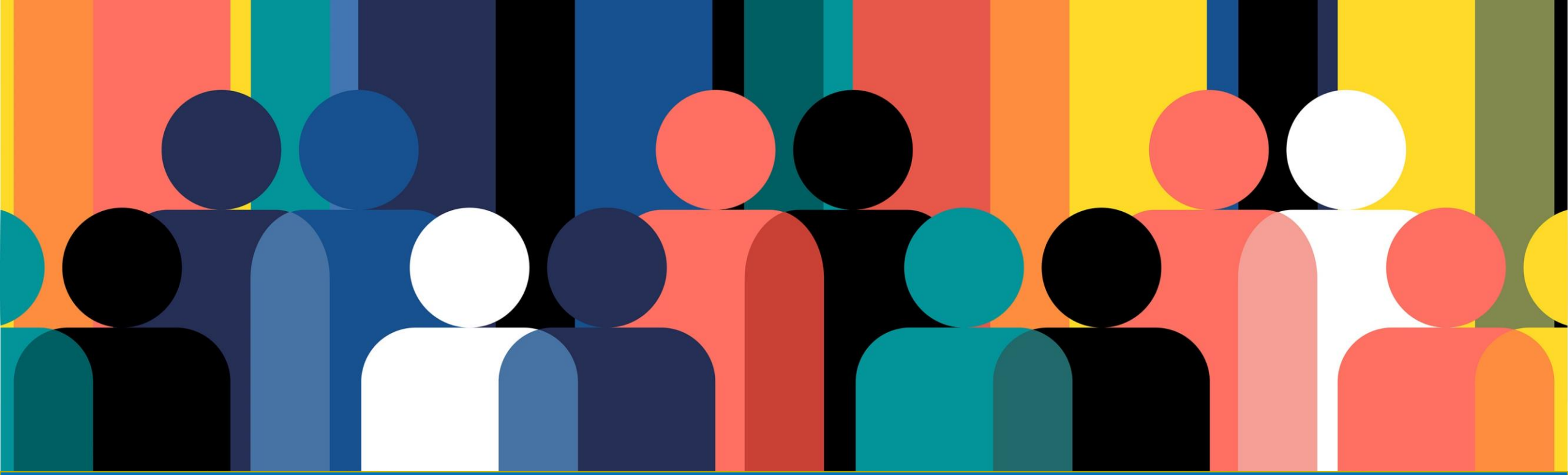

Mental Health & Psychosocial Support: Global Principles and Practices

Poland MHPSS Technical Working Group

29 May 2025

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Global & Regional Context: Forced Displacement

🌍 **Global Overview**
As of mid-2024, over **122 million** people were forcibly displaced worldwide
➤ Causes: Persecution, conflict, violence, human rights violations, or events seriously disturbing public order

🌍 **Europe Snapshot**
By end-2024, Europe hosted over **21 million** forcibly displaced people
➤ This represents **17% of the global refugee population**, including refugees, asylum-seekers, IDPs, and stateless persons

UNHCR October 2024

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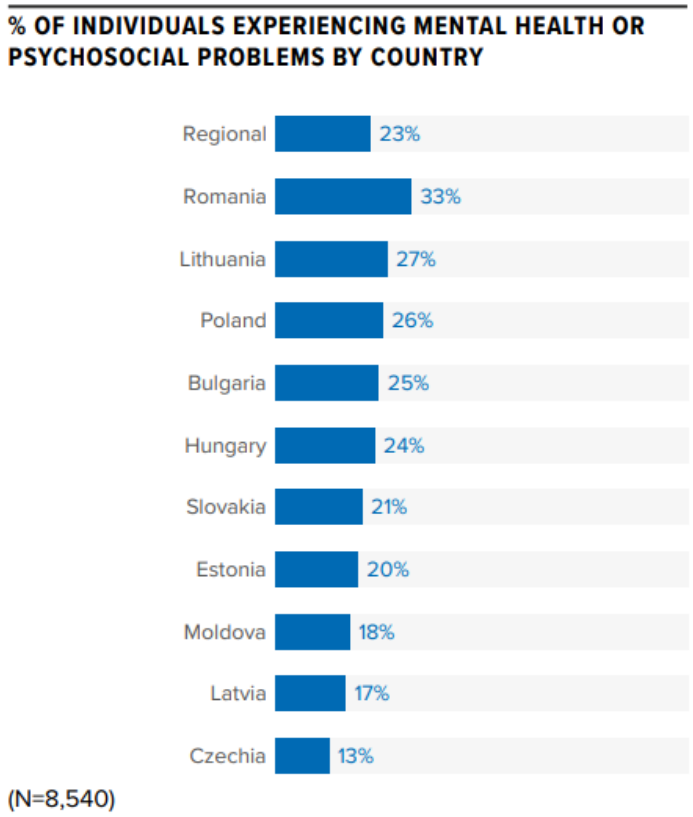
What the data tells us…

