Futuremakers: Brain and Mental Health

Episode 6: Protecting mental health in crisis contexts

Professor Belinda Lennox:

Welcome to this season of Futuremakers: Brain and Mental Health. I'm Professor Belinda Lennox, I'm a psychiatrist and a researcher here in Oxford, and this season you'll be joining me as we demystify the science behind the most complex object in the known universe, our brains, and look at the wide-reaching impacts of mental illness on individuals and society. I'll be introducing you to some of Oxford's best academic minds, working to solve the greatest challenges in brain and mental health, and I'll also be speaking to guests from beyond the university to bring their perspectives and lived experience and get a sense of the impact of what we're doing. Join us as we discover how Oxford is shaping the future of brain and mental health research.

Welcome to this episode of Futuremakers, where we're going to be discussing mental health in crisis contexts, covering both conflict and natural disasters. And I'm really lucky to be joined by an expert panel of guests to discuss this really important issue. So let me firstly introduce you to everyone that's here, and perhaps you each, perhaps each guest can describe briefly their role and cover their current areas of focus around mental health in crisis situations. So first of all, we have Ben Perks, who's Head of Campaigns and Advocacy at UNICEF. Welcome, Ben.

Ben Perks:

Thank you very much. Great to be with you today. I oversee global advocacy across a whole range of issues related to child protection, survival and development and have a passionate interest in child mental health.

Professor Belinda Lennox:

And then next, we have Sabine Rakotomalala, who is Technical Officer for the Violence Prevention Unit at the World Health Organisation, welcome Sabine.

Sabine Rakotomalala:

Thank you very much, Belinda, and thank you for having me on this episode. And so my name is Sabine Rakotomalala, and I work actually only since three years at the World Health Organisation in the Violence Prevention Unit. Before that, I've worked with an NGO called Terre des hommes, with UNICEF, with the Global Partnership to End Violence. And really since 22 years, I've been working on mental health and the prevention of violence against children.

Professor Belinda Lennox:

Thank you. And then we have three colleagues of mine from the University of Oxford. So firstly, we have Dr Jamie Lachman, who's senior research and teaching fellow in the Department of Social Policy and Intervention.

Dr Jamie Lachman:

Hi, Belinda. It's a pleasure to be with you and colleagues today in this discussion. I've been focusing my research on the development, the optimization, evaluation and scale up of innovative parenting support interventions in the Global South and particularly in areas of crisis, really with the aim to support child well-being and prevent violence against children and looking forward to this conversation.

Professor Belinda Lennox:

Thank you. And we have Dr Isang Awah, who is Head of Advocacy also in the Department of Social Policy and Intervention.

Dr Isang Awah:

Thank you so much, Belinda. And I'm really delighted to be here. Like you've just said, I'm Head of Advocacy at the Global Parenting Initiative. And in the past few years, I have been involved in the different humanitarian responses that the Parenting for Lifelong Helps team has launched. And I'm really interested in providing mental health and psychosocial support for families.

Professor Belinda Lennox:

And last but definitely not least, we have Stephanie Eagling-Peche, who is a DPhil student and Research Manager in the Department of Social Policy and Intervention. Welcome, Stephanie.

Stephanie Eagling-Peche:

Thank you so much, Belinda. It's a pleasure to be here. So, my name is Stephanie Eagling-Peche. And as mentioned, I'm a doctoral student and research manager in the Department of Social Policy and Intervention. I have a background in psychology and my doctoral work now focuses on mental health and parenting practises of refugee and migrant caregivers. So at the moment I'm working on developing a parenting intervention with and four families from Myanmar who are living along the Thailand-Myanmar border.

Professor Belinda Lennox:

And it will be great to discuss that more with you as we go through. But to start off with, I mean, Ben, maybe you could start by just telling us why is it so important to support the mental health of families in crisis situations?

Ben Perks:

It's important Belinda to support the mental health of all children everywhere at all times, and we know for children that the biggest preventable cause of poor mental health throughout the whole life cycle is when people don't live as children, feeling safe and loved and free from adverse childhood experiences. The risk for adverse child experiences is particularly high in conflicts or emergency situations. There are additional stresses on parents in situations where children are separated from families, where children are directly under fire, and all of the secondary attachments they have in the community and school can also be affected by things like attacks on schools, shelling, natural disaster.

So what's really important in those situations is to focus on ensuring that parents and communities know how to protect children, how to make them feel safe and loved, so the immediate effect of the emergency doesn't have a lasting, traumatic effect on the child. And I just want to evoke an image that many people would know who have seen the film Life is Beautiful with Roberto Benigni, where a child and a father are sent to a concentration camp and the father does everything they can to

protect the child from the from the trauma of that situation. And as long as parents can be supported, protected, empowered to protect their children. We're doing the best we can to prevent crisis having a lasting traumatic impact on kids.

Professor Belinda Lennox:

Yeah, I mean it's just sort of self-evident how vitally important it is, I don't know, is it possible, either Ben, or maybe Sabine, just describe what kind of responses actually do happen on the ground when you when you get one of these disasters? What work do you do to support families and mental health with child?

