International Federation of Red Cross and Red Crescent Societies – Mental Health Framework

International Federation
of Red Cross and Red Crescent Societies

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Contents

Foreword

All too often we learn of stories from around the world of the horrendous treatment that persons with mental health problems face in their communities and families. Ashamed of or attempting to protect a suffering family member, it is not uncommon for caregivers to resort to hiding persons with mental health problems in their homes or abandoning them in asylum or prison like facilities.

These stories illustrate how severely and regularly the rights of persons with mental health problems are violated in many countries. Incidents of families and health and social care providers disregarding the, human rights, humanity and dignity of persons with mental health disorders, are not unusual. The provision of appropriate care, treatment and facilities that enable persons with mental health disorders to live well, are not typical. Still today, in some parts of the world individuals abandoned within shelter or at care facilities are chained to the walls leaving them bound, isolated, neglected and dejected for the remainder of their lives. In other parts of the world, persons with mental health disorders are incarcerated within prisons, due to the perceived lack of alternative facilities and services.

While each person's story is unique, stigmatization and ill treatment of persons living with mental health problems is more or less a global phenomenon and as a global community we have failed to reach out to and support those suffering. Entire countries lack appropriate resources and means to provide basic mental health care. Communities and families often report feeling helpless in knowing how to support their family members with mental health problems. Individuals living with mental health problems are not often provided opportunities or equipped with appropriate resources to understand or recognize their ability to live better, healthier lives.

The time has come to remedy this failure. Now is the time to build upon the successes of the International Federation of Red Cross and Red Crescent Societies' Reference Centre for Psychosocial Support in building National Society capacity to respond to psychosocial needs in times of emergency and disaster. Now is the time to grow the capacity of the Reference Centre for Psychosocial Support, the Red Cross and Red Crescent Societies and the Secretariat to contribute to preventing and alleviating further suffering for persons living with mental health disorders, and their families.

Realising this goal will require the commitment and dedication of many and it is with this goal in mind I call upon all Red Cross and Red Crescent parties to take up their role in achieving the mission.

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Introduction

There is no health without mental health. Positive mental health and well-being "enable people to realize their potential, cope with normal stresses of life, work productively, and contribute to their communities."[1]

The Federation's comprehensive mental health concept aims to unite diverse scientific approaches and disciplines within mental health to work toward the common goal of every individual realizing his or her potential and a positive state of well-being.

This framework identifies the Red Cross and Red Crescent (RCRC) approach to mental health. It is intended to broadly outline mental health conditions found among populations, serve as an orienting tool for National Societies to assess mental health and psychosocial needs in their contexts and establish guidance for the Secretariat's and National Societies' future work in mental health. The framework is intended to highlight the interrelatedness of mental health to other health and non-health programmes, projects, interventions and actions of National Societies' and the Secretariat.

Background

Mental health problems exist in all regions of the world. The World Health Organization (WHO) estimates that one in four persons will experience mental illness in their lifetime and that mental, neurological, and substance use disorders currently account for 14% of the global burden of disease. It is estimated that by 2020 they will account for nearly 15% of the disability adjusted life years (DALY) lost due to illness and by 2030 depression will be the biggest contributor to burden of disease globally.[2]

It is also established that people with mental health problems have a lower average life expectancy than people without. Most (85%) [3] live in low- and middle-income countries where the coverage of mental health services is poorer than in high-income countries. According to WHO, four out of five persons in low- and middle-income countries who are in need of services for mental, neurological and substance use disorders do not receive appropriate care and support. [3]

It is estimated that after a humanitarian emergency, rates of severe (chronic) mental disorders increase from 2-3% to 3-4%. Additionally, mild to moderate mental disorders are estimated to increase from 10% to as much as 15-20% in the same population. Although these estimates show how significantly humanitarian emergencies and other protracted contexts can influence mental health, they do not capture the large numbers of other people who experience general psychological suffering. In light of this reality it is evident that developing accessible mental health and psychosocial interventions for populations affected by adversity are a priority[4].

The challenges of establishing, developing and maintaining basic mental health services within a nation are numerous and complex. National development plans, mental health legislation, national economies, health system capacity and culture each impact a nation's ability to prioritize or scale up mental health services. Actors at all levels must consider the range of challenges in a given setting in order to work toward reducing burden and meeting needs.