- The 2024 **Socio-Economic Insights Survey (SEIS)** gathered data directly from refugees across 10 RRP countries in Europe to understand their needs, access to services, and well-being
- **23% of refugees** regionally report MHPSS challenges impacting daily life
- **36% of households** have at least one affected member
- Only **46% of those with needs seek help**- due to stigma, lack of awareness, inaccessibility
- Women, older people, persons with disabilities most affected



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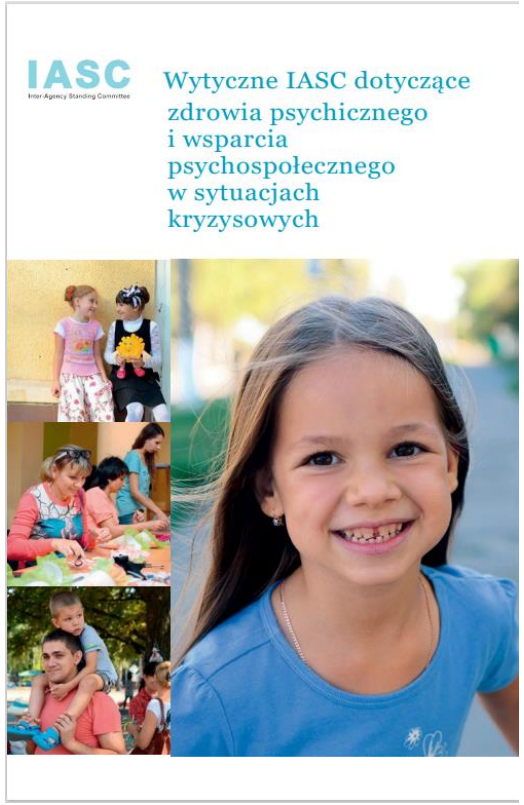
What is MHPSS?

Mental Health and **Psychosocial Support**

- Describes **a wide range of actions** that address social, psychological and psychiatric problems that are either pre-existing or emergency-induced.
- These actions can be any type of support that aims to **protect** or **promote** psychosocial well-being and/or prevent or treat mental health conditions.
- Requires **coordinated action** among all government and nongovernment actors.



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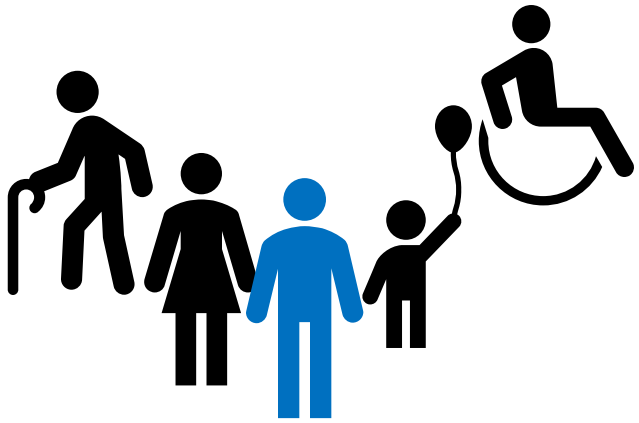
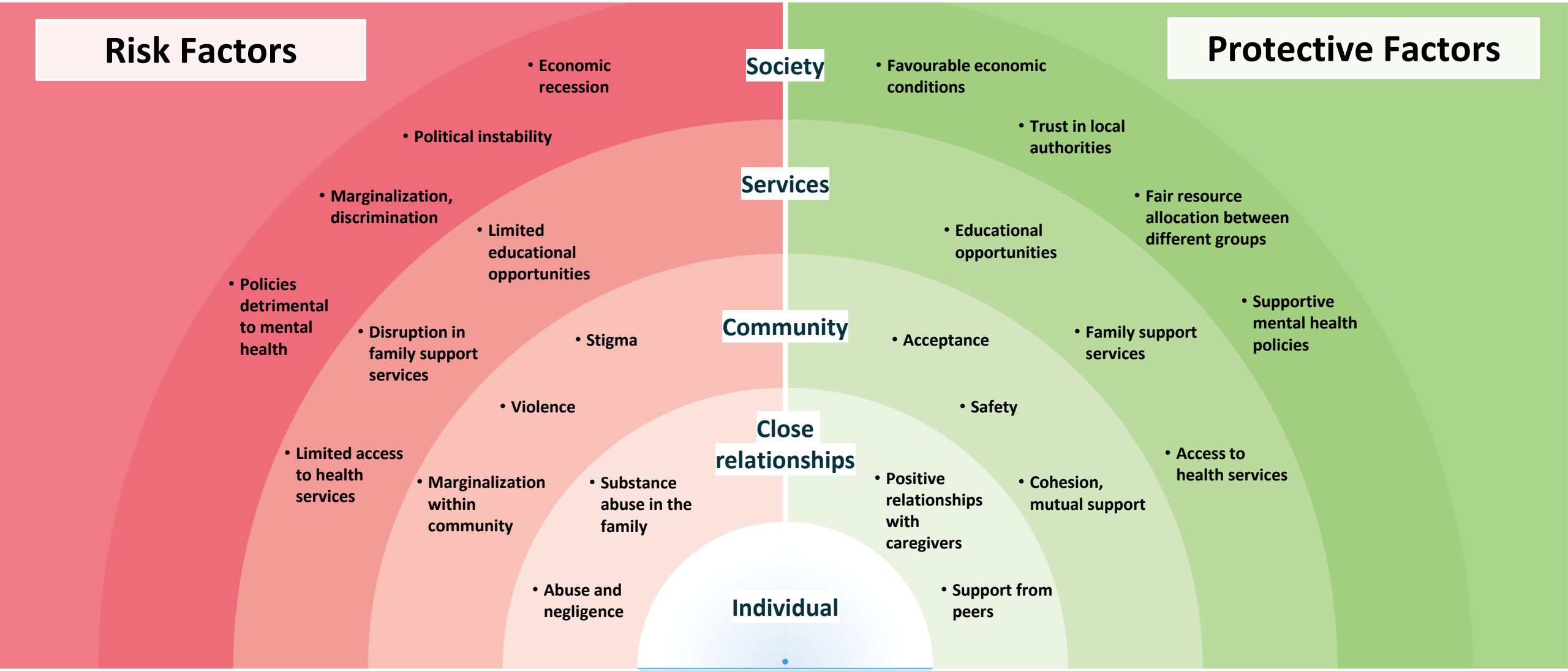
Why is MHPSS important?