Sabine Rakotomalala:

Thank you, Belinda. I will build on what Ben says, just a small anecdote, I'm a child psychologist as well. In the first 10 years of my career, I worked as a child psychologist for an NGO going straight to the field when there was an earthquake or a sudden outbreak of a conflict. And so Haiti earthquake, and Pakistan earthquake and Peru and then conflicts and Central African Republic and, I often found that the children that were in fact most affected were those that were already struggling way before the conflict, at home, and we see, we know from statistics today that one out of two children suffers from violence, either physical, sexual, emotional or neglect. So those are huge figures.

And so, when you supersede that with a conflict or natural disaster of course the situation gets so much worse, but it's important to remember that many of these children already suffer in households and those that were suffering get worse. But those that were fine, as Ben is saying, actually, if we can get, if the families are around them and can continue to give them the care and support that they need. And then in fact the child is quite resilient and the family is able to get through it.

In terms of your question, Belinda, what are the types of support that are provided? It's really a continuum. So, there's four levels of a pyramid. So, the first one is providing basic services and security to children, access to information. It's the very first thing, as we all know, when you don't have information, you can get very anxious when you get the information, services, where are the services? Where can I get the food? Where is the shelter? What time can my child go to a makeshift school, that is already a huge support. Then the second level is community and family support. So supporting parents and caregivers. Their mental health, supporting the community and to acknowledge what they're going through.

Then there's the focus, non-specialised support, which is the third level of the pyramid and here we're already looking at children that are suffering from post-traumatic stress or from depression or from bed wetting, internalising behaviour, externalising behaviour and then the top level of the pyramid is a specialised services, and those are often children that already had severe mental health issues like psychosis or depression or anxiety, and those need very much additional support, often by psychiatrists, those so, those are the four levels of the pyramid that we look into.

Professor Belinda Lennox:

Ben, you want to come in?

Ben Perks:

Yeah, two points. Firstly, yeah, just to add to that, I think that a lot of the ethos of what we try and do for children in terms of mental health and you know, crisis response is try to get a resumption of what we call normal child activities. The right to play, support and space for parents and for

parenting, and to try and get kids back to school as quickly as possible. We saw during COVID, the impact on the mental health of children to be locked down, and that's something the whole world can understand.

The second thing that I want to just highlight, is that there's a political incentive for this as well, because all of the evidence shows us that when children are exposed to trauma, to toxic stress, when they grow up in contexts where they don't feel safe, they're much more likely to become perpetrators or victims of violence. So often cycles of conflict and intergenerational trauma are exacerbated by our failure to respond in the moment to the risk of trauma for the child. And this is really important in peace building and something that is not given enough attention.

Professor Belinda Lennox:

So it's a huge problem and it has a sort of a legacy far beyond the immediate situation for it's a generational impact actually. Jamie?

Dr Jamie Lachman:

Yeah. Not only that, it's also a huge economic impact, economic impact of violence against children or delayed development because of mental health issues is immense and particularly for areas in the world where there is very low resources and so the impact on the economic burden of violence against children or experiencing children growing up in conflict zones is immense, and so you can think of this.

Now we're building these layers of why is it important for interventions for supporting children mental health and basic contexts, you have the child rights perspective, you have the child well-being and health aspects, you have the long-term cycles of violence, and you have the economic burden. And so, it's, really there's an immense kind of case been made for the need for effective low cost and scalable interventions that can support children in crisis zones.

Professor Belinda Lennox:

Absolutely. Isang, you wanted to come in?

Dr Isang Awah:

Yeah. And just to add to what Sabine, Ben and Jamie have already said, I wanted to mention that as much as we want to support children and adolescents, obviously the only way we can do this is through parents. And then there's evidence that parents and caregivers could serve as a primary source of mental health and psychosocial support for children and adolescents through positive parenting and that just brings me to what we have been doing the past few years through the different responses that we have had.

You know, the COVID-19 response and in the past two years, the Ukraine parenting response, Pakistan parenting response as well as the responses that we've had in Syria, Turkey and Sudan this year. So, what we have been doing is providing support for parents, helping them to cope and so that they can also support their children and adolescents to cope through the different crises.

Professor Belinda Lennox:

Yeah. Thank you. I mean cause that that links very nicely onto you know, what's the evidence base? What do we know about what works in this situation to actually improve our mental health outcomes? I don't know. Stephanie, did you want to come in with some thoughts on that?

Stephanie Eagling-Peche:

Definitely. I mean there, there is a lot of evidence to show that family and home environments can act as protective factors for child development in contexts of high violence, nurturing home environments can provide a buffer against the impact of these environmental factors. And so parenting interventions can really play a significant role in improving child outcomes and also caregiver outcomes. As you can imagine, in these settings child behaviour can change quite drastically. I mean these situations must be very frightening, but caregivers have sort of compromised capacity to deal with that, you're thinking about, you know, they're exposed to financial stress, and they're also exposed to traumatic events. And then uncertainty, even after the immediate aftermath of a crisis, you may have to resettle and move and deal with sort of acculturation stresses. So, interventions that really work to address these and help caregivers with sort of evidence based key strategies on how to work with their children to talk about difficult emotions and to yeah, really communicate spending one-on-one time with your children. These are sort of key principles that seem to run through a lot of parenting interventions.