Challenges to Reducing the Burden of Mental Illness and Disorder

- neglect of mental well-being as part of holistic health,
- under-recognition of mental health as a science,
- stigmatisation, discrimination and human rights violations against people with mental health conditions,
- stigmatisation of mental health professionals,
- lack of skilled professionals to provide basic and specialized mental health services to populations,
- low prioritisation of mental health in national health and development plans – especially in resource poor settings,
- limited availability and accessibility of mental health services in circumstances of natural disaster, conflict, and complex and acute emergencies,
- and lack of cross-sectorial cooperation.

National Societies and the International Federation of Red Cross and Red Crescent Societies (IFRC) can contribute to the goal of reducing the global burden of mental illness and disorder. National Societies are uniquely positioned to identify and work toward mental health priorities together with

global, regional and national partners, through their established knowledge and presence in communities, tradition of working to address community needs, dedication of committed volunteers and as the auxiliary to governments.

Purpose

The purpose of the mental health framework is to better enable the IFRC Secretariat and RCRC National Societies to understand and plan for addressing mental health needs among communities and nations.

The IFRC Mental Health Framework is designed to:

- orient the Secretariat and National Societies to the growing burden of mental health disorders,
- outline system level challenges associated with mental health, mental health disorders and possible avenues of action and intervention,
- establish principle guidance for the Secretariat's and National Societies' work in mental health,
- aid the Secretariat and National Societies in identifying their role in promoting mental health and alleviating suffering due to mental health disorders,
- outline the next steps for moving the Mental Health agenda forward in the Movement

Scope

The mental health framework includes guidance for an array of mental health disorders that manifest due to a combination of factors (i.e. genetic, biological, social, environmental). The framework outlines potential areas of work for mental health and the interconnectedness between mental health, health and other non-health programmes of the IFRC and National Societies.

Comprehensive Mental Health Concept

The IFRC's comprehensive mental health concept is grounded in WHO's definition of mental health:

> *Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, 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.* [5]

It emphasises:

1. mental health and well-being are a part of every person's life, including persons with disabilities,
2. mental health and well-being are influenced by a range of factors – personal, social and environmental,
3. life experiences – both individual and collective – contribute to individual mental health and well-being,
4. positive mental health and the range of mental health problems, including distress, impact on functioning, illness and disability, are fundamental to a comprehensive concept.

The comprehensive mental health concept also recognizes the distinct, yet interrelated nature of mental illness, psychosocial problems and psychosocial disabilities (see glossary for further details). Left unaddressed, psychosocial problems can lead to severely compromised functioning and the development of mild, moderate or even severe mental illness. To best attend to these risks, the IFRC promotes a holistic approach to mental health services, support and care ranging

from curative psychiatric care, working with health, social and educational systems, and psychosocial support provided within group or individual contexts.

Guiding Principles

In harmony with the fundamental principles, vision and mission of the IFRC, the following principles serve as the foundation of the mental health framework as guidance for global and national work in mental health.

10 Guiding Principles

1. Mental health is a basic human right. There is no health without mental health.
2. Mental health is a fundamental element of a comprehensive health concept and it follows a rights-based approach to health.
3. People with mental health conditions should enjoy the full range of civil, political, economic, social, human and cultural rights on an equal basis with others.
4. People with mental health conditions should be treated with respect and dignity and be able to exercise legal capacity on an equal basis with others in all aspects of life. [6]
5. People with mental health conditions should be supported in exercising autonomy, informed consent and supported decision-making. [6]
6. People with mental health conditions should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.
7. Mental health services and support should be accessible to all members of society regardless of gender, age, disability, social status, nationality, ethnicity, religious belief, class or political opinion.
8. Mental health services and support should be equitably accessible to all members of society as part of a universal health care system regardless of socioeconomic status.
9. Support and care for people with mental health conditions should be evidence-informed and follow models of best practice.
10. Support and care for people with mental health conditions should be designed and developed to meet the needs of people throughout the life course, from infancy to old age.

