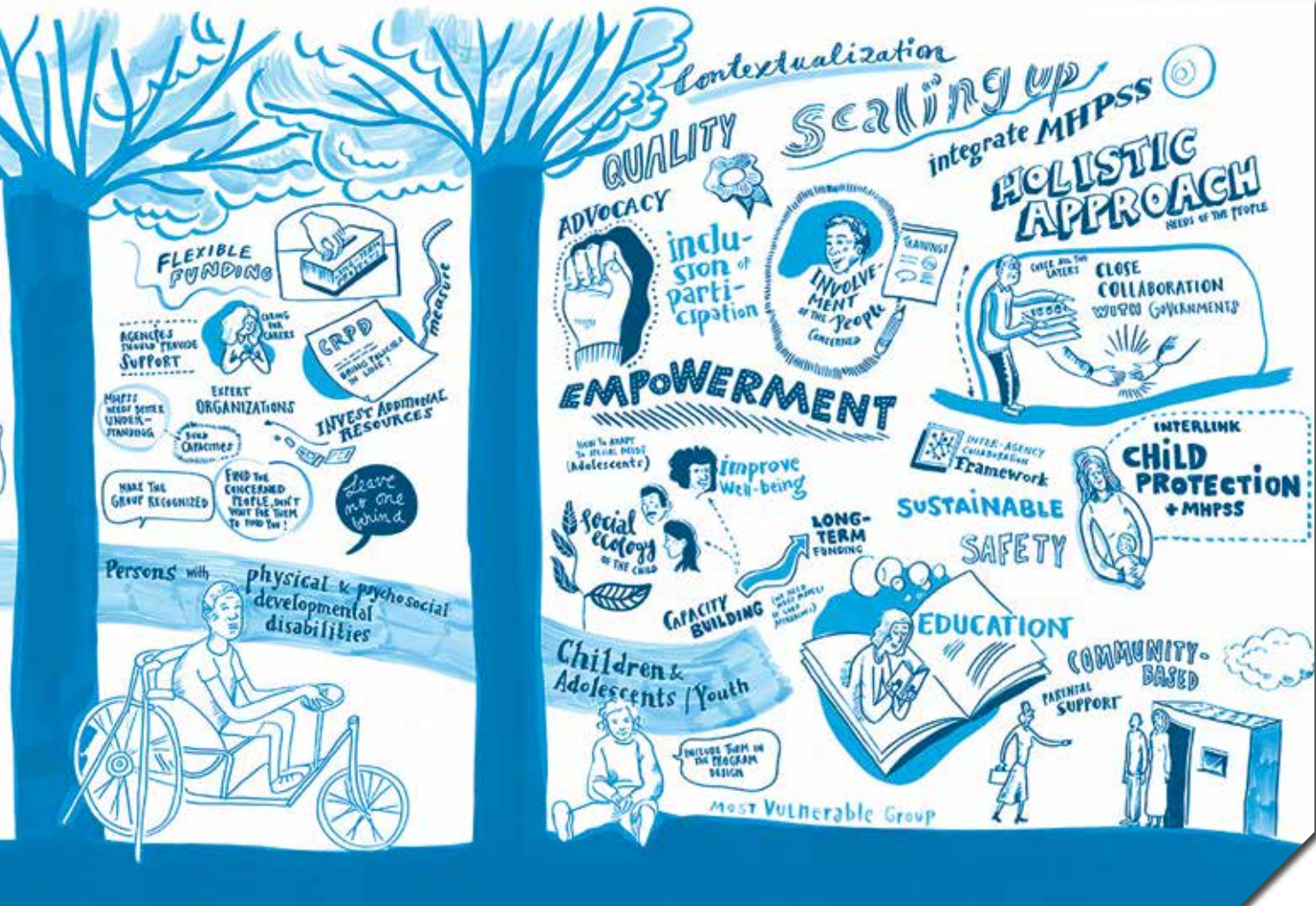




REBUILDING LIVES

Addressing Needs, Scaling Up and Increasing
Long-term Structural MHPSS Interventions
in Protracted and Post-Conflict Settings

REPORT

Expert Meeting
Berlin
4 – 5 July 2018



Federal Ministry
for Economic Cooperation
and Development

unicef 
for every child

EXECUTIVE SUMMARY	6
INTRODUCTION	8
SETTING THE TONE FOR THE EXPERT-LEVEL MEETING IN BERLIN: A POLICY AND PRACTICE PERSPECTIVE	10
Outlooks of Policymakers	10
Voices from the Field	12
FROM THE HAGUE AND WILTON PARK TO BERLIN	14
The Hague Symposium 2015	14
Wilton Park Dialogue 2018	15
BERLIN OUTCOMES: ‘SCALING UP’ AND ‘SCALING DEEP’	16
Panel One Scaling Up MHPSS	17
Case Study On Innovative Ways Of Scaling Up MHPSS The Friendship Bench	20
Panel Two ‘Scaling Deep’: Integrating MHPSS Measures In Existing Structures	22
Working Group Outcomes Recommendations And Actions By Thematic Area	25
THE WIDER CONSULTATION PROCESS	39
CONCLUSIONS AND WAY FORWARD	40
ANNEX 1. WORKING GROUP OUTPUTS FOR FUTURE CONSULTATIONS BY THEMATIC AREA	41
Thematic Area 1. Children And Adolescents	42
Thematic Area 2. Inclusion Of People With Disabilities In Humanitarian Response	47
Thematic Area 3. Gender-Based Violence Survivors	50
Thematic Area 4. Refugees And Internally Displaced Persons	53
ANNEX 2: DETAILED SUMMARY OF NEEDS FROM THE HAGUE AND WILTON PARK	61
The Hague Symposium 2015	62
Wilton Park Dialogue 2018	65

Acknowledgements

This report was written by Zeinab Hijazi (UNICEF), Insa Nieberg and Sonja Meyer (GIZ) with support from Stephanie Schell-Faucon (GIZ).

We are grateful to the chairs of panel discussions and the co-chairs of the working groups for their valuable input to the report – Alison Schafer (WHO), Dean Brooks (INEE) and Dixon Chibanda (AMARI), Hani Mansourian (CP Alliance), Leslie Snider (Global Collaborative for Child and Family MHPSS hosted by Save the Children), Sarah Rizk (HI), Julian Eaton (CBM), Ananda Galappatti (mhpss.net), Düzen Tekkal (HAWAR.help), Inka Weissbecker (IMC) and Amit Sen (UNHCR).

The conception and organization of the expert meeting in Berlin was a collaborative project of UNICEF (Cornelius Williams, Tasha Gill, Zeinab Hijazi, Kerstin Bücken and Susanne Hassel) and BMZ (Elke Löbel, Silvia Morgenroth, Marianna Knirsch and Micha Hummes). We would like to thank Judith Bäßler and Stephanie Schell-Faucon (GIZ) as well as Maria Haifa Awad (consultant) for their contributions.

We would like to thank all those who attended the expert meeting for their participation and support as well as participants of the consultation process.

Graphic Recording: Anne Lehmann

Photos: © Christiane Cannizzo, GIZ

Editing: Barbara Hall

Design: Büro Jenny Watkinson, Berlin

Acronyms and Abbreviations

4Ws	Who is Doing What, Where and When
AOR	Area of Responsibility
AMARI	African Mental Health Research Initiative
BMZ	German Federal Ministry for Economic Cooperation and Development
CBM	Christoffel Blind Mission
CBO	Community-based organization
CHW	Community health worker
CP	Child Protection Alliance in Humanitarian Action
CRPD	Convention on Rights of Persons with Disabilities
CSO	Civil society organization
DFID	UK Department for International Development
GBV	Gender-based violence
GIZ	Deutsche Gesellschaft für internationale Zusammenarbeit
HI	Humanity and Inclusion
IASC	Inter-Agency Standing Committee
IASC RG MHPSS	Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support
IDP	Internally displaced person
IMC	International Medical Corps
INEE	Inter-Agency Network for Education in Emergencies
INGO	International non-governmental organization
MEAL	Monitoring evaluation, accountability and learning
MhGAP	Mental Health Gap Action Programme
MHPSS	Mental health and psychosocial support
MoH	Ministry of Health
PFA	Psychological First Aid
PTSD	Post-traumatic stress disorder
RG	Reference Group
SGBV	Sexual and gender-based violence
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, sanitation and hygiene
WHO	World Health Organization



EXECUTIVE SUMMARY

Throughout the world, millions of people are survivors of severely distressing experiences and events resulting from armed conflict and humanitarian disasters. These experiences increase the risk of developing mental health problems such as anxiety, depression and other stress-related disorders and conditions. Vulnerable groups may carry heavy emotional and social burdens, and need longer-term mental health and psychosocial support (MHPSS) that goes beyond measures of humanitarian assistance.