Professor Belinda Lennox:

Thank you. I mean, I'm just thinking how do you even do that though? I mean, when you're in these crisis situations where really, you know, people are fearing for their lives and everything is in turmoil and even communications must be really challenging, how do you deliver a parenting intervention if that's not such a daft question, Stephanie.

Stephanie Eagling-Peche:

I think that's a really interesting question and something we've had to grapple with a lot in the last few years. I mean, in response specifically to COVID, we've had to do a lot of thinking around, OK, how do we how do we become quite innovative in the way we deliver these programmes? Do we move online? You have to address sort of digital gaps and who has access to technology. But that was one way that we could still provide these resources to caregivers when a lot of in person programming just had to stop.

I work in a team of intervention developers on the Parenting for Lifelong Health programme and that sort of rapid adaptations I was very excited to be involved in. One was titled parent chat and we had to adapt to an in-person programme for delivery via WhatsApp. You know, we haven't done it before, but parents were able to join in a WhatsApp group. You had dedicated time in which you were supposed to be in the group, but you could access these resources at any point in the day. So maybe you're working from home and your child is sort of is around there also being home schooled and you're really struggling with how to access any sort of information you could just go to your phone and talk to other parents and really get that sort of network of support. So, I think it's driven innovation in delivery of parenting programmes forward in a way.

Professor Belinda Lennox:

Yes, thank you. Sabine, you wanted to come in.

Sabine Rakotomalala:

Yeah, just three points on the evidence. Firstly, there is a lot of evidence for parent and caregiver support, as Stephanie was saying in terms of how effective it is even in humanitarian settings. WHO just did a full systematic review in fact, with Oxford University and it shows that at least 19 projects have been implemented in parenting and caregiver support projects, have been implemented in

humanitarian settings, both conflict and natural disasters. And have shown impact. So that's the first point. Really important to note that parent and caregiver support works in humanitarian settings.

The second point is just stepping away from parent and caregiver support. There are actually quite a lot of evidence-based interventions for children's mental health, and those include cognitive behaviour therapy, play therapy, family therapy, school-based interventions. And sometimes we have a tendency to forget that children are children and whether they're in Switzerland or in London or in Bangladesh or in Bogota, their minds function the same way, and they might be more stressed in a conflict or in a natural disaster, but they may also be stressed after they've moved school or have had a troubling situation at home. So those interventions that work in high income countries can be used and adapted for natural disasters or conflict areas.

And then my last point is about evidence generally, I think. The aid world is often very strict, and I think we need to develop a work culture where we're much more thinking about knowledge and sharing and be less strict in terms of what we have to achieve by when and I think we are getting that in organisations like Parenting for Lifeline Health from Oxford University, are very good at understanding that they quickly need to adapt in order to bring their projects to scale and so they share, they learn and then they adapt their programmes. So those are important points around the evidence.

Professor Belinda Lennox:

Really important point. So, there's sort of something about evidence being good enough to be being rolled out rather than waiting for maybe sort of gold standard level of clinical trial evidence. Jamie?

Dr Jamie Lachman:

I do think there is something that we should say that kind of gives a proviso around that evidence, and so a lot of that evidence is mostly based on randomised controlled trials of rigorously tested interventions, a lot of them delivered by incredible organisations like IRC, the International Rescue Committee, and others who have done incredible work on testing their interventions. But these are families where by and large, they've been settled already in a refugee camp. This is, we're not talking, what's the evidence for providing family support and supporting the mental health of families in crisis at the moment of the crisis itself.

Whether that is a crisis because of conflict or climate disaster, and there we still have a lot of work to do and some of the work that we have been doing around the Ukraine crisis is trying to find ways to evaluate, how can we support families with mental health support, with parenting support at the moment of the crisis situation where it's harder to do? You can't really do a randomised control trial and say OK, you guys get it, but you guys don't get it. So, we have to be more innovative in looking at how we can test the efficacy of those programmes. And sometimes we have to do the best we can with the circumstances while providing support at the same time.

Professor Belinda Lennox:

Absolutely. Ben, you wanted to follow up.

Ben Perks:

I think there's something very revolutionary happening here that I think it's important to pick up, so if we go all the way back to attachment research with Bobby and Ainsworth, one of the key findings was that the parents are less likely to transmit intergenerational trauma, neglect, violence, if they are aware and conscious of parenting, and of their own child experience and how that can affect

parenting. We then have all of the research on toxic stress and adverse trial that experiences in the way that when the brain is, when the stress response system is chronically activated because children feel unsafe or unloved that derails child development.

But strong relationships are the buffer against toxic stress, and now we have the research that are being referred to, which is the implementation science that shows this idea of parents being aware and strategic about parenting and preventing trauma and preventing mental harm to their children taking that to scale almost like a vaccine, making it available in the same way that a vaccine or another universal public health good is distributed in humanitarian context and in non-humanitarian contexts. And I think that gives us the idea that perhaps potentially we can eradicate, or at least dramatically reduce child trauma in all contexts, the way we've reduced polio, for example.