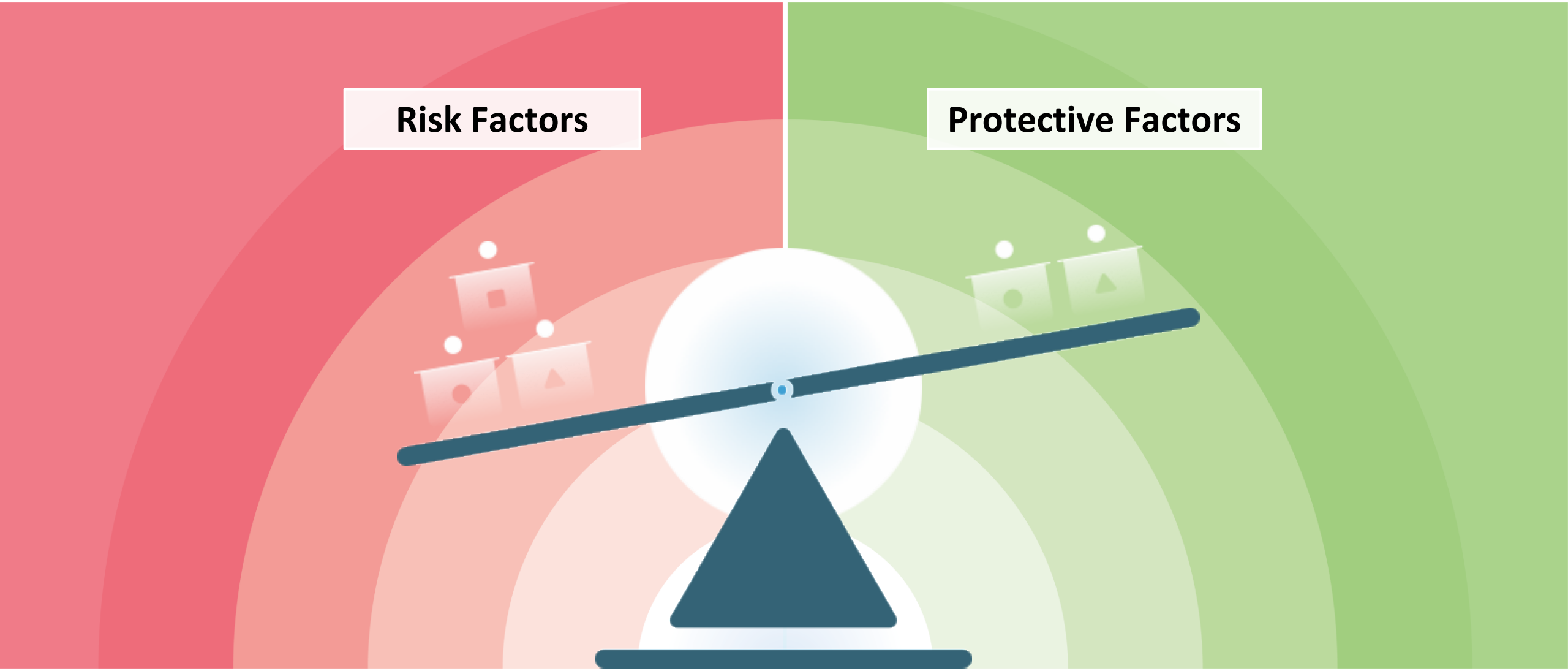


WHO estimates that **1 in 5 people** (22,1%) living in areas affected by conflict could suffer depression, anxiety disorder, post-traumatic stress disorder, bipolar disorder, and schizophrenia.