To address this need, MHPSS professionals came together in Berlin for an expert meeting hosted by the German Federal Ministry for Economic Cooperation and Development (BMZ) and the United Nations Children's Fund (UNICEF). The expert meeting in Berlin, 'Rebuilding lives', the third in a series of conferences dealing with MHPSS in contexts of crises and conflict, built on the recommendations of the symposium "Growing up in conflict" in The Hague, hosted by the Government of the Netherlands in cooperation with UNICEF, and the conference "Dealing with the mental health needs of children and adolescents affected by conflict" in Wilton Park, convened by the United Kingdom and Save the Children. Continuing the momentum of these conferences, the expert meeting in Berlin aimed to provide new impetus, which is fundamental to the development of the MHPSS sector in protracted and post-conflict settings by engaging in dialogue on addressing gaps in

knowledge and practice for improving MHPSS systems and services.

While the previous conferences focused on MHPSS in humanitarian settings, the expert meeting highlighted the contributions of the development sector and longer-term structural support in the area of mental health and psychosocial wellbeing. Discussions included (1) the scaling up of community-based MHPSS while safeguarding the quality of those interventions, and (2) the integration of MHPSS into existing local systems and service structures to meet the varying, complex and long-term needs of those affected by protracted conflict.

In addition to the focus on children and adolescents of the previous conferences, the expert meeting focused on three other vulnerable groups: people on the move (refugees and internally displaced people [IDPs]), people with disabilities, and survivors of gender-based violence (GBV).

The discussions, findings and recommendations of the expert meeting are summarized in this report. The recommendations (Annex 1), which were drawn up in a participatory process, can serve as an advocacy tool for improving the funding, planning and implementation of comprehensive, quality and sustainable MHPSS interventions in protracted and post-conflict settings.



After the expert meeting, together with partners, BMZ and UNICEF issued the following call for collective action:

1. We call on **donors and governments** to:

- prioritize long-term, multi-year funding to enable sustainable MHPSS programming with better outcomes for all vulnerable groups, especially children and youth;
- support programming that is evidence-based and that has been proven effective in mitigating mental health risks and problems in conflict settings;
- prioritize the integration of MHPSS into existing services, including general health care, education, employment and job opportunity schemes, and protection and nutrition systems.

2. We appreciate and welcome **the role of researchers** and their important commitment to the advancement of the field of MHPSS by:

- building knowledge and evidence on what works in complex humanitarian settings;
- providing data to advocate for mental health and psychosocial wellbeing as a priority area of funding and intervention;
- linking research to planned or existing mental health and psychosocial services to uphold ethical considerations and protect the expectations of vulnerable communities.

3. We encourage **agencies and field practitioners** to address key gaps in the

service approach and service provision identified at the expert meeting, including by:

- increasing interventions that focus on community empowerment and that are built on the resilience and agency of all vulnerable people and communities served;
- allocating resources to develop innovative approaches for the changing needs, especially of children and youth affected by protracted conflict;
- increasing the protection of staff from the negative impacts of working with distressed vulnerable groups in crisis and conflict by institutionalizing staff care policies.



INTRODUCTION

On 4–5 July 2018, in Berlin, Germany, more than 50 experts met at the expert meeting “Rebuilding Lives”. Participants included government representatives from the United Kingdom, the Netherlands, Denmark, Germany, Jordan, Lebanon, Iraq, Yemen and Palestine, representatives from United Nations agencies including United Nations High Commissioner for Refugees (UNHCR), United Nations Children’s Fund (UNICEF) and the World Health Organization (WHO), as well as representatives from non-governmental organizations (NGOs) and researchers. Over the course of the meeting, funders, policymakers, academics and implementing partners discussed ways to improve the quality of mental health and psychosocial support (MHPSS) services and suggested recommendations and actions towards evidence-based and sustainable MHPSS interventions. Following the conferences in The Hague and Wilton Park, the expert meeting in Berlin was the third in a series of events focusing on the MHPSS sector and aimed at building on the findings and recommendations of the two prior events.

Conflicts have become increasingly protracted; hence, there is an increasing need for MHPSS among those affected by conflict worldwide. Currently, there are more than 68.5 million refugees and internally displaced persons (IDPs). Two-thirds of refugees live in protracted displacement situations; MHPSS needs to adapt to these evolving circumstances. Although many of those affected by armed conflict and violence show a great degree of resilience, these events may have longer-term effects on their psychosocial wellbeing.

Studies reveal that consequences of violence experienced as a child can be devastating and significantly impact a child’s emotional and physical health, and social development throughout life. In early childhood, exposure to violence can hamper the development of a child’s brain. When the nervous system is stressed to a very high level, known as ‘toxic stress’, it disrupts the developing brain and can have lifelong effects on learning, behaviour and health. Witnessing or experiencing severely distressing and traumatic events caused by violence can result in low self-esteem, bad health and poor school performance. In some cases, it can lead to depression, alcohol and drug use, self-harm, and even suicide. Furthermore, field data show that the problem is worse in countries affected by protracted conflict. For example, in Jordan, 50 per cent of displaced Syrian children suffer from symptoms of severe distress that they have been exposed to since the onset of the crisis, such as nightmares, various forms of sleep disorder and bedwetting.

Other population groups may be marginalized and thus more vulnerable in situations of armed conflict and violence. In Ukraine, around 30 per cent of individuals affected by the armed conflict are elderly people; among them are those living with disabilities and experiencing various psychosocial challenges due to the ongoing violence and displacement. During the Rohingya crisis in Myanmar, massive atrocities were reported, including sexualized violence used as a weapon of war against women and young girls, but also against men and boys.

Discussions during the meeting revolved around



unmet MHPSS needs in situations of conflict that have become increasingly protracted. In light of these long-term needs for MHPSS, experts discussed effective ways for scaling up MHPSS, while ensuring both quality and sustainability, and collective actions for strengthening overall MHPSS systems and services.

Following keynote speeches by policymakers and practitioners, the expert meeting began with a panel discussion on scaling up evidence-based MHPSS. The panellists, representing government agencies, NGOs and academia, assessed various important factors to consider when replicating and scaling up MHPSS interventions, such as a solid evidence base and the need for coordination among actors.

With a second panel on integration of MHPSS into existing structures, the expert meeting also provided an opportunity for those engaging with governments, government representatives and practitioners to share experiences on this issue. The message to involve government structures wherever possible was clearly conveyed and different perspectives were able to shed light on experiences across different countries and to gather good practices.

In addition to the two overarching aspects of long-term structural support – scaling-up and integration into existing systems – and the key role of development cooperation in this regard, the expert meeting developed specific recommendations and actions for groups that are essential to shift the current MHPSS dialogue, including donors, policymakers (e.g. government and United Nations agencies), implementing agencies, and researchers.

Working groups were created according to four thematic areas: (i) children, adolescents and youth; (ii) persons with disabilities in humanitarian response; (iii) survivors of GBV; and (iv) refugees and internally displaced persons (IDPs) ('people on the move').