Professor Belinda Lennox:

Wow, I love that idea. A parenting intervention as a vaccine against poor mental health in the future? That's just that's so powerful, isn't it? Isang, you wanted to speak.

Dr Isang Awah:

Yes, and I really agree with everything that has been said so far. I just wanted to respond to your last question about delivery in humanitarian settings. So, building on from what Jamie and Stephanie said one of the things I think first of all is important to mention that all the parenting responses that we have carried out have been collaborations with UN agencies, international organisations and other partners. And one of the first things that we do when we are about to launch a response anyway is look is to look for, identify partner organisations, local NGO's that we can partner with in the adaptation of the resources that we have, which are all evidence based. Sabine, Jamie and Ben have already spoken about the evidence, so we work with the local partners to adapt the resources and then work with them, support them to deliver this so we don't actually go there to the different settings, but through the local NGO's and partner organisations. The translations are done and then indeed, resources are delivered.

Professor Belinda Lennox:

Yeah. Do you want to tell us a bit more about that? I know you've been working with partners in Nigeria. What are the, what are the challenges of trying to deliver actual real-life implementation of these programmes?

Dr Isang Awah:

We have made with a number of challenges, and I think the best thing is the evidence and research in humanitarian settings is quite limited, so we haven't had a lot of activities there. So, we need more evidence on what interventions work best and what. And in the different settings, you know when we talk about humanitarian settings, they are all different, like COVID is so different from the flood situation in Pakistan. Or the climate crisis in Syria and Turkey, or the conflict in Ukraine. So, you have different settings. And we really actually need more evidence than that. And then another challenge we have had is that I've just talked about working or partnering with different local organisations. They are limited in capacity and in resources and some of the challenges we've had is limited funding as well.

So typically, when there is funders and people who want to support, funding bodies. But I think the first thing, the needs that they prioritise are things like shelter, food and clothing and this is not to say that these are not a priority, but this is the case, is that just to say that mental health is also,

should also be a priority, so you don't find that there is so much support for that in crisis, because people don't really think about the mental health support of the people who are affected by crisis. So, for that reason we have limited funding and then many of the local organisations that would really want to partner are limited in terms of human resources and other resources. So that's another challenge.

Professor Belinda Lennox:

A major challenge, yes.

Dr Isang Awah:

Sure. And then just to say that we are currently working on an evaluation of the Ukraine parenting response and the resources that we have carried out in Pakistan, and we hope that with that will add to the evidence that already exists.

Professor Belinda Lennox:

Yeah. Thank you, Sabine?

Sabine Rakotomalala:

I'd like to add to this. I have three challenges that have come to my mind over the years. Repeatedly, in every emergency. The first one is time you wish that you had time to do a proper ethnographic review of what the values are, the morals, the partners on the ground, and take time to assess that. And then think of the implementation. So that's the first one. The second one is innovation. Ideally, you have managers that are pushing for innovation. Often agencies are afraid, so they copy paste interventions. Whereas again PLH is a good example that is ready to innovate between Ukraine, between Pakistan and we need to dare to innovate to make mistakes, to learn, to improve. And the third one is evaluations. Often, we don't have the funding to put money into evaluations, so we just do something and then after six months we don't bother to evaluate. So doing the proper analysis, being able to innovate and having evaluations in place are three core components.

I also just want to add that there are two very strong groups working on mental health. That's the Interagency Standing Committee on Mental Health and Psychosocial Support that's been running for over 15 years. And in every emergency, they are there, they're coordinating their response. And trying to do what I've been saying, the assessments, the innovation and the evaluations, and the other one is a much more bottom-up community of practise called the MHPSS, Mental Health and Psychosocial Support Network, who asked frontline practitioners from the ground in the emergencies to upload resources to a web platform. So those are two groups that are very active in the mental health space.

Professor Belinda Lennox:

It's all absolutely crucial, isn't it? Because of course, if the assumption is that everything we do is gonna be helpful, but that's absolutely not the case is. I mean, history has shown that actually some psychological interventions after crises are positively unhelpful, aren't they? I'm thinking of debriefing after traumatic events. For instance. Jamie, do you want to go?

Dr Jamie Lachman:

Yeah. One of the things we're really excited about is the collaboration that we have with the university between the University of Oxford and UNICEF World Health Organisation called Partnership to End Violence Against Children and the Early Childhood Development Action Network.

And this collaboration is coming under the formation of a new consortium or partnership called the Global Initiative to Support Parents and the key component of that partnership and that initiative that we at the University of Oxford are serving, is really building that evidence of what works best and where and how and for whom? And a large component of that is around parents of crisis. It's really grown out of the work that we did in co-leading the COVID-19 parenting emergency response that Isang and Stephanie and others have talked about.