- Refugees and asylum seekrs face a **wide range of psychological and social problems** at individual, family, community and societal levels.
- The **prevalence of people suffering** is **high to very high** in emergency situations
- Most people will recover over time and need to **build resilience**
- MHPSS is more than "treatment“. It's also about **strengthening family and community support**

Social Ecological Model



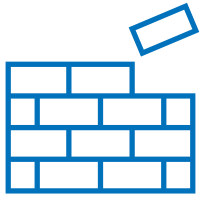

Risk Factors
Protective Factors

Six Core Principles

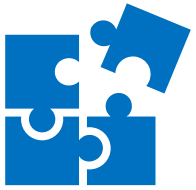
Human rights and equity

Inclusion and participation

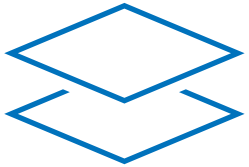
Do No Harm



Take advantage of available resources and capabilities

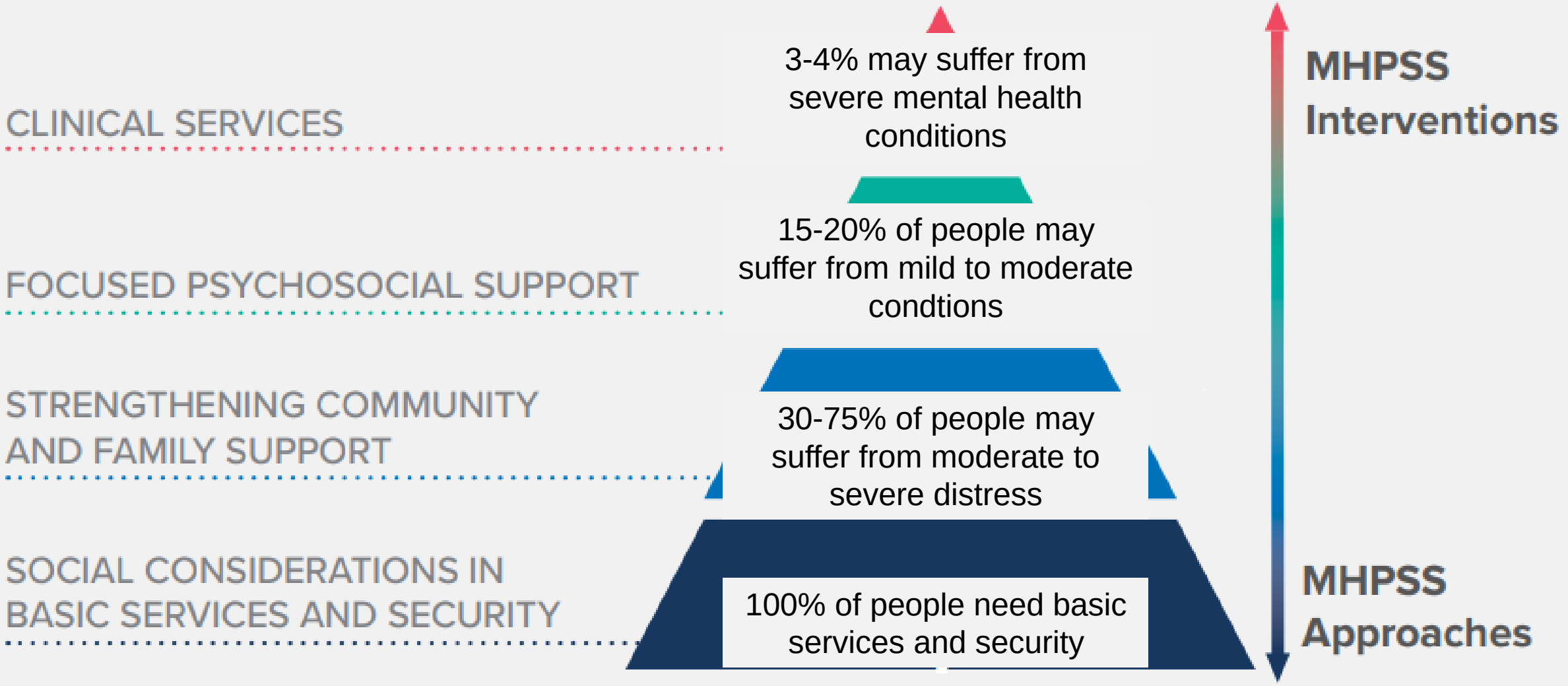


Integrated support systems



Multi-layer support

MHPSS Pyramid of Interventions



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Layer 1: Basic Services and Security