*In observation of their role as auxiliary to government, National Societies are bound to operate and provide services in agreement with national policies. In cases where national policies and practices do not fully embody the intent of the guiding principles, National Societies should consider the principles as aspirational principles and advocate for their inclusion into planning and programming.

A Person-Centred Approach

The IFRC approach to mental health is rooted in the conviction that persons with mental health problems should be involved in the processes of deciding their care and should be viewed as key stakeholders and contributors to dialogue around mental health support and care practices. "Nothing about us without us." [7]

Inclusion of persons with mental health problems in determining their own care enables and encourages individuals to exercise autonomy, informed consent and independent or supported decision-making. By placing people at the centre of their own care, interventions and programmes can:

- better address prioritized concerns of persons with mental health problems and their families/ caregivers,
- more readily be tailored or adapted to individual needs of persons with mental health problems and their families/ care givers,
- more holistically assist people with mental health problems in attaining health and well-being,
- and better enable persons with mental health problems to exercise and strengthen their resilience.

The participation of persons with mental health problems in designing, implementing and evaluating mental health support and care services is also crucial. Participation in these capacities can enhance relevance and effectiveness of mental health services and contribute to increasing the acceptance, sensitivity and sustainability of services and programmes in diverse settings.

Social Determinants of Mental Health and Resilience

> *Resilience is the ability of individuals, communities, organizations or countries exposed to disasters, crises and underlying vulnerabilities to anticipate, prepare for, reduce the impact of, cope with and recover from the effects of shocks and stresses without compromising their long-term prospects. – IFRC* [8]

Social determinants of mental health are social, economic and environmental factors (e.g., social inclusion, socioeconomic status, access to education) that influence the mental health of individuals, groups and communities.[9] Early or prolonged exposure to hardship or disadvantage (e.g., social inequality, discrimination, exclusion, human rights violations, poverty, and trauma) in these domains, contributes to vulnerability, and can impact one's ability to cope and be resilient in times of adversity.

The IFRC believes persons with mental health disorders and their families/care givers have the ability to be resilient. In order for persons with mental health disorders to realise their full potential and exercise resilience, mental health programmes, projects and interventions must first conduct comprehensive assessments of a person's social determinants of health and then develop or tailor interventions to address them.

IFRC Holistic Mental Health Approach

The mental health framework identifies six key areas of action focused on the mental health of individuals and populations. These six areas are intended to provide a framework through which National Societies can assess needs and identify potential areas of action for mental health within their communities.

Three highly interrelated areas:

- Anti-stigma and anti-discrimination
- Promotion of mental health and prevention of mental illness
- Provision of services, support and care

and three cross-cutting areas:

- Research and identifying innovative approaches to mental health interventions
- Advocacy for greater prioritization of mental health (e.g., health policy, health and social care systems)
- Partnership with external bodies for advances in mental health

Anti-stigma and Anti-discrimination

Few communities in the world consider people living with mental health disorders to have equal public standing as their 'healthy' peers. Often defined only by their condition, individuals with mental health disorders rarely receive recognition of their capabilities. Alternatively, persons with mental health disorders experience much stigma, discrimination, exclusion and human rights violations from family members, caretakers, health systems and communities.

Persons with mental health disorders may lack access to, or support in accessing, legal mechanisms to protect and promote their human rights.[10] As a result it is not uncommon for persons with mental health disorders to be robbed of opportunities that define quality of life (e.g., safe housing, employment, satisfactory health care) and rendered more vulnerable to experiences of exploitation and abuse (e.g., physical violence, sexual abuse, bonded labour, human trafficking).

The Role of National Societies in Anti-Stigma and Anti-Discrimination

- Develop inclusion and anti-discrimination policies, programmes and campaigns - (e.g., RCRC hiring and volunteer recruitment policies, RCRC Youth and Parent Skills Programmes).
- Integrate messages about inclusion, disability and human rights into existing and on-going programming.
- Proactively engage with international thematic days on mental health issues e.g., World Mental Health day (10 Oct), Epilepsy awareness day (23 March), Austism/ developmental disorders day (2 April) and persons living with disabilities day (3 Dec).
- Partner with organizations such as the Special Olympics[11], Autism Speaks[12] or national Alzheimer's associations [13] to learn from and build upon existing efforts in stigma reduction.
- Support establishment and strengthening of civil society organisations for and run by people with mental health disorders, and their caregivers.
- Organize programmes to promote social inclusion by facilitating contact between persons

with mental health problems and persons without. [14]