And this initiative that is co-led by other colleagues around the world at other universities, especially in six specific countries, so in Thailand, Philippines, Malaysia, Uganda, Tanzania and South Africa under the Global Parenting Initiative has been focusing on, how do we design and optimise and test these innovations, these programmes to support the mental health and well-being of families and particularly in crisis situations, and one of the ones that I'm especially excited about is one that Stephanie is working on very closely along the border of Thailand and Myanmar around supporting families there and I was just wondering maybe if Stephanie wants to share more about this because it is really in a crisis situation that is quite acute, and it took some innovative ways of working with the community to develop the interventions, but then also how to test them so that we're building the robust evidence of how they work.

Stephanie Eagling-Peche:

Absolutely. So I'm working on a very exciting multiyear project and as Jamie mentioned, the context that I'm working in, it is a crisis setting, but it it's very much a sort of protracted crisis. This region has seen a lot of migration in response to sort of eruptions of violence that have been happening across the border in Myanmar, so it is a population where some people have been there for a really long time and uh, sort of quite challenging circumstances. And then also there's an influx of people entering the region at the moment and as part of this we thought, you know, it's really important to talk to people who have been working in this area for a long time.

So, we've been collaborating with community-based organisations. We've got sort of partnering with local NGO's and several academic partners and we've found it to be really key to put community voices at the heart of the intervention design process and the way that we've decided to sort of address the needs of the community as they came out through interviews, was to take a multistage approach. So, the first one addresses this sort of more like touch intervention that's been mentioned in the in the pyramid. So, it's something that we're going to show to many caregivers in the area and it's quite innovative. We have decided to develop a film that promotes positive parenting and again is very community driven. I had the pleasure of working very closely with our director who is from the Community and who developed the script with input regarding specific evidence-based sort of parenting practises that we want to be sort of shown in the film. And this will be screened across the region and we will be evaluating it in a cluster randomised control trial, so really contributing to this evidence base of you know, how effective are these light touch interventions that do have significant capacity for scale up.

And then in terms of the, the slightly more intensive needs of other caregivers, we are working again with local NGO's to develop a caregiver focused intervention. And what this actually looks like is going to depend a lot from the sort of upcoming work that we're doing where we're bringing all service providers in the region who work across child protection and mental health to really understand what's happening at the moment, people have identified that there's quite a sort of fractured service provision landscape. So how do we work with everyone to provide a service that's not going to overburden people who are are trying to help community members and how that it can be a sustainable part of their programming, beyond when this project finishes and I think that's

another really important part of the work that a lot of us are focusing on is how do we make them, just how do we make interventions and programmes sustainable and scalable.

Professor Belinda Lennox:

Absolutely. Well, thank you for telling us about that. It sounds absolutely fascinating work.

Professor Belinda Lennox:

Hello, I hope you're enjoying this episode of Future Makers, Brain and mental health. If you'd like to learn more about our work here in Oxford, head to ox.ac.uk/brain or let us know what you think on social media using the hashtag Oxford brain.

I was really struck, Jamie, you're saying the key is to work out what works for who? I mean that that's, you know, true of everything we do, isn't it? In research. But I'm wondering. Sabine, you know, at your level, how do you decide what interventions to put in place? Does it depend on the nature of the conflict situation, for instance, or the crisis situation? Does it depend on the region of the world you're dealing with? How sort of tailored are the responses that you look to deliver.

Sabine Rakotomalala:

Thank you. That's a really good question. I just also want to take a step back on the link between child protection and mental health, if that's OK, because there's such a strong correlation there. I think it's really important to note that, often individuals that have mental health issues, be they depression or psychosis or substance abuse, alcohol abuse or history of trauma, can be more violent and therefore either put themselves at risk of violence if they're young people or put others at risk of violence or put their children at risk of violence. And then the converse is true as well as well. So, children that have suffered violence will, according to a lot of evidence, demonstrate short- and long-term psychological damage resulting from the violence and so maybe some children will not show clinical levels of concern. But other survivors will show depression, anxiety, substance abuse, even cognitive impairments and then some children will actually meet the full criteria of psychiatric illnesses. So, it's important to to make that link and see how much violence there is, just to answer your question, Belinda, to understand the violence that's happening not just in the community but also within the homes and then to address that through parent and caregiver support programmes, for example or through school-based interventions. And then assess which children need which type of support. Do you have a high number of children that have psychiatric illness? And in which case you need probably medicine, psychologist, psychiatrist. Or is it actually a majority of children?

I'm trying to think for example in Peru when I was there after the earthquake. There are very religious communities also where the earthquake happened and in fact, they were doing OK. They very quickly came together around their religious communities and were able to support each other. The government response was quite solid and they were able to step up quite quickly. So, it really depends not on the nature if it's a conflict or a natural disaster, but more around which systems were in place before. How you can rely on those systems, and I'm talking about community systems and government systems, and then how you can build on those and then build back better where possible.

Professor Belinda Lennox:

Oh yeah, okay, so that's such an important point, isn't it. Ben?

Ben Perks:

I just wanted to riff off that and say that there's a brilliant definition of child trauma. Trauma is the disruption of connection. And connection is the most important protective factor in the lives of children in the sense that they belong, and they feel love and are safe where they live. The, you know, danger for children is not just the presence of violence, it's also the absence of love. So, what Sabine's referring to there is, the religious community is local resilience. It's a community that has a sense of connection and belonging that it can quickly recover that connection within the community and support families to recover. And I think part of the long-term effort to insulate all societies against our trauma in conflict and non-conflict is to build those resilience characteristics in in all of our communities, not just parenting, but also ensuring that schools, communities, religious organisations are able to respond to child trauma before it's too late.