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1. Social and psychological considerations regarding the provision of basic services and security

- Ensure that the **provision of basic needs and essential services** (food, shelter, water, sanitation, basic health care, control of communicable diseases) and **security** is done in a way that facilitates the dignity of all people
- Promote and advocate for **good humanitarian practices** that protect the dignity of persons of concern
- Provide **information** on how, where and when humanitarian services can be accessed may be vital in reducing distress
- This approach should be **inclusive** of those with special vulnerabilities. **Avoid exclusively targeting a single group of persons** to prevent discrimination, stigma and potential further distress. (AGD Approach)

Social Store- Lasi County, Romania

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Layer 2: Community and Family Support

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2. Strengthening community and family support systems

- Promote activities that **foster social cohesion** among refugee and host populations
- Supporting the **re-establishment or development of community-based structures that are representative** of the population in terms of age, gender and diversity
- Promote **community mechanisms** that protect and support its members through participatory approaches
- Ensure **play and recreation spaces and activities** are an essential part of this layer, especially for children

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Layer 3:
Focused
(Non) Specialised
Support

3. Focused non-specialised support

- Provide **emotional and practical support** through individual, family or group interventions to those who are having difficulty coping using only their personal strengths and their existing support network.
- Evidence-based **brief psychological/mental health therapies** for mild /moderate mental health conditions. Brief scalable psychological interventions (5-8 sessions)
- Usually delivered by **non-specialised workers** in health, education or social services, after training and with ongoing supervision
- Widely used method: **Problem Management Plus (PM+) -** PM+ is provided in five sessions of **90 min** and can be delivered in individual format or group format.
- **mhGAP**: WHO's clinical guidance for non-specialists to identify and manage priority mental health conditions in primary care.

Evidence-Based Scalable Psychological Interventions

Method	Description	Format	Research
Problem Management Plus (PM+)	Based on Cognitive Behavioral Therapy, • stress management, • problem solving, • behavioral activation, • strengthening support.	• Individual : 5 sessions 90 min) • Group: 5 sessions	Moderate effects sizes in Pakistan, Kenya (Bryant, 2017; Rahman, 2016; Rahman, 2019). STRENGTHS consortium, six RCTs for Syrian refugees (Sijbrandij, 2017)
Interpersonal Therapy for Depression (IPT)	Aims to reduce depression by improving interpersonal skills to address 1) loss, 2) role transitions, 3) interpersonal conflicts, and 4) social isolation.	• Group: 8 -12 sessions • Individual: 8-12 sessions • 3 session first line treatment	Strong improvements on depression in Uganda (Bolton, 2007; Bolton, 2003) Ongoing research Colombia and Nepal (Rose-Clarke., 2020; Shultz, 2019)
Self Help Plus (SH+)	Guided self-help for emotional distress with a self-help book and audios.	• 5 weekly sessions for 30 people	South Sudanese women in Uganda small –moderate effects (Tol, 2020) Refugees and migrants in Europe: preventive effect for mental health problems (Purgato 2021)

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Layer 4: Specialised Services