After intensive days of inputs, discussions, exchanges and work, each of the working groups drew up action-oriented recommendations for their thematic area. The recommendations were discussed with policymakers, representatives from implementing agencies and researchers.

The expert meeting marked the beginning of a consultative process. The recommendations were presented to, inter alia, German civil society, during the Inter-Agency Standing Committee Reference Group on MHPSS (IASC MHPSS RG) Open Forum Annual Meeting in Amman, Jordan and during a follow-up online consultation through MHPSS.net. They were also discussed and validated through participatory consultation and thus represent the input of a broad range of international and local actors – the consolidated recommendations are found in the Annex of this report. They are the basis for joint commitment to a stronger dialogue and exchange between policy, research and practice in order to improve MHPSS, contribute to evidence-based and sustainable interventions, and to better transition MHPSS programming from emergency to longer-term development. The action-oriented recommendations are a guiding document for future engagement of BMZ and UNICEF, a valuable input for political dialogue, and an important source when designing new programmes.

The report is divided into five sections:

- **Section 1:**
Setting the tone for the expert-level meeting in Berlin: A policy and practice perspective
- **Section 2:**
From The Hague and Wilton Park to Berlin
- **Section 3:**
Berlin outcomes: "Scaling up and scaling deep"
- **Section 4:**
The wider consultation process
- **Section 5:**
Conclusions and way forward
- **Annexes, including the action-oriented recommendations from the four working groups by thematic area.**



SETTING THE TONE FOR THE EXPERT-LEVEL MEETING IN BERLIN: A POLICY AND PRACTICE PERSPECTIVE

OUTLOOKS OF POLICYMAKERS

SPEAKER

Cornelius Williams, Associate Director and Global Chief of Child Protection for UNICEF's Programme Division.

Worldwide, communities affected by war and violence depend on our interventions. Right now, there is space and need for global leadership in the area of MHPSS.

This expert meeting is a call for collective action to donors, practitioners and regional governments.

Its recommendations need to target the groups that are most at risk and most affected by conflict. In many cases, the context of interventions has evolved. The number of people on the move, for instance, will increase, and MHPSS interventions need to be adapted to this context. Accordingly, services and institutions that formerly relied on one-on-one sessions now have to adapt to new circumstances. Training community-based volunteers is one of the ways in which support can evolve.

The current situation concerning the Rohingya has shown that it takes weeks to put in place a system that can respond to urgent needs.

The topic of MHPSS is 'invisible', yet other humanitarian and development interventions will not yield results unless the mental health and psychosocial wellbeing of those affected by conflict is considered.

Generally, it is necessary to establish a basic structure and framework for the longer-term process of transforming recommendations into action. It is necessary to build on findings from conferences in The Hague and Wilton Park, which laid a solid foundation for identifying gaps and potential for further action. In addition, outputs from this expert meeting should be brought back to the humanitarian community and to operations in the field, and, with their support and expertise, a plan should be drafted on how best to operationalize these actions.

We need to ask ourselves: Are guidelines accessible, simple and understandable? Is the language we use accessible? What difference does it make to the practitioner in the field?

The success of the road map for further action can only be measured through the improvement and success of the work of practitioners on the ground.



Today, we see an unprecedented, worldwide crisis of forced displacement. Those affected often carry a heavy psychological burden, particularly the most vulnerable such as women, children and young people. Forced displacement and related experiences of violence are deeply linked to feelings of disempowerment that can lead to psychical disorder and trauma.

Beyond the individual dimension of trauma and psychosocial stress, these experiences have important implications for societies as a whole.

Therefore, psychosocial support is often a pre-condition for rebuilding stable societies and economies. Hence, BMZ stepped up its support for mental health and psychosocial support through its Special Initiative “Tackling the Root Causes of Forced Displacement, (Re)integrating Refugees”, which alone funds more than 40 projects with MHPSS components worldwide

Political stabilization and social cohesion, reconciliation and physical reconstruction will only work sustainably in situations where people can build on their psychological stability and strength.

We are convinced that the complexity of an issue such as achieving scale and quality in our MHPSS

SPEAKER

Elke Löbel, Commissioner for Refugee Policy and Director for displacement and migration, crisis management and prevention at the German Federal Ministry for Economic Cooperation and Development (BMZ).

response to protracted conflicts and post-conflict settings requires first-hand information about local realities and new ways of working together.

Multi-stakeholder approaches such as through this expert meeting are crucial to identify replicable and scalable measures and to establish key recommendations for increased impact in MHPSS.

Practical experiences and recommendations need to be translated into broader policy recommendations for governments and implementing agencies.

They also need to be included in international policy processes. The recommendations drawn up at the end of this meeting can help to ensure that the implementation of the Global Compact on Refugees incorporates the best available evidence on MHPSS.



During the expert meeting, Düzen Tekkal's movie 'Jiyan' was screened

VOICES FROM THE FIELD

SPEAKER

Düzen Tekkal, a German citizen with Kurdish roots and member of the Yazidi community, is a journalist and Chair of the NGO HAWAR.help

The expert meeting in Berlin represents a great opportunity for HAWAR.help to share each other's experiences and to learn from them. My attendance at this meeting as the representative of an organization supporting women in northern Iraq is due to an unexpected career change. I first travelled to Iraq 2014 as an ordinary journalist with the aim of reporting on the Yazidi community. However, in the midst of the suffering I witnessed, I became a war reporter. Having travelled through the north of Iraq and having met Yazidi women who had survived literal hell, I had become an activist by the time I returned to Germany.

When we started our NGO HAWAR.help, we were auto-didacts. Several elements were of great importance to developing our campaigns and projects: we realized early on that it was crucial to network with other actors and institutions.

The political commitment to the plight of the Yazidi women of the German Government, and especially BMZ, was essential to us.

It was a true game changer, and we are very grateful for the support we received.

Capacity development of our organization continues to be at the core of our efforts.

Just like any other NGO and institution, we have to cope with growing fast and building on the lessons learned of other organizations in the field. Access to experts, improvement of organizational structures, and cooperation with other actors have proven key to success in this regard.

In 2018, HAWAR.help started a project for survivors of slavery.

In order to improve the psychosocial well-being of women affected by long-term crisis and stress, our project empowers them, allows their voices to be heard, and supports them on their way 'back to life'.

Many of these women are self-confident actors who assume important roles and responsibilities within their communities. Support such as literacy classes provides them with skills and strengthens their role within society. Implementing these projects in situations of conflict is highly complex and risky, but a task worth undertaking and a responsible we all share.



Children all over the world are exposed to conflict. These children exhibit a variety of stress reactions including withdrawal, feelings of guilt, desire for revenge, depression, a sense of helplessness, nightmares and bedwetting. These effects can be long- or short-term, and can be rooted in direct experience, something they witnessed, or a loss of close family members, or other supporting relationships. But most children have significant reservoirs of resilience in the face of such situations.

We need to support children's rights to be and act like children and work to restore their sense of stability and routine – especially in the context of war and violence.

In Mosul, in 2016, for instance, I saw how feelings of loss and grievance may be transformed into signs of hope and resilience when I watched children draw and play in a child-friendly space. Almost 80 per cent of adolescents from Mosul who were interviewed in a survey said that they felt physically or mentally insecure. The long-term consequences of conflict depend on a variety of contextual and personal factors; stable, affectionate relationships between children and their closest caregivers are a protective factor against psychological disturbance, especially if the adults are able to maintain their caring roles.

Therefore, UNICEF and its partners have begun operationalizing their commitment to implementing comprehensive community-based MHPSS programming across three tiers: children, caregivers and the community. Through this approach, UNICEF enhances the capacity of children and the social environment around them, including parents and communities, to identify child protection risks and needs. We develop and implement responses that

SPEAKER

Peter Hawkins, UNICEF Representative in Iraq

encourage children, families, and communities to protect themselves. In refugee and IDP camps in Iraq, child friendly spaces were the norm; nevertheless, they are but a means to an end – not an end in itself. They need to evolve with the needs of children, and they need to evolve as an entity. Very importantly, they need to be linked to education.