Professor Belinda Lennox:

Thank you, both of you made the point very eloquently. And it's such an important one. I want to come on and ask each of you what your hopes for the future working in this field are. Where do you see either the research or the implementation side, you know, what are you hopeful about for the future? Who shall I start with? Ben, shall I start with you?

Ben Perks:

Yeah, I'd like 4 things to happen. I'd like. I'd firstly, I'd like us to recognise that we don't spend enough on child mental health in all contexts, including humanitarian. Jamie alluded to the costs, 7% of GDP globally is the conservative estimate, are the costs of not addressing or preventing child trauma in in all settings. So, for governments to invest in prevention and response. The second one is to have a conversation in every community on mental health, violence against children, all of those issues remain taboo and often characterised by myth in most parts of the world. But now we have the ability to address that and ensure there's a conversation in every community. The third thing to do is to make sure that parenting programmes are unified, because the evidence from over 270 randomised controlled trials in the WHO systematic reviews show that they have huge impact and fourthly, to make sure that every school and every community is trauma reformed and able to respond to child mental health. So, investment, a conversation in every community, universal parenting programmes, and all schools to be trauma informed or trauma aware.

Professor Belinda Lennox:

Wonderful. Sabine, what are your hopes for the future?

Sabine Rakotomalala:

First, very similar to Bens. Maybe I just want to add one to his four, is the voices of children and the voices of parents. The children that are suffering most, whether they're children with disabilities or children suffering from violence in their household or children living on the streets, they are suffering day and night. They're afraid, they're hungry, they're have no vision of their future and yet, yet we don't hear them. We don't give them a space to speak up. And we talk about other issues that are important to adults. And so having a voice for children, for me is so essential.

And the other thing is having a voice for parents, anyone that is a parent, or who has a parent which is every single one of us, knows how tough the relationship with parents can be and how difficult parenting can be. And I think, as Ben said, breaking the taboo on that. So, breaking the taboo on mental health, but also breaking the taboo on difficulties around parenting, not just early childhood, middle childhood, adolescence as well, and I think giving voices to those who we're working with and for is absolutely essential for children and and parents.

Professor Belinda Lennox:

And it's it's wonderful to see The WHO really, you know, active in this area and really promoting mental health. I mean, you know, I've been around a long time. I may look young, but I'm not. But it really is relatively new that actually mental health is actually now a sort of an accepted kind of mantra. So, thank you, I guess.

Dr Jamie Lachman:

Exactly, but and then building on that, it's one of the things that gets me excited and hopeful for the future is to see how these large institutions and governments and players have come around, coalesced around the issue of supporting families to provide the best support for mental health and well-being and for children and that hadn't happened very often happened around other kind of diseases or other kind of context, but not around mental health and not around violence prevention until really recently.

And so that makes me very hopeful that we can get over some of the silos that we operate in and see how, you know, even in this podcast. We have people from academia and people from UN agencies and people who come from implementation and media backgrounds all coming together talking about mental health issues. And so that's one thing that really brings gives me hope is that people are seeing this as, the supporting families in crisis context is a crisis of itself, and we need to coalesce around that then, but more than that I really am hopeful for our ability to shift away from a reaction to crisis.

We were very reactive to the COVID-19 pandemic or to the war in Ukraine, or the floods in Pakistan, or all the climate issues that are happening right now. And I would love to see the I see there being the potential to shift from there to a place of being a building preparedness and resilience for communities and families, and the ability to both avoid those mental health impacts, but also to be able to respond and not react to those. And I think that one of the things that I mean it's kind of like there and it's all around us, is the ability to or the potential to harness what technology can offer to help us build those solutions, even AI driven solutions could be a game changer in our capacity to address mental health issues, even if they're simple things of supporting parents or those who support parents and families.

And that all builds to my large kind of big picture, my hope is that, you know, we have that Parenting for Lifelong Health and the Global Initiative to Support Parents in Oxford, where that vision of, that every parent everywhere has access to effective, freely available, relatable support that is, for every parent everywhere and really especially those in crisis context and for those who get ignored, those living with disabilities, those who are on the fringes of the support, those who maybe we see that there were from crisis context, but now they're refugees and migrants in Europe and they're avoided, you know, they're even ignored or put on barges in our in our own country. And where is the support that we need to provide the support for, so really going beyond the barriers of access and support that we normally see.

Professor Belinda Lennox:

I love the vision, Jamie, absolutely. And this idea of a sort of mental health preparedness plan for crisis. And I don't know if anybody's actually doing that, are they? I mean we had a lot of pandemic preparedness, but I don't think anyone's considering the mental health aspects of preparedness.