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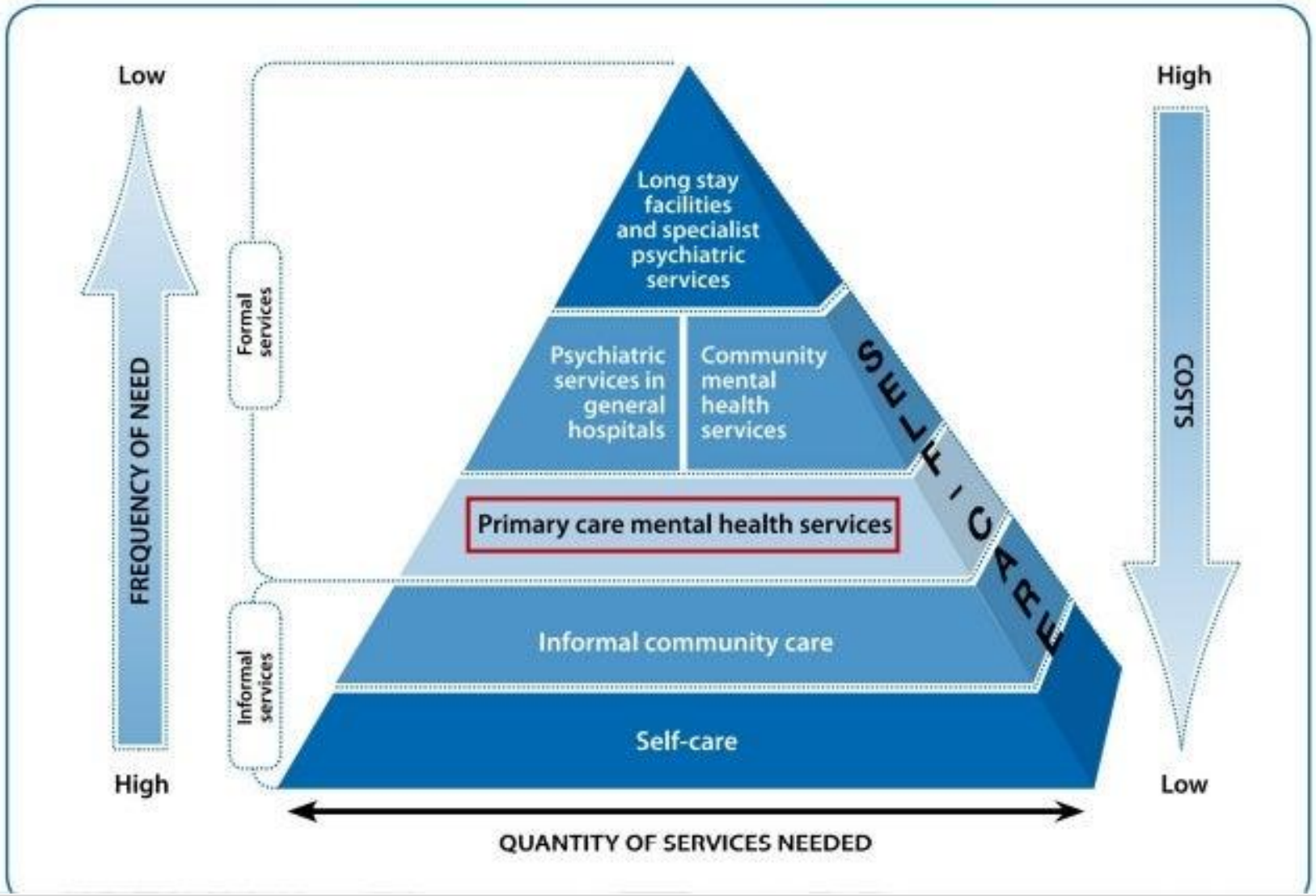
4. Specialized Services

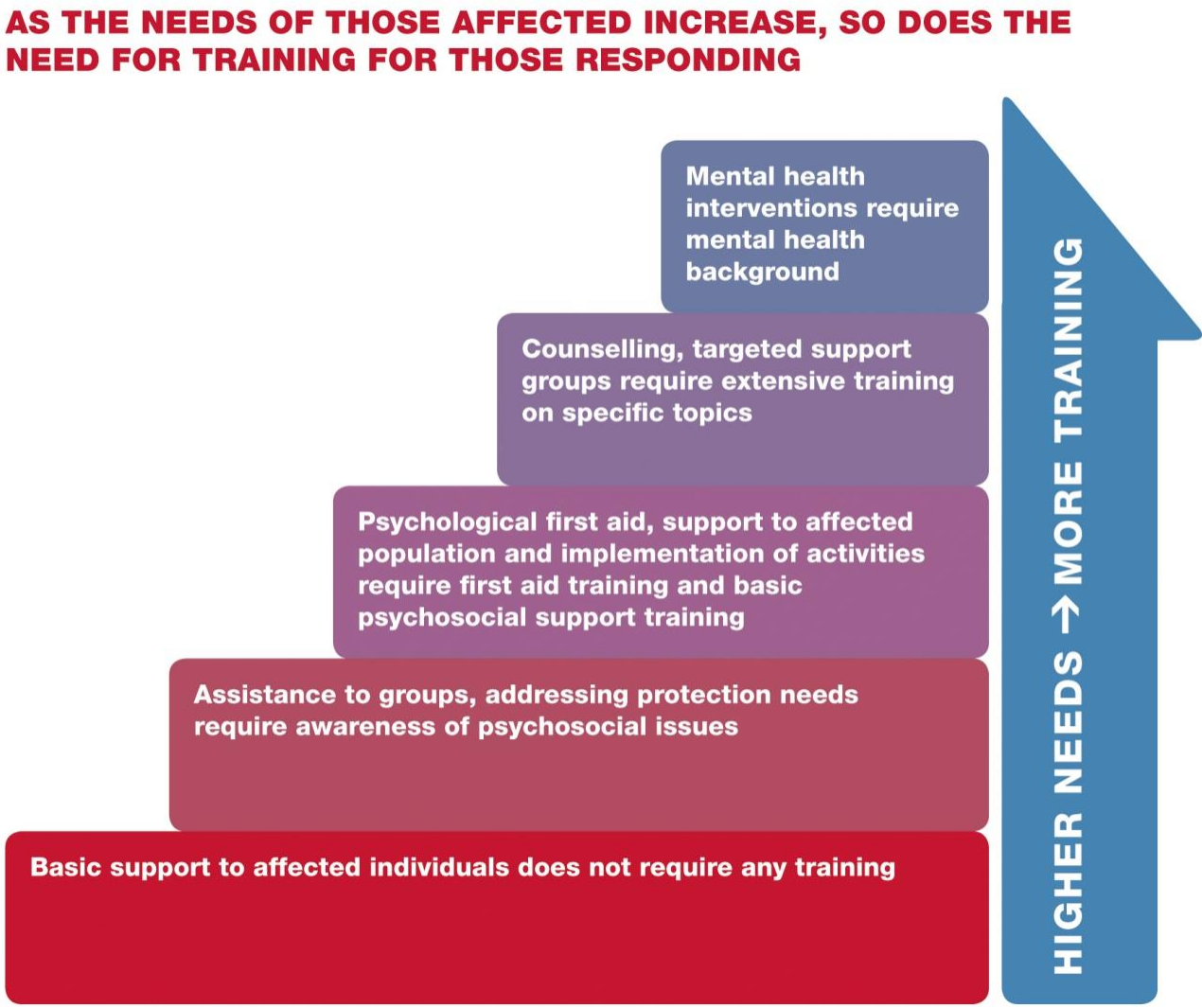
- Deliver clinical mental health services to those with **severe symptoms or an intolerable level of suffering**, rendering them unable to carry out basic daily functions
- This group consists of people with **pre-existing mental health conditions, psychosocial, intellectual and cognitive disabilities,** and emergency-induced problems, including but not limited to: psychosis, drug abuse, severe depression, disabling anxiety symptoms, and those who are at risk to harm themselves or others
- The interventions are usually led by **mental health professionals**

WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health



Who Can Provide MHPSS?

- ✓ Educators
- ✓ Social workers
- ✓ Teachers
- ✓ Psychologists
- ✓ Healthcare workers
- ✓ Counselors
- ✓ Faith leaders
- ✓ Community volunteers
- ✓ And the list goes on…BUT training, supervision and support is needed!



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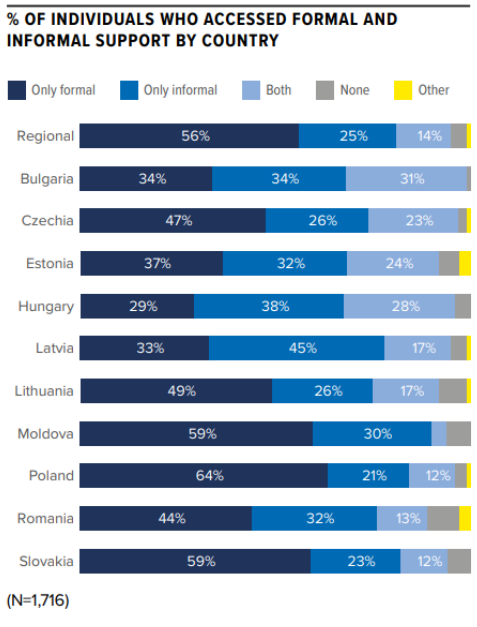
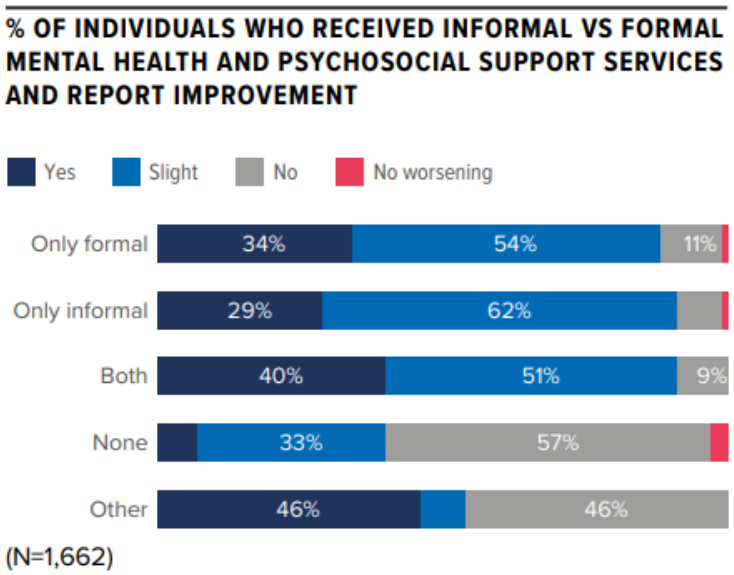
Back to the data: A Case for Multilayered Support





This shows the importance of integrating MHPSS into everyday services where people already seek support — the essence of mainstreaming

- 46% of those with MHPSS needs **sought support**
- **Formal support** included psychotherapy (44%), creative psychosocial activities (19%), structured interventions (17%)
- **Informal support** was significant: 33% relied on family/friends, 12% on spiritual support
- 88% of people who received support reported **improved well-being**
- Improvement was slightly higher when **both formal and informal** supports were accessed