I remember asking girls and boys on the street what they wanted – ‘to go back to school’ was the single response. These children are an inspiration.

Investment in education is as important as investment in child-friendly spaces. For those children who were affected by the conflict but who stayed in their communities, it was important that they could access education and carry on a normal life.

Increased investment from the Government of Iraq and substantial support from the international community are crucial to deliver basic, quality decentralized services across the country so that the children of today can build a future of prosperity and security.

We need to ensure that the children of today do not become the victims of tomorrow.



FROM THE HAGUE AND WILTON PARK TO BERLIN

In preparation for the expert meeting in Berlin, priority areas and themes were developed by identifying gaps in knowledge and practices from a review of the key literature and of discussions and findings from the 2015 Hague Symposium “Growing up in conflict” and the 2018 Wilton Park Dialogue “Dealing with the mental health needs of children and adolescents affected by conflict”. Both events identified knowledge gaps and formulated recommendations of great importance to the MHPSS community. The review was summarized in a background paper and was used as the basis for discussions throughout the sessions in Berlin.

THE HAGUE SYMPOSIUM 2015

In May 2015, UNICEF convened The Hague Symposium with the Government of the Netherlands, which brought together a wide range of humanitarian and academic partners to review current interventions in the mental health and psychosocial field. The symposium primarily focused on adolescents growing up in conflict settings who are experiencing long-term repercussions to their physical, mental health and psychosocial well-being. The symposium concentrated on a review of evidence and practice within the scope of MHPSS for children affected by armed conflict and displacement by considering key factors including cultural adaptation, contextualization, resilience and the social ecological approach to designing and implementing MHPSS interventions.

Five needs emerged from the symposium with respect to MHPSS interventions:

- to focus on children, adolescents, and families;
- to increase community empowerment;
- to link MHPSS, education and child protection;
- to integrate peacebuilding components into MHPSS Programmes;
- to develop innovative approaches for changing needs.



It was important to start off the expert exchanges at the meeting in Berlin with the joint session, ‘Recap of The Hague and Wilton Park: What are we building on?’, by **Fahmy Hanna** from the World Health organization (WHO), also the co-coordinator of the Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support (IASC RG MHPSS) in Emergency Settings.

He led the participants through this session, enriching it further with lessons learned from the work of the IASC RG task teams. This joint session was particularly important for participants at the expert meeting who had not participated in one or both of the two previously held high-level conferences in The Hague and Wilton Park.



WILTON PARK DIALOGUE 2018

In January 2018, the Wilton Park Dialogue, in partnership with the UK Department for International Development (DFID) and Save the Children, convened over 50 MHPSS experts to discuss the current challenges in the response to mental health needs of children and adolescents affected by conflict internationally, and specifically in the Middle East. Although there were common frameworks for MHPSS responses in general, there was a lack of specific child-focused interventions and there were no international MHPSS guidelines in a humanitarian response setting.

The Wilton Park Dialogue sought to build on recommendations from The Hague Symposium with the experts present at the UK conference.

Overall, the objective of the Wilton Park Dialogue was to:

- discuss and evaluate good practice in MHPSS for children and adolescents during and after conflict, lessons learned globally, and innovations in new programming;
- share effective approaches in making programmes multi-sectoral, coordinated and integrated with humanitarian missions;

- address issues on implementing MHPSS programmes that include but are not limited to age and gender sensitivities, stigma, accessibility to regions that are difficult to reach, and on strengthening national capacity, specifically in the Middle East;
- create a global roadmap defining the priorities, challenges, solutions and necessary collaborations in MHPSS programming for children and adolescents in conflict zones.

See Annex 2 for a detailed summary of The Hague Symposium and Wilton Park Dialogue outputs.



BERLIN OUTCOMES: 'SCALING UP' AND 'SCALING DEEP'

Through long-term support in protracted crises, development cooperation can ensure that interventions become accessible for a larger number of people ('scaling up') and are embedded and integrated into existing service and support structures ('scaling deep').

Scaling up of MHPSS interventions and programmes can entail the integration of local programmes into regional or national frameworks and strategies, thus reaching more beneficiaries. Scaling up can also entail covering a broader geographic by transferring a successful approach to another context or sector. All of these measures aim at broadening the impact and target group of MHPSS interventions and approaches. However, there is a risk that scaling up interventions might diminish the quality standards of the activities developed for crises settings.

To this end, scaling up can best be achieved by supporting existing systems that serve people beyond short-term humanitarian assistance and meeting immediate needs. The integration of MHPSS into existing service structures is a cornerstone of development cooperation. While humanitarian assistance is indispensable for meeting immediate needs, especially in the context of MHPSS, actors of development cooperation are also responsible for supporting systems of care and thus are they able to effectively deliver psychosocial services in the medium and long term. Engaging with partner structures ensures ownership, participation, and thus ultimately, the sustainability of intervention. Development cooperation intends to co-create and strengthen lasting structures on all levels that 'outlive' MHPSS programmes implemented by external/international actors.

Two panels and a presentation of a case study from Zimbabwe were convened to share and discuss effective approaches and challenges in scaling up interventions and integration of interventions into existing systems in different contexts:

PANEL ONE



PANEL ONE | SCALING UP MHPSS

Great and highly specific needs

Available resources and human capital are not sufficient to meet the significant MHPSS challenges posed by protracted, large-scale conflicts such as observed in the Syria crisis, State of Palestine and countries hosting refugee populations. There are very few mental health professionals available to meet demand.

Scaling up is needed in these contexts, and there is the good will to do so within the international MHPSS community. At times, however, providing mental health and psychosocial support to a greater number of people and ensuring quality and effectiveness of approaches can be considered a trade-off. Nonetheless, valuable experiences in scaling up MHPSS interventions and lessons learned can inform future implementation.

While guidelines and approaches exist, they need to be adapted for the context in which they are applied; i.e. there is no singular standard model with each population group, and contexts require elements of unique programmatic approaches. For instance, there are differences between the refugees and IDPs living in camps and those who live within host communities. The latter often face greater challenges when accessing, for example, health services due to a lack of registration. Other groups, such as unaccompanied children, often require more specific support systems that take into account their individual circumstances. While guidance and approaches may have many similarities across contexts, caution is needed, and adaptation or modifications may be critical to the success of MHPSS programmes.

What do we scale up?

What we know and what we do not know

Research, a solid evidence base, and an assessment of the interventions for prospective scale-up are first steps. Further, process evaluations to assess the quality and implementation facilitators and barriers (i.e. not just client outcomes/ effectiveness) are also necessary to inform the scale-up of interventions; this helps to limit risks of compromising on both intervention effectiveness and quality.

Evidence base

While the improvement of the evidence base on MHPSS is significant, there are still gaps in research: evidence on community-based psychosocial support initiatives and replicable programme designs needs greater attention. The same is true for evidence on the longer-term consequences of suffering due to armed conflict and violence on child to adult development, an area with a comparatively weaker evidence base. Discourse on the long-term impacts of conflict-exposed individuals and communities will benefit from being more effectively communicated to donor agencies in order to encourage longer-term support and programming beyond shorter-term humanitarian assistance. Transparency on evidence gives partners –

Chair: Allison Schafer

Panel:

- Seid Amman (Imagine1day, Ethiopia)
- Samah Jabr (State of Palestine)
- Ahmed Bawaneh (International Medical Corps, Jordan)
- Alastair Ager (DFID)



governments as well as NGOs – the opportunity to make informed decisions on the approaches that best fit their needs.

Needs assessment

Thorough and community-based needs assessments are crucial to identify approaches that fit the context, address existing gaps and potentially scale up interventions. In order to identify ways to scale up interventions and integrate them into existing support and care systems, a clear mapping of current capacities is essential. For community-based programmes in particular, assessments can explore entry points by identifying trusted individuals that people are likely to turn to in situations of distress, such as teachers, nurses and doctors, or organizations such as the Red Cross.

