SH+ 360: novel model for scaling up a mental health and psychosocial support programme in humanitarian settings

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We explore multi-sectoral integration as a model for scaling up evidence-based mental health and psychosocial support interventions in humanitarian settings. We introduce Self Help Plus 360, designed to support humanitarian partners across different sectors to integrate a psychosocial intervention into their programming and more holistically address population needs.

Keywords

Mental health and psychosocial support; scale up; humanitarian settings; Self Help Plus; implementation.

Background

Many evidence-based mental health and psychosocial support (MHPSS) interventions require a substantial clinical workforce that is not typically available in low-resource humanitarian settings; these settings can encompass a range of emergency situations such as armed conflicts and war and disasters triggered by natural, industrial and technological hazards.[1] Current evidence-based interventions for mental and behavioural health problems also tend to focus on a single mental disorder and reach individuals rather than groups. The high resource requirements are a key factor contributing to low levels of implementation of evidence-based MHPSS interventions in low-resource humanitarian settings.[2] To address this deficit, psychological interventions that target a wider range of problems including psychological distress more broadly, that can be delivered without a specialised workforce, and that reach larger numbers of people during delivery have been developed and tested.[3] Building on evidence of benefits, innovative approaches are now needed for scaling up such interventions. In this context, we refer to 'scaling up' as 'deliberate efforts to increase the impact of innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and programme development on a lasting basis'.[4]

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In the field of global mental health, scaling up has historically been implemented vertically (i.e. within government health institutions) and horizontally (i.e. in new contexts). Both the vertical and horizontal type of scale-up aligns with international recommendations of integrating mental health in non-specialised healthcare settings (e.g. primary care), which is an important pathway to scale.[5] Multi-sectoral integration is another viable scale-up pathway, which has been underutilised for MHPSS in humanitarian contexts.[6] We propose that integration of MHPSS into programmes and sectors outside health represents a complementary pathway to scale, alongside integration of MHPSS with health programmes. Widely used humanitarian consensus guidelines, including the Inter Agency Standing Committee MHPSS guidelines for emergency settings, provide specific recommendations for integrating MHPSS programmes within diverse sectors of humanitarian response. These include food security and nutrition, education, shelter and site planning, and water and sanitation.[7] These recommendations are supported by growing recognition of the need to more holistically address population needs in humanitarian settings, given that the well-being of crisis-affected populations is determined by inter-related health and social factors.[8] Multi-sectoral integration requires strong partnerships and collaboration outside traditional silos.[8] In addition to more comprehensively addressing humanitarian needs, multi-sectoral integration may also facilitate more rapid and widespread scale-up of evidence-based MHPSS interventions within diverse types of existing humanitarian programming, as this provides more opportunities for implementation. An argument for

the integration of MHPSS interventions in diverse (non-health) sectors of humanitarian programming rests on the observation that mental health and psychosocial concerns are often tied in complex bidirectional relationships with other humanitarian needs (e.g. protection from violence and livelihoods).[8,9] For example, people who experience poverty are at higher risk of common mental disorders, and these common mental disorders in turn elevate the risk of (further) experiences of poverty.[10] Addressing these interlinked concerns may result in more sustainable and cost-efficient impacts.

SH+ 360

To exemplify an integration-focused model, we present SH+ 360, a model for scaling up the evidence-based MHPSS intervention called Self Help Plus (SH+). SH+ is a low-intensity guided self-help intervention that provides strategies for managing psychological distress and coping with adversity broadly.[2,11] SH+ has been tested in different contexts, including among South Sudanese refugee adult women, and is currently being tested among South Sudanese refugee men in Uganda.[2] Other studies in Europe and Turkey have tested SH+ with refugees and asylum seekers from various backgrounds.[12,13] Progressions and challenges from piloting to scaling have been described elsewhere.[14,15] The major challenges specific to SH+ 360 delivery include quality control in training, supervision, and monitoring and evaluation; these are described in the SH+ 360 model component section.

Development of SH+ 360

Our approach to bringing SH+ to scale has undergone multiple iterations. Initially, we proposed scaling up SH+ through a more conventional model, that is, expanding the training and implementation workforce of HealthRight International that tested the intervention in-country. Through reflection, stakeholder consultation and iterative development, our model evolved into SH+ 360, which in its present form centres around the creation of a technical support hub. We now intend to scale up SH+ through a model of tailored support (SH+ 360) that will facilitate the integration of SH+ into routine programming of selected partners operating at scale across diverse humanitarian sectors (i.e. multi-sectoral integration). Under SH+ 360, HealthRight International will not directly deliver SH+ but will support humanitarian partners as they integrate core model components into their own existing humanitarian programming to ensure ownership and sustainability of implementation.

