INCLUSIVE MHPSS response

Ukraine, MHPSS TWG coordination
19 August 2020

Dr Anita Marini, PhD
International MHPSS advisor
WHO MHPSS consultant
Outline

• The impact of COVID 19 pandemic on MHPSS
• Vulnerable groups
• Persons with disabilities
• Barriers and risks
• Inclusive MHPSS response
COVID-19 pandemic

Different emergency

Very high impact at different levels

What about the impact on mental health and psychosocial wellbeing?
Impact of COVID-19 pandemic

• People all over the world are facing severe impacts on their mental health and psychosocial wellbeing due to the COVID-19 pandemic.

• Psychological distress is widespread among large segments of the populations, due to the immediate effects of the virus on health, due to the consequences of measures to contain the spread, such as physical isolation and suspension of services, and due to the worries about loss of livelihoods and education.

• The direct effects of the pandemic are compounded by the effects of ongoing humanitarian emergencies and sociopolitical and economic fragility in countries hosting vulnerable populations.
Defining Vulnerable Groups

• Who are the vulnerable groups?

• **Persons who face higher and multiple protection risks** in a given context.

• Who are the vulnerable groups in emergency settings, and even more specifically during the current pandemic?
  • **Persons with disabilities**
  • **Persons with invisible disabilities**
  • Children
  • Girls and women, pregnant women
  • Elders
  • LGBTQ+
  • Those who lost relatives due to COVID-19
Disability frameworks

• Social and Human Rights models

• CRPD art. 1 «Persons with disabilities are those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others»
Examples of barriers in emergency settings

- Exacerbated pre-existing negative, discriminatory and sometimes overtly hostile societal attitudes towards persons with disabilities.

- Misconceptions, prejudices and stigmatizing beliefs among humanitarian workers, policy makers and health professionals (i.e. erroneous ideas about being dangerous or being unable to make decisions or to contribute to the emergency response, especially in reference to persons with psychosocial, cognitive and intellectual disabilities).

- Diminished service accessibility due to damage and destruction of equipment and infrastructure as results of conflicts and natural disasters. Reduced ability of services to function where essential staff are themselves affected by emergencies.

- Insufficient capacity of humanitarian staff to adapt information, communication, infrastructures, and service delivery to the requirements of persons with disabilities.

- Exacerbated pre-existing and contextual restrictions in being able to exercise legal capacity or make decisions about all aspects of life, including about medical treatment.

- Being constrained (i.e. forced institutionalization, forced treatment, and physical and chemical restraint) which violates human rights and strongly prevents any form of participation in society and access to humanitarian services.

- Limited opportunities for persons with psychosocial, cognitive and intellectual disabilities to participate in and lead research, or influence research agendas.
• Psychosocial disabilities are disabilities resulting from impairments related to mental health conditions in interaction with participation barriers.

• Psychosocial disabilities during humanitarian emergencies may be temporary, long term or recurrent.

• The term is usually reserved for people with more persistent or recurrent functional impairment, who are confronted with systematic exclusion and participations barriers.

• The term is less often used for persons with temporary mental health conditions that recover quickly, sometimes in response to MHPSS interventions.
Examples of additional barriers in covid-19

• More difficulty exercising preventative measures due to inaccessible information and communication

• De-prioritized in access to health care due to negative perceptions about their value to society

• Discriminatory criteria in decision-making processes regarding health care rationing, not based on individual prognosis but assumptions about quality or value of life

• Technology used for remote service delivery (i.e. online MHPSS) may not be accessible to persons with disabilities, particularly in humanitarian settings where access to technology is already more limited

• Distance/remote learning and return to school programmes may not be inclusive of and accessible to children with disabilities

• Beliefs that persons with disabilities cannot contribute to the response to COVID-19

• De-prioritization of pre-existing services for persons with disabilities to re-direct resources toward the COVID-19 response
Higher and multiple risks faced by persons with disabilities

- Persons with disabilities are most at risk of being left behind and marginalized.
- Of violence, coercion, abuse and other violations.
- The rate of premature mortality is higher than that of persons without disabilities.
- Girls and young women with disabilities face up to 10 times more gender-based violence than those without disabilities and are most at risk of marginalization, exclusion, discrimination.
- Children, youth, elders with disabilities are more subjected to abandonment, neglect, abuse and exploitation.
- Persons with invisible disabilities such as intellectual, cognitive and psychosocial disabilities, and persons living in residential institutions are at increased risk of being left behind, of discrimination, violence, persistent violation of human rights, under-identification, and being excluded. Furthermore, disability related services and supports and DPOs themselves target more often and mainly persons with physical and sensorial disabilities.
- In pandemic:
  - In pandemic, heightened exposure to health problems, late detection, limited access to treatment and care.
  - In pandemic, violence, exploitation and abuse at both the household when families are under increased stress and separated from community support networks and at the residential settings, which are further isolated from protective families and network due to distancing measures.
  - In pandemic, children and adults with intellectual, cognitive and psychosocial disabilities may become particularly distressed at a change in routine.
At risk groups and intersectionality

• Diverse group, varying in age, gender, ethnicity, type and severity of impairment, barriers faced and settings of living.

• As is the case with anyone, these factors determine how persons with disabilities are affected by emergencies, including in the way that their wellbeing is impacted.