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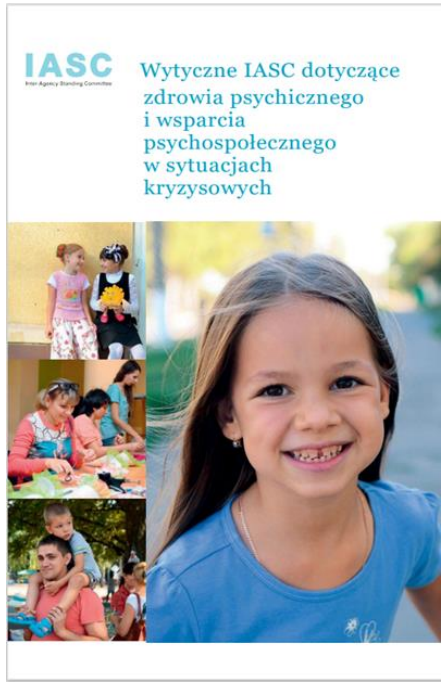
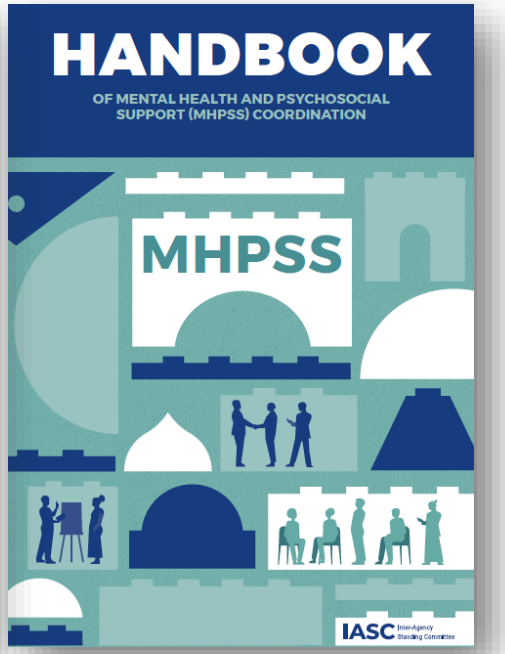
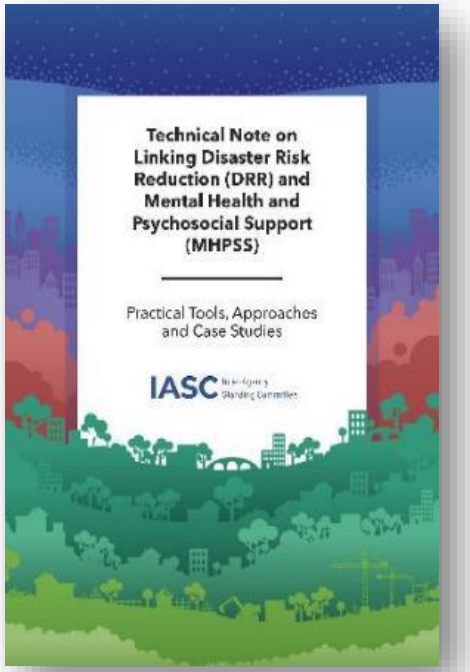
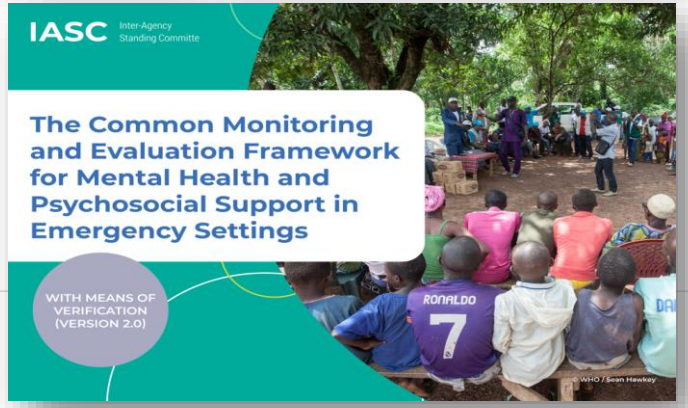
No need to reinvent the wheel!









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Key Recommendations

- ✓ Coordinate across sectors- encourage multisectoral approach across health, social services, education etc. – the TWG and Government
- ✓ Build on what already exists- strengthen and integrate MHPSS into systems and services
- ✓ Apply a systems approach – support all layers of MHPSS, not just a single intervention
- ✓ Strengthen capacity of health care workers, social workers, teachers, counselors, psychologists –especially culturally
- ✓ Strengthen community capacity to also provide and access mental health care and psychosocial support
- ✓ Use rights based, community based, and participatory approaches

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Sofia Casas

Regional MHPSS Officer- UNHCR- Europe

casas@unhcr.org

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