SH+ 360 model components

The core components of SH+ 360 (Fig. 1) align with the programme cycle, beginning with completing an assessment of needs and resources with partner organisations. This needs and resources assessment enables both HealthRight International and partner organisations to understand (a) how SH+ may be adapted to meet unique population needs and (b) how SH+ could be embedded into specific services and training programmes that are already being delivered by partner organisations. The SH+ format was intended to be generic; adapting the intervention for implementation in new sociocultural contexts is critical. HealthRight International will support partners in translating and adapting SH+ according to their needs and help to identify non-specialists within their organisations that can be trained to serve as SH+
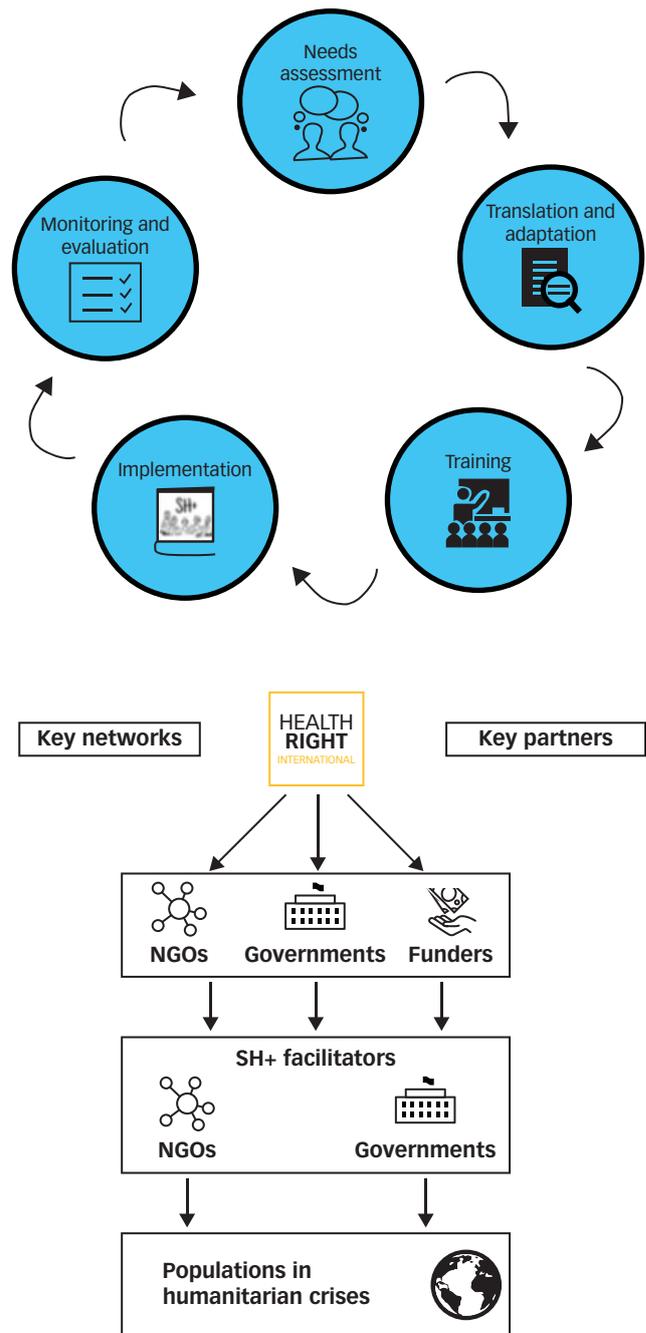

Fig. 1 SH+ 360 core components align with the programme cycle. The planning phase corresponds to needs assessment, translation, and adaptation and training. The implementation phase corresponds to implementing SH+, and the evaluation phase corresponds to the monitoring and evaluation component. NGO, non-governmental organisation.

facilitators. Using a digital mental health support assessment for MHPSS called Ensuring Quality in Psychological Support, the skills of non-specialists facilitating SH+ delivery can be assessed before, during and after a training programme to ensure quality delivery.[16] As people experiencing mild to moderate forms of psychological distress benefit most from SH+, those experiencing more severe psychological distress should be immediately referred for specialised services. Thus, HealthRight International will support partners in developing recruitment, screening and referral procedures. Each partner organisation will then implement SH+,

with support from HealthRight International. One major challenge that we foresee that is specific to scaling SH+ is quality control, as we will be training other organisations to implement SH+. To mitigate this challenge, we aim to co-design an SH+-specific monitoring and evaluation subsystem that can be added into partner organisation's existing systems, making it possible to track key indicators and maintain quality at each level of SH+ implementation. Indicators will reflect outcomes, outputs and processes ascertained from SH+ participants, facilitators and programme records and will be jointly analysed.

SH+ 360 application and testing

Approaches to scaling up need to be tested before they are implemented broadly.[17] SH+ 360 will be tested in Uganda through initial integration of SH+ into existing health programmes currently delivered by one partner and into gender-based violence, reproductive health, peaceful coexistence and livelihoods programmes currently delivered by another partner. HealthRight International will manage the SH+ 360 technical support hub that will support integration and implementation. Application and testing of the SH+ 360 model of scaling up can be understood through operational, implementation and financial elements.