How to scale up interventions?

With respect to ways of scaling up evidence-based psychological interventions, discussions focused on working with non-specialized actors, the importance of coordination within the MHPSS sector, cooperation with other sectors, and capacity development of relevant local stakeholders.

Working with non-specialized actors

Involving non-specialized actors in task-shifting or task-sharing approaches can be an appropriate means

for scaling up and thus reaching a greater number of individuals in need. The range of non-specialized actors that can contribute to scaling up MHPSS is diverse: accepted and respected community leaders can be key partners in efforts to provide MHPSS to communities. In Ethiopia, for instance, religious leaders are trained and supported by social workers who belong to the same community.

In addition, the elderly can be an important, untapped resource in a community; indeed, there have been positive experiences in connecting the youngest and the oldest generations in the framework of MHPSS projects. In situations of forced displacement, there is great benefit in involving the host community in MHPSS interventions in order to promote social cohesion and create a new level of trust and sense of belonging.

The education sector yields a variety of examples of successful task sharing between specialized and non-specialized actors. Providing training to teachers, school counsellors and education experts has proven an effective way to address greater numbers of pupils with psychosocial needs and identify and refer children with more severe conditions. In Jerusalem, for instance, schools established an MHPSS Task Force, yielding outcomes that depicted the MHPSS of more than 70 per cent of children were met within the school setting, while more severe cases were referred to specialized actors. Cooperation with non-specialized actors, however, is marked by certain limitations. Despite the great benefits of involving non-specialized actors, there are risks of assuming that they can *address* all psychosocial needs; this is not the case for more severe disorders. However, community-based approaches can train non-specialized actors to identify those cases where professional care is needed and refer where this basic level of support is not being helpful. Since these approaches rely on the existence of these systems, there should be a balance between specialized and non-specialized support and investment in all levels of care. However, to date, governments have dedicated a significant share of mental health funding to institutional care despite its ineffectiveness, leaving limited funding for community and primary levels of mental health treatment and care. An important funding shift is needed, therefore, which would require ongoing advocacy at the local, national and global levels.

Coordination

Coordination among MHPSS actors is critical to ensure the greatest possible coverage and in promoting stepped care approaches. Coordination supports a more efficient use of professionals as well as non-professionals. Coordinating and cooperating with other sectors is an opportunity to scale up interventions. Although coordination is essential, it remains a challenge in many contexts.

All agencies are responsible and accountable for coordination. We, as agencies, need to create the effective coordination we want.

Coordination within sector

MHPSS Working Groups have a critical role in coordinating MHPSS response. Several factors can support or impede this role, including competing agency mandates and priorities, and competition for resources and funding. This particularly applies to organizations that co-chair a working group whereby they represent their own agencies in this coordination role, rather than represent and coordinate an inter-agency forum towards a successful, overall MHPSS response in a specific context. The MHPSS Working Group in Jordan can serve as a good practice example with respect to coordination in times of crises. The coordination system had already been well established when the Syria crisis started to develop. The early engagement of the Ministry of Health (MoH) and its active membership was a success factor contributing to a coordinated response to increasing needs.

National governments also play a key role in coordination. In order to ensure national ownership, it is essential that activities are supported through the national coordination mechanisms. In Jordan, for instance, all new agencies that plan to implement activities, are required to register first and then share their intention with the Ministry of Planning (MoP). In addition to a solid evidence base for decisions, there is also a need to empower relevant government actors to evaluate planned approaches and enter into dialogue on the programmes that are most suitable for meeting needs. To this end, developing the human resource capacities in relevant ministries is an essential part of longer-term structural support and dedicating financial resources for developing

Multi-stakeholder approaches: Development of a national strategy for Suicide Prevention in the State of Palestine.

Given that the issue of suicide is highly controversial, joint efforts of the media, the Ministry of Religious Affairs and members of the police in a multidisciplinary network are an example of how less specialized actors have a significant role in improving mental health services.

government structures is an important donor responsibility.

In general, and where capacity allows, it is highly beneficial for national governments to lead in coordination efforts, and adjustment in their structures enhances their preparedness for future crises.

Coordination across sectors

There are important linkages between MHPSS and other sectors that have strong potential to provide PSS to more people. In addition to the health sector, other sectors such as education, nutrition, economic development and sexual and reproductive health benefit from the integration of MHPSS interventions. By integrating MHPSS within the approaches of other sectors and raising awareness of actors in these sectors on MHPSS concerns, mental health and psychosocial wellbeing can be improved.

One example of cooperation is between the MHPSS sector and the Water, Hygiene and Sanitation (WASH) sector in Zaatari camp in Jordan. Since water tank drivers are in direct contact with refugees and often witness the distress of people, they were the first people approached when trying to promote Psychological First Aid (PFA) in the camp. Approaching the WASH Working Group with this idea was perceived as an unusual but appropriate way forward when incidents involving delivery underlined the need for common action.

Capacity development

Scaling up not only concerns providing MHPSS to more people, but, also importantly, developing the capacities to do so. In Jordan, the Mental Health Gap Action Programme (mhGAP) training, case management and PFA are the core programmes for reaching greater numbers of beneficiaries and scaling up MHPSS interventions. Agencies active in these areas aim to fill remaining gaps and, generally, coordination between different actors is efficient.



© Friendship Bench Zimbabwe

CASE STUDY ON INNOVATIVE WAYS OF SCALING UP MHPSS | THE FRIENDSHIP BENCH

SPEAKER

Dixon Chibanda is a psychiatrist and the Director of the African Mental Health Research Initiative (AMARI). In 2007, he started the Friendship Bench project in Harare, Zimbabwe.

Watch Dixon Chibanda's TEDTalk here: <https://tinyurl.com/yxp6feyk>



The project, “The Friendship Bench”, developed in Zimbabwe, is a successful example of scaling up psychosocial support delivered by non-specialists. In essence, the Friendship Benches are a collaborative stepped care approach and a task shifting of psychological interventions by trained and supervised lay health workers. Friendship Benches have provided valuable lessons learned on how to scale up by increasing the number of adequately trained and supervised community-based non-professionals and by transferring established approaches to new contexts. Lessons learned from the project show the importance of: strengthening of evidence bases of interventions; a culturally appropriate design of MHPSS; integration of measures in national care systems; and the role of technology in scaling up interventions.

In 2005, the politically motivated Operation Murambatsvina (‘removing the filth’) necessitated innovative means of delivering MHPSS to a greater number of people. During this campaign, houses in the slums of Harare were destroyed. It is estimated that more than two million people were affected, of whom up to 40 per cent showed symptoms of PTSD. Moreover, there was only one psychiatrist working in a public health institution. In light of this enormous treatment gap, an initiative was needed to tackle the enormous psychiatric morbidity. The idea behind the Friendship Benches is as simple as it is innovative: there is a huge treatment gap that can be filled by grandmothers.

How do the Friendship Benches work?

According to the approach of the Friendship Benches, elderly women are key to success: grandmothers proved to be trusted, reliable and approachable persons who could help in assisting community members with their challenges. The approach encompasses problem-solving therapy with components of behavioural activation. The first Friendship Benches were located outside of primary health care facilities in Harare. Clients were referred from these facilities. By now, referral pathways to other services provided by NGOs and local structures such as schools have been established, as well as to

more specialized MHPSS services for more complex cases identified.

What happens on the Benches?

Generally, the grandmother guides her client through six sessions. Once the range of challenges experienced by the patient is explored and listed, the patient together with the grandmother identify one main issue on which to concentrate and brainstorm on possible solutions. Throughout the process, the grandmother uses her listening skills and shows empathy. Thus, the patients approaching the benches do not say that they are “going to therapy”, but rather, that they are “going to tell their story”.

How was the programme scaled up?