Sabine Rakotomalala:

I think they are actually Belinda because it's a lot about training, mental health care is a lot about people supporting people, so they're around the world, hundreds, thousands of people being trained on psychological first aid, whether they're water, sanitation, people or shelter people and nutrition people. So that's definitely one area in which we're being better prepared. Another one is assessments. So, understanding the Haitian culture so that when there's the next earthquake in Haiti, you're ready to intervene, saying the right thing to the right religious groups in the right way. Another thing is I know they for example work a lot on birth registration and sharing information and knowing where children have to go when there's an issue to which hospital and how. So, there are preparedness plans that that continuously get put up, especially in the countries that are most affected by natural disasters and wars.

Dr Jamie Lachman:

And you can even go further with than that and look at like, how we can build the preparedness of the family, building the competencies of families to be able to have that resilience within themselves, whether that's helping them learn simple ways of supporting their mental health. Being able to deal with stress even in non-crisis situations that can be applicable to the, when they become under acute crisis. Also, the ability to have positive and supportive relationships with your child, those things that builds the resilience in the family to be able to withstand some of those shocks. And I think that's something that when Ben and colleagues talk about universal provision of evidence-based parenting support, those things build their resilience in those families so that they can thrive in the face of crisis.

Professor Belinda Lennox:

Wonderful. Isang, do you want to talk about your hopes for the future?

Dr Isang Awah:

Thanks, Belinda. First of all, I think Sabine, Jamie and Ben have already said a lot of what I would have liked to say. But the first thing that struck me is that, you know, we're having this conversation here. And it feels so normal, so natural for us to be talking about this. But in my home country, like in most places in Africa, talking about mental health issues, there's so much stigma around that. So first of all, I hope that we can get to a point where there isn't a lot of stigma or there is no stigma really that should be the case and where it feels so normal. You know, as I listen to us talk about this, I thought, wow, you know, I wish that this could happen in Nigeria in other places. So, I would hope that my hope for the future includes getting to a point that this is not, mental health is not, a taboo subject in Nigeria, in Africa and in developing countries, and I hope that it's something that, you know, not just we would not just normalise the conversation, but we would go on to be able to provide support to everyone who needs it. That it will become, you know, just like you access healthcare services. Everybody will be freely able to access mental health support so that includes part of what I really, really hope for the future. And then personally I'm looking to. I'm really hoping one thing I really desire and hope that I can do in the next few years is to continue to carry on research with victims or with people who have been affected by humanitarian crisis, and particularly I'm looking and I'm very keen on working with victims of Boko Haram in Nigeria.

Professor Belinda Lennox:

Wow. Thank you and good luck to you. That sounds such important work. Stephanie, what are what are your hopes for the future?

Stephanie Eagling-Peche:

I think building on what everyone has said before, I think they are great points. I think also just really centering community voices in the work that we do and part of this is you know it's saying alluded, well talked about this before the stigma around talking about mental health. But I've also seen in a lot of my work, although the stigma around talking about mental health explicitly, there are some sort of natural and existing practises that that support people's mental health. There are things that people engage in. Maybe they don't talk about it in terms of mental health, but it will be sort of, if you ask about what people are doing when they're stressed, they'll allude to some practises they already engage in. So, I think sort of building that into interventions that we're developing at the moment. And sort of strengthening that maybe with the evidence based moving forward, I think that's something I'm quite excited about. And again, on my previous point about sustainable interventions, things that can be built into existing systems and this goes to the preparedness point that Jamie raised. I think if you have culturally acceptable interventions that have been developed with communities and are already integrated into like healthcare settings that can be provided by community health workers, for example, I think that's a really exciting avenue for the future and something I hope to see more of.

Professor Belinda Lennox:

Thank you, Stephanie. You're all very good communicators. It's really powerful, actually. I mean, I was sort of like, God!

Sabine Rakotomalala:

It it is our job, day and night, it's our bread and butter since many years. So if we not good at it, we'll be worrying.

Ben Perks:

There's also. There's also an interesting thing that when you look at the stuff that that human rights and development organisations and others do a lot of. The argument has already been won, so vaccines, nutrition, like I oversee advocacy in different areas sometimes. And it, you know, the arguments already been won, you're just going out trying to get policies to the policymakers to live up to their commitments. With mental health, prevention of child maltreatment, all of that, the arguments not yet been won that this is this should be a global norm. So, we have to be good communicators because we've got to go and convince presidents and prime ministers and other religious leaders to make this happen. And so that's why it's great that all the people on the call are such fantastic community communicators because it's a revolutionary idea and we hope it becomes normal within the next few years.

Professor Belinda Lennox:

It's it's such a key point, isn't it? I feel as though I spent 30 years shouting into the wind, basically about the vital importance of mental illness and severe mental illness, and what the absolute criminal shame in it, you know, lost opportunities and lost lives that this isn't treated properly or researched properly, you know, so. But it does feel as though you know, there is a growing awareness isn't it?