Promotion of Mental Health and Prevention of Mental Illness

Promotion of mental health and prevention of mental illness are parallel approaches to a common goal of mental health and well-being. Promotion focuses on recognizing and encouraging positive choices, behaviours, and lifestyles that support healthy development, mental health and well-being. Prevention of mental illness and associated activities can be separated into three categories: primary, aiming to prevent onset of illness before symptoms present; secondary, aiming to minimize the impact of illness through early detection and treatment; and tertiary, aiming to reduce impact of on-going, complex illness.

The IFRC Reference Centre for Psychosocial Support (PS Centre) hosted by the Danish Red Cross was one of the first to pioneer work on mental health promotion and prevention within the Movement through a lens of providing psychosocial support. The PS Centre conducts extensive work in mental health promotion and primary and secondary prevention of mental illness in conflict and disaster settings. The PS centre, as well as other actors in the humanitarian context (i.e., the Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support in Emergency Settings), often refers to the services that fall under this complex combination of promotive and preventative services as *mental health and psychosocial support*. It is essential to implement programmes and interventions that both encourage positive choices, behaviours and lifestyles that promote wellbeing as well as aim to reduce or eliminate choices, behaviours, lifestyles and circumstances that increase risk for mental health problems. National Societies already have some experience in implementing health promotion programmes across the lifespan, from newborn to old age. In many cases these efforts are part of on-going health and/or social programmes. By including mental health promotion and secondary prevention in health and social programmes National Societies can reach a key vulnerable group, increase overall cost effectiveness of programmes, reduce stigma associated with mental health disorders and simultaneously promote holistic health throughout the life course.

National Societies' programmes on mental health promotion and the prevention of mental, neurological and substance use disorders

Prenatal development and infancy:

- Promotion of breast feeding results in positive influence on child intellectual, emotional, social, cognitive, behavioural development
- Programmes targeting alcohol abuse during pregnancies to prevent foetal alcohol syndrome and other intellectual disabilities
- Parenting programmes for families/caregivers and support to parents suffering from post-partum depression

Child and adolescence:

- Nutritional supplements to promote appropriate neurological development (e.g., iodine supplements)
- Life skills programmes – have demonstrated positive impacts in reducing substance abuse
- Youth programmes promoting inclusion
- Suicide and self-harm prevention programmes

Adults:

- Work-based programmes addressing chronic stress syndrome and burn out
- Intervention targeting alcohol and substance use disorders
- Suicide prevention through helplines, follow-up care and improved treatment of depression and substance use disorder
- Trauma treatment centres for persons with anxiety, depression, stress and PTSD related disorders.

Older people

- NCD programmes and healthy life style to contribute to reduced risk of dementia
- Active aging programmes and exposure to complex cognitive activities to protect against some forms of cognitive decline (e.g., dementia).

Programmes for populations:

- Social inclusion and anti-discrimination programmes: inclusion of people with disability increases social acceptance and improves quality of life (e.g., Special Olympics Unified Sports programme)

Programmes for target populations:

- Self-help groups
- Positive parenting programmes
- Training for caregivers and families (ex: increasing skills and coping abilities of those who care for family members with mental health conditions)

Mental Health Services, Support and Care

The IFRC supports and advocates for universal health care and comprehensive health services. More specifically, the IFRC recognises and affirms the necessity of including mental health services, care and support as part of basic health services for populations.

This section on mental health services, support and care outlines a broad range of mental services that should be included in holistic mental health care. It highlights:

- diverse methods of service delivery,
- a spectrum of diversely trained professionals who may provide services,
- and the ideal combination of services necessary to provide comprehensive, holistic mental health care.

Delivery methods of mental health services, support and care should range from completely independent of providers (community, family and individual initiatives) to being closely facilitated and directed by one service provider such as a mental health professional. This range of available services enables persons with mental health problems to engage with supportive mechanisms at the earliest recognition of ill-health appropriate for their needs and desires at the time.