In the summer of 2018, Friendship Benches were set up in more than 70 communities in Harare, Chitungwiza and Gweru. Currently, the intervention is also being rolled out to more urban as well as rural areas, and managers have developed a component for adolescents (Youth Bench). Before scaling up, the approach was tested in a randomized control trial. The success of the Friendship Benches has also allowed the programme to spread beyond Zimbabwe: they now operate in Malawi, Zanzibar, United Republic of Tanzania, and in New York, United States of America. In Malawi, benches are operated by young people. Lay health workers in New York are a diverse group between 24 and 60 years. The Friendship Benches have been proven sustainable and scalable when they balance the following three platforms:

- **A primary care component:** It is essential that the approach be feasible and acceptable to the community where it is applied. Therefore, simple, user-friendly and culturally appropriate screening tools need to be developed and/or adapted for local use. The Friendship Benches use the locally validated screening tool, the Shona Symptom Questionnaire (SSQ-14).
- **Community-based concepts:** Such concepts have become an important part of efforts to scale up the Friendship Benches. The approaches used here include peer to peer group interventions and interventions on public transport. Community involvement has proven particularly beneficial when addressing critical issues such as suicide.
- **Digital platforms:** The Friendship Bench project developed a first version of an app called Inuka to tap the potential mobile technology available for scaling up of interventions. This app, currently operating in Kenya, provides direct, albeit virtual support provided by non-specialist health workers applying the Friendship Bench approach. The app offers a possibility to self-screen and direct communication through guides that in

Adapting interventions to the local context

The approach of the Friendship Benches is adjusted to the local context and applied in a culturally appropriate manner. This includes the use of language that resonates with patients: challenges are not labelled in Western medical terms, but rather expressed in the local language, Shona. Thus, the term 'depression' is not used – people referred to the Benches go there because they suffer from kufungusisa, which literally means 'excessive thinking'. Post-traumatic stress disorder (PTSD) is referred to as kufungusisa kwe Njodzi, which means 'excessive thinking resulting from a traumatic event'. Grandmothers were instrumental in bringing about this adapted language in order to make the intervention acceptable to potential users.

turn are supervised by more senior colleagues. In early surveys, Inuka has been very well received, in particular by younger people.

In addition to these three pillars, there are several issues that need to be considered when scaling up interventions: non-specialist health workers' fidelity to the approach they are trained in is ensured through supervision, online support by more senior colleagues, randomly recorded sessions and exit feedback from clients. The Benches are integrated in existing systems such as the Thrive NYC initiative. To ensure quality when scaling up, the project uses clinical trials as well as approaches such as collaboration with international researchers, and constant supervision and monitoring.

Psychosocial challenges faced by clients in New York are very similar to those faced by clients in Harare.

Does the Friendship Bench also address post-traumatic stress disorder?

Grandmothers were able to identify symptoms of PTSD such as flashbacks and referred to PTSD as 'excessive thinking due to traumatic events'. Approaches to addressing PTSD were integrated into the Friendship Benches through a well-defined research component. An algorithm was developed around common symptoms of PTSD to support in the identification and appropriate referral of cases requiring more specialized support.

How much does it cost?

In the beginning, the Friendship Benches operated on a small private budget. Financial support became more important when formal trials were run. Over the last five years, the Friendship Benches had a budget of approximately US\$2.5 million, which was mostly spent on research; only a small amount is dedicated to scaling up the intervention.



PANEL TWO | 'SCALING DEEP': INTEGRATING MHPSS MEASURES IN EXISTING STRUCTURES

The panel discussed lessons learned by government and humanitarian partners. It presented good practices and major challenges in taking a cross-sectoral approach to MHPSS and developing long-term sustainable solutions to the psychosocial challenges that arise in situations of crises and displacement.

A paradigm shift in refugee assistance

The Global Compact on Refugees and the Comprehensive Refugee Response Framework represent a paradigm shift in international refugee assistance that has emerged over the past ten years. Refugees and

IDPs have increasingly claimed the right to participate in decision-making and be self-reliant actors instead of depending on assistance designed by humanitarian experts. This has also led to a new way of working with MHPSS, with an increased focus on community mobilization and holistic responses to psychological distress. Not only do conflict in the country of origin and the experience of loss and displacement affect the psychosocial well-being of individuals and the larger community, but also long-term uncertainty, the denial of information, and the inability to participate in decision-making or to use one's own skills, to feel and be useful to society, and to have a sense of control. The way humanitarian actors provided assistance in the past has led to dependency and the loss of status rather than restoring dignity and self-determination.

Chair:
Dean Brooks (Inter-Agency Network
for Education in Emergencies)

Panel:

- Dr. Rabih El Chammay (Ministry of Health, Lebanon)
- Louise Kryger (Danish Red Cross)
- Emad Abdulghani (Ministry of Health, Iraq)
- Amit Sen (UNHCR)

Participation and community engagement: Key to needs-based responses

Different agencies have come to realize that the way of providing assistance has a big impact on the level of satisfaction and therefore on the psychosocial well-being of refugees. All of the panellists highlighted the importance of inclusive needs assessments and planning processes. Indeed, while one of the major concerns among displaced populations is meeting basic needs such as food supply, health care

and access to services, experience has shown that how assistance is provided plays a crucial role in the psychological healing of refugees. The level of community participation can have a significant impact on how the recovery process starts. Recognizing this correlation from the very beginning of humanitarian assistance in crisis settings is therefore crucial. This leads to the question of how to determine the most prevalent needs. Engaging beneficiaries in need assessments and planning processes has proven to be a vital part of a holistic and intersectoral response. Monopolizing communication in a top-down manner and having experts decide for the beneficiaries have sparked outrage and protests against UNHCR in various contexts. As a result, UNHCR has shifted its approach towards more community engagement, volunteer training and local capacity development. This is particularly important in times of limited humanitarian support and constraints in humanitarian access, such as in the case of Syria.

Refugees are experts for their own needs. We need to recognize the role and capacity of people who are affected.

Similarly, other agencies involve beneficiaries in MHPSS responses by training volunteers in PFA, providing mobile support and carrying out home visits. This ensures a holistic understanding of the situation and restores the dignity, ownership and participation of the target groups. While there may be a lack of MHPSS experts in crises, this approach strengthens people's feeling of self-efficacy and self-determination and also ensures that all levels of the IASC MHPSS intervention pyramid¹ are addressed.

Restoring self-efficacy through livelihoods – addressing psychosocial needs in other sectors

The Government of Iraq conducted a participatory MHPSS needs assessment² by adapting to the local context the humanitarian toolkit published by WHO and UNHCR. The needs assessment clearly showed that in addition to the displacement situation, IDPs are mostly concerned with livelihood and income generation as well as covering other daily needs such as food and water. More than 95 per cent of IDPs live below the poverty line. The Government therefore designed a comprehensive MHPSS programme that is integrated into livelihood activities and vocational training, thereby increasing psychosocial well-being and helping to restore social relationships. Only 46 per cent of the respondents cited psychosocial issues as a major concern. This highlights the fact that more advocacy and outreach is needed to ensure good and accessible psychosocial services and increase public

awareness. Providing people with opportunities to take part in society and make a living can mobilize their individual healing resources and promote positive coping strategies.

Self-efficacy needs to be restored across sectors and cannot be achieved by MHPSS interventions alone. However, in most contexts the silo approach still exists even though an integrated response has proven more effective. Expert meetings are mostly held separately, and opportunities to influence other sectors are rarely grasped. In Iraq, the Government established a National Council for Mental Health that comprises different ministries such as health, education, justice and social affairs. The Council developed the National Mental Health Strategy. As a result, the Ministry of Education included mental health in its curriculum, trained school counsellors, and increased cooperation between mental health practitioners and researchers. The Ministry of Social Affairs, in cooperation with the World Bank, designed reconstruction programmes that combine support to housing and education, with MHPSS outreach and services. In line with the need for community engagement, the Ministry trained outreach teams who provide psycho-education and basic psychological counselling. The Government also established a Psychological Military Committee, which serves as a platform to exchange experiences between the different sectors and provides advice with regard to the psychological aspects of crises responses and disaster management.

