development of skills (competencies) and reach across multiple sectors. There is, however, emerging evidence of better human resourcing improving

access, for example, how trained and supervised community workers can provide psychological treatment for depression⁵⁷.

- **Include the well-being of humanitarian staff and volunteers in organisational development plans and programmes.** Mental health among humanitarian workers has recently gained more attention. This movement has highlighted the importance of MHPSS services being accessible to both international and national staff as well as volunteer workers.
- **Ensure MHPSS is included in national and community level emergency preparedness, response, and recovery systems and plans and support country-level cross-sectoral MHPSS Technical Working Groups in FCAS.** Psychosocial support and mental health services must be planned in advance and are a crucial component of effective response and recovery⁵⁸. Multi-sectoral and integrated approaches can increase access to mental health services and support bridging the humanitarian to development divide. In Syria, WHO and other humanitarian actors have rolled out support to make MHPSS accessible to the conflict-affected population. This has meant a shift from institutionalised mental health care to community-based mental health care, now widely provided in primary and secondary health care facilities, as well as by women's centres and community-based organisations¹⁵.

Measuring Impact

Measurement in mental health and psychosocial support is essential for tracking change and progress, and yet poses a number of challenges.

It is important that measurement systems i) capture policy, legal frameworks, and rights, as well as service coverage⁵⁹; ii) move away from narrow individualised, causal models of determinants of mental health, to address structural conditions and root causes; iii) and meaningfully involve service users and people with psychosocial disability in decision-making about what counts in mental health i.e. what should be measured and how.

The most commonly used existing indicators on ambitions on mental health are from the SDGs and the WHO Mental Health Action Plan (2013-2020). An introduction to monitoring and evaluating impact is covered in [DFID's K4D Topic Guide on Mental Health for Development Professionals](#)⁶⁰. There are additional tools including the [IASC Monitoring and Evaluation Framework for MHPSS in Emergency Settings](#)⁶¹.

The monitoring indicators above focus on measuring progress on mental health and psychosocial support. It is also important to measure how wider development interventions are reaching people with mental health conditions and psychosocial disabilities. The [Washington Group Questions](#) were designed to improve data on persons with disabilities and are recommended as monitoring questions for disaggregating progress across sectors by disability status. Both the enhanced [Short Set](#) and [Extended Set](#) of questions on disability and functioning include questions that capture some dimensions of mental health⁶².

Annex A: Important Definitions

Naming and defining identities and groups within mental health is complex. The power to define one's own experience on one's own terms is important. The definitions below are not all inclusive nor entirely distinct, people may identify in more than one way, and diverse perspectives exist within each group.

Box 1: Common terms and definitions^a

COMMON TERMS	DEFINITIONS
Mental health and psychosocial support	Mental health and psychosocial support (MHPSS) – is support to protect or promote psychosocial well-being, address social determinants or treat mental health conditions ⁶³
Mental health and wellbeing	Mental well-being is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community ⁶⁴
Mental health service user	A person who uses mental health services
Psychosocial disability	Used to describe the experience of people with participation restrictions associated with mental health problems and conditions. This identification is closely linked to legal rights and to the UNCRPD, often seeking to centre advocacy outside of definitions based on health
Psychiatric survivor	A person who identifies as having had a negative or traumatic experience related to mental health and/or accessing mental health services
People with lived experience and experts by experience	People who identify as having current or past lived experience of psychological or emotional issues (which may or may not be distressing), and irrespective of whether they have a diagnosed mental illness and/or have received treatment
Service user/survivor movement	'Refers to the work of individuals who advocate for their personal and collective rights within the context of discrimination faced as a result of having experienced mental health difficulties and/ or being diagnosed as having a mental illness' ⁶⁵
Mental health, substance use and neurological conditions (MNS)	MNS conditions are a heterogeneous range of disorders that owe their origin to a complex array of genetic, biological, psychological, and social factors. This category includes diagnoses, such as depression, schizophrenia, epilepsy, and substance-use conditions. A range of social determinants influence the risk and outcome of MNS disorders, including socioeconomic status, demographic factors, and environmental events ⁶⁴
User/survivor-led groups and research	Groups and/or research led by people who have used mental health services and/or who identify as having a psychosocial disability
Recovery and recovery oriented approaches	Emerging from the Recovery Movement, recovery-oriented approaches are strengths-based, do not focus solely on symptoms, see recovery as an ongoing process, and emphasise recovering control over one's life, including the ability to transform living conditions. Recovery means different things to different people, with a focus on having a good quality of life, that is full and meaningful ⁶⁶ , so is defined by the person themselves, not others' definition of what recovery means
Social determinants of health	Economic, environmental and social conditions and inequalities can determine people's risk of developing mental health conditions and their access to effective support. The social determinants of mental health encompass five key domains (demographic, economic, neighbourhood, environmental, and social or cultural) ⁶⁷ . Social determinants of mental health (such as, poverty, housing, working conditions) and health inequities, are themselves shaped by unequal distribution of power, money and resources at global, national and local levels
Quality Mental Health Services	In mental health care, quality is a measure of whether services increase the likelihood of desired mental health outcomes and are consistent with current evidence-based practice. This definition incorporates two components. For people with mental disorders, their families and the population as a whole, it emphasizes that services should produce positive outcomes. For practitioners, service planners and policy makers, it emphasizes the best use of current knowledge and technology ⁶⁸
Intellectual disabilities	People with intellectual impairments experience issues with cognitive functioning, which can affect ability to understand or learn new information and skills. These impairments become a disability when they interact with various barriers that may hinder a person's full and effective participation in society on an equal basis with others. People may also acquire cognitive impairments as adults, for example through head injury or dementia, but this is not defined as intellectual disability

^a Definitions are adapted from the National Survivor and User Network (NSUN)'s glossary of terms <https://www.nsun.org.uk/Pages/FAQs/Category/glossary> except where separately referenced.

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