Ben Perks:

We're hopeful our historical process, right, if you read the, Steven Pinker, wrote this brilliant book, The Stranger by Nature, about how violence very slowly is reducing over time. And he reminds us that until a few centuries ago infanticide was very common in every country in the world. Anything

related to mental health was being seen as being possessed by the devil. It's only in the Enlightenment when people began to float the idea that maybe if you stop beating kids they might actually become happier, healthier people and gradually, you know, even in the early 20s. In the United States early 1920s in the United States. People from John Hopkins University Department of Psychology were advising people not to kiss and hug their children because it would spoil them, right? So this is a this is a historical process and we're part of that and we're trying to accelerate it in the same way that people just a generation ago accelerating our understanding of vaccines. And we have, we're lucky to live a time when we have all this brain science that strengthens the arguments that we've had from psychology and psychiatry and gives us something that is more compelling for hardnosed policymakers.

Professor Belinda Lennox:

Well, I was gonna actually, maybe that is a question, you know, how do you get policymakers to really respond and really listen, what's the voice that they really listen to, I guess.

Ben Perks:

There are multiple angles that we have now. I think, Jamie, it's been alluded to them and you know there's the economic argument. We know that the primary preventable cause of poor mental health, addiction, probably crime and a whole range of other things, are adverse childhood experiences. And they're preventable, right? Soif you want to prevent terrorism, violence, all of the addiction, poor mental health, all of the things that cost that 7% of GDP, you can, right. There are ways to do it, but we just have to create the political conditions. I think that's the first thing. The second thing is that often as an advocate I would go to see very conservative and religious leaders or or either, because often the liberals are sometimes easier to persuade because they're more they take the human rights approach, but for others I mean showing the brain science I've been to see leaders and taking brain scans of what happens to children in situations under stress and those kind of bringing the science, the economics, the human rights. Making it a cross-constituency issue is really important. There are many competing parties, you know, basic arguments right?

Sabine Rakotomalala:

If I just can add one thing, I love how Ben always makes a seamless link between the mental health issues, violence against children and parenting support. And so, I think it's so essential because that's the link that people need to start understanding. I do think in the past 25 years, we've made enormous progress on mental health. I mean. WHO has the mental health gap programme. UNICEF has this programme called mind the GAP and so it's a lot about mental health, but it focuses quite a lot on adults and on the more serious psychiatry. But I think what Ben is also alluding to is this link, is still not clear between the adverse childhood experience, the mental health outcomes and how we can then support that. And I think in addition to Ben's ideas about having to show the numbers, unfortunately, and having to show the science, I think showing the solutions is 1/3 way forward because the more we say parenting is a solution, school-based interventions are a solution, that is a little bit more hopeful. So sometimes you kind of have to have to hit them with all three, with the evidence of the problem, the data and the science and then the solutions to bring them along with you.

Ben Perks:

And there's one other thing. So just to talk of that is that the prevalence, right? People don't get the prevalence. People think that child protection, mental health is 2 to 3% of the child population. All of

the 40 or so adverse other experiences surveys show that more than half of any given trial population are experiencing some kind of serious risk factor for trauma. Some form of child adverse experiences, and people that have not experienced that loves somebody that has, or knows somebody that has, is related to somebody that has. This is not marginal issue, it's not a them issue, it's an us issue. It's an everybody issues and that's why we need universal primary prevention response.

Dr Jamie Lachman:

Yeah, I think another another issue that we have is, we can show the, make a very strong case for the need for mental health interventions and parenting support interventions. But when we're working with policymakers, they need the how as well, so it's not just that there is a way to do this, but how do you actually provide it to the people that need it most, and how do you do that within constrained budgets? And this is where we're really excited in our department and our collaboration with our partners around driving innovation around how do you design interventions that are scalable from the point of design that have the buy in of the communities and the implementers and policymakers.

And so, we're working on mental health and violence prevention intervention with the government in Malaysia and we're involving the Malaysian government in the design process so that they also, they're buying into it, but also that the solutions that we're coming up with, we're not gonna do a randomised control trial of an intervention that cannot be scaled, it's just, we can't waste the money and the time that. We've gone down the path where we designed these incredible interventions, but they're just too clunky or intensive to be delivered to millions of families. And so, this is like, being able to provide solutions that are realistic, is really an essential part of that. And policymakers, really, they. They respond positively to that that question because that's where they're under the crunch. A lot of the ones that we're talking to, whether it's in the Department of Social Welfare or it's in the Department of Health in Sri Lanka, or if it's in the educational department, they get the need in a lot of respects, maybe not the top decision makers that Ben talks to and you know they're having to make those really critical decisions on like green lighting this. The people who are in the doing aspect of policy, but they don't have the solutions that can be scaled, that are effective, and I think that's where we're driving the future of our research, of our innovation and of our delivery.

Professor Belinda Lennox:

Well, thank you everyone for your contributions. I've been blown away by the importance and the impact of the work that I mean, you know, is so impressive and so important. I can't think of anything more important really. So thank you all for your time.

Ben Perks:

Thank you.

Dr Jamie Lachman:

It's been a pleasure.

Sabine Rakotomalala

Thank you very much, Belinda.

Dr Isang Awah:

Thank you. Thank you, Belinda.

Professor Belinda Lennox:

I hope you enjoyed this episode of Futuremakers, Brain and Mental Health. You can find more episodes of future makers wherever you get your podcasts and more on Oxford's research at ox.ac.uk/brain. Thanks for listening.