• Furthermore, the type of emergency can aggravate further the risks faced by persons with disabilities. For example, the social distancing required in pandemics and the massive use of technology in service delivery may exacerbate barriers to equal participation and access.

• Intersectionality based on disability, age, gender, ethnicity, class, sexuality, type of emergency etc. compounds risks faced by the person and their impact, as for a synergistically negative effect.

• Therefore, among persons who have disabilities in emergency contexts, there are groups that face higher risks, such as children, youth, elders, girls and women, LGBTQ+, persons with invisible disabilities such as intellectual, cognitive and psychosocial disabilities, persons with multiple disabilities and persons living in residential institutions.
Long-stay institutions

• In most of the low- and middle-income countries, standalone psychiatric hospitals and long-stay institutions, where human rights violations are extreme and recurrent, are unfortunately common. Those institutions and hospitals cannot but deliver inadequate and inhumane care.

• During emergencies, especially pandemic, those long-stay institutions and hospitals become even more life-threatening settings, violations of human rights are exacerbated, any kind of protection and health risks are heightened, and abandonment is likely to happen.

• Examples?
The reform of hospital based MHPSS systems, the closure of long-stay and residential institutions and the provision of supports to live and participate actively in communities are a priority. Emergencies may offer an opportunity to move in this direction.

Nevertheless, when an emergency occurs, if the MHPSS system is not community based and human rights oriented and still includes long-stay residential institutions, it is essential that plans are in place to ensure that persons living inside are not left behind and neglected in humanitarian response.

Is this the case during COVID-19?
MHPSS RESPONSE
The challenges

- Globally, there is insufficient inclusion of persons with disabilities in humanitarian MHPSS responses, particularly where pre-existing mental health systems are inadequate (i.e. limited availability of trained human resources, discriminatory staff attitudes, poor conditions and accessibility of the premises), not community-based, recovery and human rights oriented.

- There is a lack of guidance on how MHPSS programmes can be made more inclusive of persons with disabilities, which may lead to unintentional harmful or discriminatory behaviours by the aid actors themselves.

- Similarly, MHPSS is rarely mentioned as a relevant issue in guidelines for working with persons with disabilities, despite the fact that persons with disabilities are often at increased risk of developing psychosocial problems and mental health conditions, especially in emergency settings.
WHAT TO DO?
MHPSS inclusive of persons with disabilities and adaptation of MHPSS response to COVID-19 pandemic

1. **Mainstreaming disability within MHPSS** planning, programming and budgeting in order to remove barriers to participation to the MHPSS response and support accessibility of persons with disabilities on an equal basis with persons without disabilities.

2. Designing and implementing **disability focused actions** as part of the MHPSS response to ensure that the specific and individual disability related needs of persons are met.

3. Furthermore, it is essential to advocate for **psychosocial, cognitive and intellectual disabilities and MHPSS considerations being not overlooked** within broader disability planning and programming.
The Convention clarifies the concepts of reasonable accommodation and universal design, as complementary means of inclusion.

“Universal design means the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design” (art. 2). Target is the entire population (i.e. ramp entrance, automatic doors).

“Reasonable accommodation means necessary and appropriate modification and adjustments not imposing a disproportionate and undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms” (art. 2). Target population is an individual or a group of individuals with disability related requirements (i.e. providing sign language interpreters or closed captioning at meetings and events).
KEY Actions

- Consultation with OPDs, self-advocates and persons with disabilities as partners and agents of change in the MPHSS response
- Persons with disabilities are recruited
- Safety and Universal design
- Reasonable accommodations
- Assistive devices
- Capacity building
- Communication and resources are available in multiple and accessible formats
• Interagency and intersectoral MHPSS referral mechanism
• Service organization is retrofit and adapted
• Rehabilitation opportunities
• MHPSS options for family members and caregivers
• Focused MHPSS support targeting disability diversity
• Adapted existing structured PSS programs
• Accessible and inclusive feedback and complaints mechanisms
• Awareness campaign
Disability-Inclusive Covid-19 Response: Key Recommendations from International Disability Alliance

- Persons with disabilities must receive information about infection mitigating tips, public restriction plans, and the service offered in a diversity of accessible formats with use of accessible technologies
- Additional protective measures must be taken for people with certain types of impairments
- All preparedness and response plans must be inclusive of and accessible to women with disabilities
- No disability-based institutionalization and abandonment is acceptable
- During quarantine, support services, personal assistance, physical and communication accessibility must be ensured
• Measures of public restrictions must consider persons with disabilities on an equal basis with others.

• Persons with disabilities in need of health services due to COVID-19 cannot be deprioritized on the ground of their disability.

• OPDs can and should play a key role in raising awareness of persons with disabilities and their families.

• OPDs can and should play a key role in advocating for disability-inclusive response to the COVID19 crisis.
Resources:

MHPSS COVID-19 TOOLKIT
CORONAVIRUS DISEASE (COVID-19) PANDEMIC
Version 2.0
Mental Health and Psychosocial Support Network
15 June 2020
CASE STUDIES

• Polish Humanitarian Action response
• Italy, Romagna subregion
Discussion

• In your response to COVID-19 pandemic, are you taking measures to ensure equal access to messaging, care and continuing access to supports?
• Are people with disabilities getting the right support if in quarantine?
• In your to COVID-19, have you ensured OPDs involvement in the planning?
• Are OPDs engaged during the crisis?
Thank you!