Attaining the ideal combination of services in comprehensive mental health care systems requires availability of services and skilled capacity at multiple points of contact within systems (see Figure 1). Spanning from informal community care to specialized mental health facilities, mental health services can be provided through a variety of skilled professionals in diverse settings. To this point, the WHO's Mental Health Gap Action Programme (mhGAP) is the initiative to scale-up capacity of under-resourced health systems by training primary health care providers (General Doctors, Nurses and Community Health Workers) in the assessment, treatment and maintenance of mental health, neurological and substance use disorders of highest prevalence. [3]

In addition to formal (mental) health services, there is an array of non-specialized services, support and care that trained laypersons can provide to support mental health. Psychosocial support, support groups and educational and assistive programmes for persons with mental health problems are a few examples.

Some of the core considerations for organizing and developing Mental Health Services, Support and Care are illustrated in Figure 1. The figure illustrates that mental health support and care takes place in the formal as well as informal care systems. The figure furthermore outlines a layered approach to mental health services ranging from non-specialized support and care to more specialized support.

Services Necessary to Provide Comprehensive, Holistic Mental Health Care:

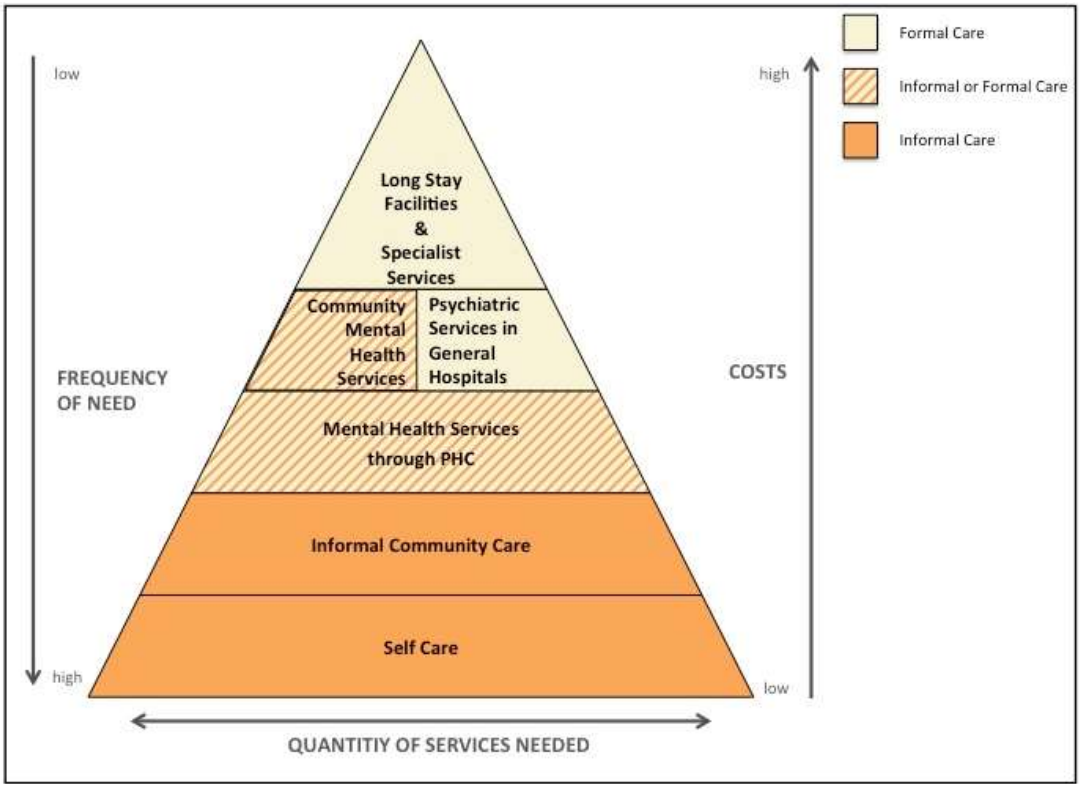

Figure 1. Adapted from WHO Optimal Mix of Services [15]

In addition, mental health care and support can be delivered using different service delivery methods and service providers as outlined below:

Service delivery method:

- Independent/Autonomous: self-help materials, online tools, audio books
- Guided: support groups, guided internet-based self-help
- Facilitated: Psychological First Aid, individual therapy, group therapy, psychiatric intervention, community interventions (e.g., reconciliation council)

Service providers:

- Trained lay persons (e.g., RCRC volunteers and staff)
- Trained medical professionals (e.g. Doctors, Nurses and Community Health Workers)
- Specialized mental health and social care professionals (e.g., Psychiatrists, Psychologists, Social Workers, Case Workers, Psychiatric nurses and Psychotherapists).