From first responders to institutional and local support

Early response and long-term engagement are particularly important for psychosocial well-being. Ensuring that first responders are sensitive to symptoms of severe distress and trauma and that services are provided early on in order to prevent and respond to mental health and psychosocial problems is crucial in crises because it lays the foundation for future individual and collective recovery, including reconciliation processes.

Crises are an opportunity to shake up the system and channel new funding.

The shift from humanitarian approaches towards development approaches has proven challenging. Many funding mechanisms cannot provide the support needed to ensure sustainable reforms. While many actors are aware of this challenge, most donors focus on high beneficiary numbers and still expect a set outline of activities at the onset, which does not provide sufficient room for flexible adaptations throughout the project cycle. The influx of large

¹ Inter-Agency Standing Committee (IASC, 2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.

² <https://www.mhinnovation.net/sites/default/files/downloads/resource/IMC%202016%20Iraq.pdf>



numbers of Syrians into Lebanon has put a serious strain on existing systems. Building the system from scratch in response to the crisis has been a curse and a blessing at the same time: it provides an opportunity to design a cohesive system from the beginning so that refugees and the host communities can equally benefit from the services provided. This, however, requires careful coordination in a complex system of different actors and interests.

Institutional support – engaging with systems

Even though institutional change is time-consuming and sometimes tedious, integrating interventions into existing service structures instead of creating parallel systems is key to success. Following a UNHCR service provision assessment, the Lebanese Government established an MHPSS Task Force and developed an Action Plan, quality standards, as well as job descriptions for psychiatrists and psychologists. This attracted institutional support by UNICEF and other international organizations for the development of the National Mental Health Strategy that includes refugees and vulnerable Lebanese population groups. Thus, sustainable support systems beyond the immediate needs of the crisis were put in place. Strong political commitment and a collaborative network of individuals are two major success factors that help to ensure sustainability.

Engaging with systems is crucial, however difficult and flawed these systems may be.

However, as a next step, it is crucial to transition from international to local support in terms of resources. Operating in a 'project mode', with three-month project phases, severely hinders longer-term planning and reform.

In addition to the support provided at the national level, it is essential to cooperate with local structures such as municipalities, local authorities, and traditional or religious leaders to develop a cohesive emergency response and ensure coordination. Since civil society and governments address the same problem from different angles, close collaboration at the operational level is needed. This ensures a top-down and bottom-up approach at the same time and ensures an appropriate level of community engagement.

Overall, the panel highlighted the main challenges and success factors when building on and integrating MHPSS services into existing structures. Coordination and close collaboration among a variety of actors as well as buy-in at the political and community levels are major success factors with regard to long-term and high quality psychosocial support.

WORKING GROUP OUTCOMES | RECOMMENDATIONS AND ACTIONS BY THEMATIC AREA

The main part of the mental health expert meeting included working group sessions that aimed to address gaps in knowledge and action, and develop specific recommendations for groups such as donors, policymakers (e.g. government and United Nations agencies), implementing agencies and researchers, which are essential to making shifts in the current MHPSS dialogue.

The division of working groups was informed by gaps in knowledge and action-oriented recommendations identified by a thorough review of discussions and findings from the previous conferences in The Hague and Wilton Park. The four working groups aimed to promote the inclusion of all people across age, ability, gender, and living situations. The four thematic areas covered in this session were:

Working Group 1. Children and Adolescents/ Youth | Three tiers of the social-ecological framework: children, family/caregivers and the community (including the elderly)

Working Group 2. Inclusion of Persons with Disabilities in Humanitarian Response | Support and inclusion | Children and adults

Working Group 3. Survivors of Gender-Based Violence | Prevention and response | Children, women and men

Working Group 4. Refugees and IDPs| People on the move | Transitions from short-term emergency to longer-term development as part of protracted conflict and emergencies

The following section highlights the priority themes and outputs identified in the four working group sessions. Detailed action-oriented recommendations can be found in Annex 1.



Thematic Area 1. Children and Adolescents/Youth

Co-chairs Hani Mansourian, Co-Coordinator of the Alliance for Child Protection in Humanitarian Action with UNICEF, and Leslie Snider, Director of the Global Collaborative for Child and Family Mental Health and Psychosocial Support (MHPSS) hosted by Save the Children, summarized the main themes established by the Working Group on Children and Adolescents as follows:

1. The social ecological framework

The social ecology of the child must serve as the framework for all MHPSS interventions. **Donors and policymakers** can ensure that funding is targeted to MHPSS programmes that incorporate the broader social ecological environment of children, focusing attention on carers and care environments (i.e. community structures, available resources, local context and the environment). **Donors** should prioritize and fund multi-sectoral approaches so as to ensure proper programme design (i.e. taking into consideration the social ecological environment, culture, and context) and a long-term focus on response, recovery and maintenance of mental health and psychosocial well-being for children and families.

Inter-agency forums should seek clear agreement at the global and country levels across sectors on how they contribute to MHPSS outcomes, including sectors that are not traditionally considered part of MHPSS (e.g. livelihoods).

Implementing agencies can shift MHPSS programming to systematically incorporate children's social ecological environment to improve their

well-being and prevent the more severe impacts of distress and trauma, for example, by: increasing community and family engagement with basic psychosocial interventions such as child-friendly spaces; integrating psychosocial models with education services, and engaging and support teachers; and implementing community-based public MHPSS models in varied settings (including urban settings). **Governments** can build structures to provide MHPSS services, which can be maintained by establishing and/or strengthening functional referral mechanisms across all layers of the intervention pyramid within the IASC Guidelines on MHPSS in Emergency Settings.³ Implementing partners need to give priority to community-initiated approaches over externally imposed models while ensuring that MHPSS approaches work through a range of delivery platforms that are relevant to children and adolescents in different circumstances (e.g. children out of school, children in the workforce) and for different types of help-seeking behaviours such as by adolescents and former child combatants. Finally, **implementing agencies** need to synthesize available evidence on the effectiveness of MHPSS interventions for children and families (including a clear Theory of Change for MHPSS) and translate it into programmatic approaches in contexts and communities experiencing severe adversity.

Researchers need to identify key elements of success in the most effective models of MHPSS programming in different contexts and with different population groups (e.g. children/families on the move,



child-/adolescent-headed households). They also need to identify key risk factors to inform preventative MHPSS approaches as well as short- and long-term impacts of severe adversity on children and adolescents in different circumstances. The aim is to better understand how environmental and other factors shape outcomes for children and families in different circumstances (e.g. those who do not flee, are in detention, or are resettled and experience change in their usual support).

2. Build MHPSS capacity within communities

2.1. MHPSS workforce. Inter-agency forums need to develop an inter-agency and evidence-informed competency framework for staff working at different levels of MHPSS interventions, in collaboration with researchers. They can also begin to advocate for and assist in the institutionalization of capacity development along the continuum from preparedness to recovery to response. **Donors** can fund long-term training initiatives that build the MHPSS workforce at all levels, including a specialized workforce (e.g. psychiatric nurses, psychologists) to address the needs of children, adolescents and families who have experienced severe adversity and/or with (pre-existing) mental, neurologic and substance abuse disorders. **Policymakers** can institutionalize capacity development models through certification program-

mes (including intensive, quality training) for social workers, para-social workers, psychologists and others.

Implementing agencies need to implement longer-term training initiatives that incorporate coaching and supervision for non-specialist MHPSS staff at all levels, including social workers, who are part of competency frameworks. Capacity development initiatives embedded within current structures will build long-term engagement and sustainability. An incentive system linked with capacity development programmes in low- and middle-income countries would allow staff working at different layers of the IASC MHPSS intervention pyramid to choose the training/competency that they need (e.g. modular training that builds on basic competencies over time).