Operational component of SH+ 360

The operational component of a scale-up model is a key feature that guides planning, implementation and learning and enables successful scaling up of interventions.[18] As multi-sectoral integration requires strong partnerships and collaboration outside traditional silos,[8] the operational component of the SH+ 360 model relies heavily on developing and maintaining strong partnerships between organisations. The goal of each partnership is to scale up SH+ delivery and reach new populations by developing partner internal capacity to deliver SH+ fully and independently, with a high level of quality, to meet the mental health and psychosocial needs of specific populations, drawing on HealthRight International's extensive experience with SH+ implementation and evaluation. HealthRight International will provide leadership, mentoring and tailored technical support to build the capacity of partner organisations to deliver SH+ to specific target populations in particular implementation contexts. Technical support under SH+ 360 is intended to be short term and time bound. This operational model, focused on knowledge-sharing to embed SH+ delivery within diverse ongoing humanitarian programmes within a variety of organisations, is intended to support sustainable delivery over the longer term. Anticipated challenges related to partnerships include working with different partners who have a range of organisational priorities and who may not be used to delivering MHPSS. To mitigate partnership challenges, co-development and partner ownership over integration and implementation are important components of the SH+ 360 model. Findings from the initial testing of the SH+ 360 model will inform future partnership-building processes and will provide a blueprint for co-creating implementation plans with partners in the future.

Implementation component of SH+ 360

The implementation component of a scale-up model refers to the application of a clear sequence of activities needed to take interventions to scale.[19] For the SH+ 360 model, implementation refers to the steps required to successfully integrate and deliver SH+ with existing health and non-health programming of partner organisations. This integration pathway to scale expands an intervention in terms of the breadth of populations and/or geographic locations reached (i.e. 'scaling out'). For example, we intend to test SH+ 360

with two partners working in diverse sectors and with diverse populations who are already engaged in these programmes. Successful integration will therefore likely require translation or adaptation of intervention content or implementation procedures for SH+. Partners' procedures for implementing existing interventions may also require adaptation. We aim to assess how integration will ensure that positive outcomes from both programmes are maintained and that the integrated version of the programmes is feasible to deliver. Some challenges that we anticipate in partner implementation of SH+ under SH+ 360 include mobilising participants for group delivery, identifying referral pathways for people who need specialised mental healthcare, identifying space to run SH+ sessions and working with a dynamic refugee population that is mobile. Some of the mitigation measures we have successfully employed in the past, and will continue to use, include engaging with and involving community gatekeepers such as refugee leaders and community advisory boards to facilitate mobilisation of participants and using existing spaces within settlements to address space constraints. Through use of SH+ 360 with different partners, we will be able to test various aspects of implementation; identify commonalities and differences across implementing contexts, populations and organisations; and build an evidence base for (multi-sectoral) integration as a pathway to scale in the context of real-world programming.

Financial component of SH+ 360

The financial component of a scale-up model is a framework for generating and sustaining funding to support the journey to scale.[20] The financial component includes identifying funding sources and describing the impact and financial implications of activities over time. Traditionally, approaches to funding and programming in the humanitarian sector include: (a) a dependency of implementing agencies on humanitarian donors; (b) a separation of humanitarian versus development aid; and (c) funds being provided for implementation rather than to support core functions of a humanitarian organisation.[21,22] The SH+ 360 model requires start-up funding that covers consultancy-type support from HealthRight International and support for co-design and implementation activities for partner organisations. In the present case of SH+ 360, funding and other resources to support participation in the model by HealthRight International and partner organisations are drawn from an SH+ 360-focused grant held by HealthRight International with subcontracts to partner organisations and in-kind contributions to the project (e.g. through staff time, existing materials and resources), thereby leveraging existing resources and minimising the cost of integrating SH+ into existing programming.

In the future, the SH+ 360 financial model will include start-up costs in joint applications with humanitarian agencies (e.g. as part of consolidated appeals). We have strategically partnered with an international non-governmental organisation already operating at scale not only in Uganda but in other parts of the world. We envision that once we integrate SH+ within their programming and it proves to be beneficial, our current partner and subsequent humanitarian organisations will be motivated to include SH+ costs in their own fundraising efforts. Integrating SH+ into the standard MHPSS toolkit of large humanitarian organisations operating at scale will facilitate sustained funding for the implementation of SH+ after the scale-up phase, particularly as large organisations may have access to funding from diverse sources, in contrast to smaller organisations specifically focused on MHPSS. Another approach to ensure financial sustainability that we are employing with our government partner is to work together in adapting SH+ to fit their context within government structures. The World Health

Organization's report on sustainable mental healthcare after emergencies also recommends integrating humanitarian programming into standard mental health budgets.[23] We are also using the training of trainers model to build SH+ master trainer capabilities among government staff to ensure that they are able to continue training SH+ facilitators across the country after the project ends.

Future directions

Few MHPSS interventions in humanitarian settings have been successfully scaled up, and innovative approaches to scale are needed to address this implementation gap. Multi-sectoral integration with health and non-health programmes represents a promising opportunity to enhance the reach of evidence-based interventions while meeting diverse needs more comprehensively. With limited practical guidance on the steps required to prepare for and implement scalable MHPSS interventions such as SH+, the SH+ 360 model represents a novel platform for knowledge-sharing, co-design and supported uptake. Initial tests of the SH+ 360 model will offer key insight into partnership development, barriers and facilitators to integration, as well as various implementation factors when SH+ is delivered within real-world humanitarian programming.

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