The Role of National Societies in Mental Health Support and Care

In all cases National Societies are accountable to assess the humanitarian needs in their context and determine what they are capable and mandated to do that is in agreement with their auxiliary role to their national government. Any programmes and interventions conducted by National Societies should be aligned with the priority mental, neurological and substance use conditions for that specific country.

As a general guide, National Societies can refer to the 2016 WHO Mental Health GAP Intervention Guide Version 2.0 (mhGAP-IG), which lists the following mental, neurological and substance use disorders as priority areas of intervention.

1. Depression
2. Psychoses
3. Epilepsy
4. Child and Adolescent mental and behavioural disorders (emotional, behavioural and developmental disorders)
5. Dementia
6. Disorders due to substance use (drug, alcohol and tobacco)
7. Self-harm/ Suicide.
8. Other significant mental health complaints.

The mhGAP-IG v2.0 is a model guide and it is essential that it is adapted to national and local situations. When the mhGAP programme is rolled out within a country, the National Governments select priority disorders based upon the contextual differences in prevalence, the national mental health strategy, and the availability of human and financial resources. National Societies may then select to work on some or all of the priority disorders selected for that specific context. This should be in consultation with the national ministry of health and other mental health related bodies. Adaptation is also necessary to ensure that the conditions that contribute most to burden in a specific country are covered and that the mhGAP-IG is appropriate for the local conditions that affect the care of people with mental, neurological and substance use disorders in the health facility. The adaptation process should be used as an opportunity to develop a consensus on technical issues across disease conditions; this requires involvement of key national stakeholders. Adaptation will include language translation and ensuring that the interventions are acceptable in the sociocultural context and suitable for the local health system.[16]

In a functioning health system:
National Societies may begin by looking into existing national mental health policies, legal frameworks, mental health services, and humanitarian needs and then design the best possible programme, project, intervention or action to meet determined needs. Resulting priorities may include disaster preparedness efforts (e.g. training staff and volunteers in psychological first aid for field workers [17]), establishing or partnering with and strengthening civil society organizations for and run by people with mental health disorders, training community level health workers to support persons with severe mental health disorders, or arranging mobile teams to provide basic mental health check-ups and services to underserved groups. National Societies may also run trauma treatment centres for persons suffering from anxiety and stress disorders, survivors of torture and other human rights violations.

In a disrupted, overwhelmed or underdeveloped health system:
National Societies – and when appropriate their international partners – may temporarily serve in a capacity of bridging service gaps in formal health care (e.g. running temporary medical facilities in disasters or complex emergencies). In such functions, the IFRC and RCRC National Societies should be prepared and equipped to meet minimum standard responses for mental health and psychosocial support in emergencies as outlined by the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings[18], Mental Health Gap Humanitarian Intervention Guide (mhGAP-HIG)[19] and The Sphere Handbook.[20]

Advocacy

Advocacy is necessary in order to raise the prioritisation of mental health across global and national health agendas. Advocacy includes awareness-raising, information dissemination, capacity building, defending the necessity and utility of mental health services and denouncing poor access, violation of rights and stigmatizing behaviours related to mental health problems.[21]

RCRC National Societies are in unique positions to advocate for and influence mental health policy that reflects the principles of this framework including, but not limited to, universal and equitable access to mental health services, support and care for all. National Societies can advocate for mental health legislation in many ways: contributing to development of transnational mental health standards; national legislation promoting equal observation of civil, political, economic, social and cultural rights of persons with mental health problems; conducting mental health promotion events on thematic days e.g., on World Mental Health Day or local inclusion campaigns.

Research and Innovation

Research and the development of a body of evidence that enables innovation in global mental health are essential. The WHO identifies four reasons for health research that are equally relevant to mental health research: [22]

1. Research guides action
2. Research leads to development of new tools
3. Research enables effective planning
4. Research contributes to development

Further understanding about the health and mental health of populations can also pave way for benefits like strengthened positions in mental health advocacy. For example, health data revealing the added cost and complexity of managing a person's chronic disease and mental health condition separately compared to the reduced cost of managing them together in a holistic approach can strengthen advocacy arguments like integration of mental health services into primary health care. For reasons such as these, research in health and mental health remains a necessity in developed, developing and humanitarian contexts.

Global mental health research priorities relevant to the RCRC:

In developed and developing contexts:

- Successful integration of mental health screening and core services into routine primary health /community health setting (task shifting)
- Scalable psychological interventions (task shifting)
- Effective and affordable community-based care and rehabilitation
- Improved access to evidence-based mental health care
- Identifying risk factors and evaluating preventive measures for dementia, suicide and self-harm
- Understanding and addressing public attitudes towards people with mental health problems and intellectual disabilities
- Evaluating inclusion, anti-stigma and anti-discrimination initiatives
- Evaluation of volunteer capacity in suicide prevention interventions
- Interrelationship and synergies between community-based settings and institutionalized care
- Operational research for tasking-shifting in mental health

In humanitarian contexts:

- Stressors faced by populations in humanitarian settings
- Indicators to monitor and evaluate mental health and psychosocial interventions in humanitarian settings
- Adaptation of existing mental health and psychosocial interventions to diverse contexts
- Psychiatric care, mental health and psychosocial needs in fragile and failing states
- Psychiatric and social care in disaster and complex emergencies

The Role of the Secretariat and National Societies in Mental Health Research:

The PS Centre, with extensive partnerships in academic research for mental health and psychosocial support [28], and the IFRC Health and Care Department are committed to evidence informed programmes and practice, and contributing to the on-going development of such practice. Building on the experience of the IFRC in conducting theory and practical driven evaluations, including employment of the realist approach, the Secretariat with National Societies can work together toward greater understand of context-specific, effective programming for mental health.

National Societies can continue to contribute to advances in mental health research through partnership with research institutions and other actors as well. Often implementing programmes at

the community level or at the interface between community health systems and formal health systems, National Societies are well positioned to collaborate with their Ministry of Health (MoH), Asylum/ Immigration departments, Ministry of Social Welfare/ Social Affairs and academia – especially in the area of operational research. When engaging in research, National Societies should ensure their participation is in agreement with the principles of this framework and global standards of ethical research.[23]

One area of research that is relevant for the mental health framework and the Movement is the research on scalabale interventions, which are now recommended by the WHO[24]. These interventions explicitly build on task-shifting to deliver adapted psychological interventions based on cognitive-behavioural therapy, inter-personal therapy and stress management to address mental health conditions such as depression, anxiety and stress-related disorders, and other significant mental health complaints. In recent years a range of scalable psychological interventions have been found to be effective for people suffering high levels of stress, depression and anxiety and living in communities exposed to adversity. Although much of this work has been done in high-income countries, there is increasing momentum to develop and test similar interventions for low-income settings. The PS Centre is planning to pilot test and evaluate the feasibility of this type of intervention in a Red Cross Red Crescent context.

Current scalable psychological interventions under development or are available include:

1. Problem Management Plus (PM+), which is a brief, basic one-one-one, paraprofessional delivered version of cognitive behavioural therapy for adults in communities affected by adversity. (released 2016)

2. Self Help Plus (SH+), which is a guided group intervention for adults and adolescents employing mindfulness-based, self-help materials; (under development)

3. Online (e-mental health) low intensity interventions for youth (under development);

4. Group format of PM+ (under development);

5. PM+ for children and adolescents (called Young Adolescents - under development)

6. Interpersonal therapy (IPT) delivered by paraprofessionals (released 2016);

7. Parental skills training programme for caregivers of children with developmental disorders including intellectual disability (under development).

8. Thinking Healthy – a manual for the psychosocial management of perinatal depression (released 2015).

Partnership

Partnership is essential at local, national and global levels with actors such as the WHO, ministries of health, IASC RG on mental health and psychosocial support (IASC MHPSSS RG) specialized agencies, NGOs, activist organizations, private foundations, academia, internally within the RCRC Movement and the corporate sector in order to be able to take initiatives to scale. In doing so, the RCRC will be able to build on synergies in:

- advocacy,
- research and innovation,
- anti-stigma and anti-discrimination work,
- promotion of mental health and prevention of mental illness,
- and services, support and care for persons with mental health disorders.

Development of joint work plans with partners will facilitate partnerships to grow to their fullest potential and have an impact on the goal of reducing the burden of mental illness globally.

Moving Forward

The information contained within this Mental Health Framework needs to be operationalised by the National Societies, the IFRC Psychosocial Centre and at the IFRC Secretariat level. Below are some steps as possible ways forward for the IFRC.

1. Research and mapping of
    a. existing mental health services, and promotion and prevention programmes provided by National Societies,
    b. existing mental health services and promotion and prevention programmes provided by National Societies in humanitarian contexts,
    c. existing anti-stigma and anti-discrimination programmes implemented by National Societies.
2. IFRC Psychosocial Centre and some National Societies partnering with WHO in the pilot testing and evaluation of selected scalable interventions (for example, SH+, Parental skills programme for DEV disorders, Young Adolescents, Thinking Healthy and PM+ are promising fits with existing IFRC programmes).
3. Partnership between IFRC Psychosocial Centre and WHO to develop the Community Health Workers component of mhGAP-IG Version 2.0.
4. IFRC Psychosocial Centre to test and adapt the mhGAP Community Health Worker mhGAP component for IFRC volunteers.

Annexes

Acronyms

DALY	Disability Adjusted Life Years
IASC	Inter-Agency Standing Committee
IFRC	International Federation of Red Cross and Red Crescent Societies
mhGAP	Mental Health Gap Action Programme
MoH	Ministry of Health
PHC(s)	Primary Health Centre(s)
PS Centre	Reference Centre for Psychosocial Support
RCRC	Red Cross and Red Crescent
WHO	World Health Organization

Glossary

Disability – The inability to fully and effectively participate in society on an equal basis with others as a consequence of the interaction between persons with impairments and attitudinal and environmental barriers. [6]

Discrimination – Beliefs, behaviours and actions toward individuals and groups who are ascribed negative labels that lead to exclusion and denial of social participation.

Intellectual disability – A life-long condition characterized by an impairment of skills related to intelligence such as language, memory, motor and social abilities usually acquired at or before birth or in the very early part of life. [25]

Mental health – Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. [5]

Mental health disorders – Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, intellectual disabilities and disorders due to drug abuse. Most of these disorders can be successfully treated[26].

Mental health problem/ condition - Any mental illness or psychosocial problem that can affect a person's thoughts, emotions, behaviours, relationships and their ability to thrive.

Mental illness – Mental and behavioural disorders that fall within the International Statistical Classification of Diseases and Related Health Problems, including: depression, bipolar affective disorder, schizophrenia, anxiety disorders, dementia, substance use disorders, and developmental and behavioural disorders with onset usually occurring in childhood and adolescence, including autism.[1]

Psychosocial problems – Problems resulting from the interaction between psychological (e.g., internal thought processes, feelings, reactions) and social (e.g., relationships, family, community, culture, environment) dimensions of a person.

Psychosocial disability – Impairment of one's ability to fully participate in life as a result of mental ill-health which can include a loss of ability to function, think clearly, experience full physical health, and manage the social and emotional aspects life. [27]

Psychosocial support – The process of facilitating resilience within individuals, families and communities by enabling them to bounce back from the impact of crises and helping them to deal with such events in the future. By respecting the independence, dignity and coping mechanisms of individuals and communities, psychosocial support promotes the restoration of social cohesion and infrastructure and individual well-being. Psychosocial support refers to the actions that address both the emotional and social needs of individuals, with the aim to help people use their resources and to enhance resilience. [28]

Stigma – The negative labelling of persons, groups or concepts seen as being different from a majority.

Well-being – All relevant types of well-being such as psychosocial well-being or economical and physiological well-being. It is a multidimensional construct that includes all aspects of a person's quality of life.

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