Researchers need to identify, evaluate, document and share lessons learned from successful models of workforce capacity development specific to needs and available resources in different settings (e.g. outcomes of capacity developed for task-shifting). They also need to expand **implementation science research** together with **implementing partners** to evaluate capacity development models in different contexts.

³ Inter-Agency Standing Committee (IASC, 2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.



2.2. Families and communities as first responders.

Most disasters, be they natural disasters or war, are accompanied by the shattering of human connections. Humans are profoundly social beings, and recovery from distress and trauma heavily relies on lasting, caring relationships with others, strong support networks and the continuum of needed care.

Parents and caregivers are also directly affected by crisis events and may have difficulties in providing the necessary care to children due to their own distress. And yet, from a pragmatic or common sense perspective, when children need support the most, when disasters hit, **families and communities**, and not donors, agencies, government, etc. are the closest ones to provide them with support. Thus, focusing interventions on families and communities and on healing and therapeutic approaches is the only feasible and sustainable way forward. Inter-agency forums should therefore provide opportunities for shared learning and collaboration in developing and implementing innovative capacity development models for carers and community members, across sectors and thematic areas (e.g. children with disabilities, young mothers, girls and boys impacted by GBV).

Implementing partners need to target specific capacity development initiatives to parents and other caregivers (e.g. teachers), family members, and children and adolescents. **Carers** should be equipped to provide support to children with specialized MHPSS needs to ensure inclusive opportunities for their learning and engagement in cultural and social life, and to interface effectively with mental health care systems (e.g. work with treatment providers to ensure adherence to treatment protocols and advocate for adequate care for their children). In terms of implementation protocols, implementing partners need to emphasize and address the importance of providing support to distressed caregivers through socio-cultu-

rally appropriate models of engagement, such as through support groups, focused support or treatment for caregivers with specialized needs, and support for parenting in situations of severe adversity.

The complex interplay of factors that influence child and caregiver mental health and wellbeing can impact various aspects of child and family wellbeing, including continued cycles of violence. MHPSS programming therefore focuses on life and interpersonal skills, positive coping strategies, self-regulation of emotions, etc. The excerpt below illustrates the importance of empathy and an essential attention to caregivers' mental health and wellbeing that directly impacts their ability to respond to children with warmth and consistency.

A generation of children who have suffered from a lack of caring relationships in the early years of life (due to protracted or repeated disasters or adversity), and hence have not fully developed empathy, is more likely to continue cycles of violence. Therefore, as part of our efforts to break the cycle of violence in many of our societies, the development of empathy needs to be fostered and [be] at the centre of MHPSS interventions. And this is only possible by enabling distressed parents to continue providing the protection and care that children need. Prevention is key in building a peaceful society.

Donors and policymakers need to provide long-term funding for evidence-informed capacity development for carers, while **researchers** need to design and implement human-centred models of MHPSS

programming and evaluation. In collaboration with implementing organizations, these models would help to ensure that interventions are relevant to the particular needs of children, adolescents and families in their relevant contexts.

3. Inter-agency and cross-sectoral coordination and accountability

Coordination is critical for effective MHPSS interventions, in line with the integrated, multi-layered MHPSS approach. Agencies and sectors all agree on the need to actively contribute to inter-agency coordination, but many challenges remain and hamper integrated response. The current system lacks mechanisms to hold sectors accountable for their contributions to the broad MHPSS response and, ultimately, to the holistic well-being of individuals. MHPSS is collectively considered cross-cutting, but without a defined monitoring mechanism, there is a high risk that psychosocial well-being remains ‘everyone’s business but no one’s responsibility’.

To effectively mainstream and deliver MHPSS services, inter-agency coordination and cross-sectoral accountability need to be improved. **Policymakers and implementing agencies** need to define a system that goes beyond a shared theory towards the systematic implementation of shared practice and protocols, with clearly established sectoral roles and responsibilities, joint action plans and effective accountability mechanisms to document the process. **Donors and policymakers** need to prioritize funding to multi-sectoral programming initiatives and ensure that all sectors include MHPSS elements in their programmes and plans. Inter-agency forums should advocate with high-level and global forums such as the Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support (IASC RG MHPSS) in Emergency Settings to identify ways to hold sectors accountable to incorporate MHPSS in their programming and plans (e.g. through a definition of indicators, and allocation of resources). Forums need to ensure an adequate focus on children and adolescents (and families) within the IASC RG MHPSS and strengthen its interface with current child and adolescent reference and coordination, such as UNICEF’s Global Child Protection Area of Responsibility (AOR) and Alliance for Child Protection in Humanitarian Action. The role of forums and

partnerships can be strengthened in order to avoid duplication and fragmentation, and to ensure that global coordination and advisory groups provide relevant, user-friendly support to the field when needed.

Implementing partners should build on synergies with other sectors and agencies in planning interventions, starting with a roadmap from Who is Doing What, Where, and Until When (4Ws) mapping of MHPSS services and other assessments. Agencies should jointly assess MHPSS needs and resources across the four layers of the intervention pyramid and develop an integrated response plan addressing the needs of all groups while defining clear agency tasks and responsibilities. Where there is a national MHPSS group, this may include joint funding appeals and sharing of available technical resources such as highly skilled specialists. Finally, **implementing partners** need to harmonize data collection tools and information (e.g. disaggregation by age and by developmental stage) across agencies working with children and adolescents, and **researchers** should develop implementation protocols to feasibly measure the impact of multi-sectoral mainstreaming of MHPSS (with other outcomes of interest to relevant sectors).

4. Tailored MHPSS programming

MHPSS programming needs to translate available evidence on the healthy development of children and adolescents into programmatic language and guidelines while systematically pursuing implementation research to tailor programmes and improve their effectiveness to meet the unique needs of the most vulnerable children and adolescents.

Inter-agency forums should monitor and assess the needs of the most vulnerable children and adolescents, and facilitate working groups and inter-agency and academic partnerships to address these needs in challenging contexts. They also must advocate within organizations for bringing the child, adolescent and family focus to the fore in terms of the use of funds for MHPSS programming (e.g. unearmarked funds from donors). **Donors** need to fund lateral sharing and capacity development in innovative design models for the most vulnerable, while policymakers can ensure that the most effective community platforms are used for the delivery of MHPSS programmes for children and adolescents.

Implementing partners need to ensure that the most vulnerable children and adolescents are meaningfully included and their needs addressed in all MHPSS programming. They should support the active participation and leadership of children and adolescents in the design and implementation of MHPSS interventions, and ensure that not only are their vulnerabilities recognized, but also their strengths. Finally, implementing agencies need to focus attention on the unique risks faced by male and female adolescents (e.g. when interfacing with the police, risk of being unlawfully detained, risk of being tortured while imprisoned as well as on their risk-taking behaviours) and to design, implement and share innovative models of psychosocial support and clinical treatment to address their needs.

To achieve effective service delivery for the most vulnerable children and adolescents, **researchers** need to utilize human-centred design models in the assessment and planning of implementation science research. They also need to research, document and disseminate the impacts of detention on adolescents, giving special attention to situations of protracted detention, sub-standard conditions and torture.

Key recommendations for Thematic Area 1

Actions were developed and recommendations made based on the priority themes and outputs established in the Working Group. The four priority recommendations were:

1. Ensure that the **social ecology of the child** serves as the framework for all MHPSS interventions.
2. Build **MHPSS capacity within communities** of the non-specialist MHPSS staff, including social workers, and among **carers and community members**.
3. Improve **inter-agency and intersectoral coordination as well as accountability of stakeholders to children, families and communities** supported through MHPSS services and delivery, both clinical mental health and social service systems.
4. **Translate available evidence** on healthy development of children and youth **into programmatic language and guidelines** while systematically pursuing **implementation research** to improve the effectiveness of programmes.

5. Evidence building

While building new evidence on effective programming is important, there is much scientific evidence⁴ that is not being translated into programmatic approaches. This should be prioritized in the global MHPSS evidence-building agenda, as follows:

- Evidence shows that trauma is characterized by hopelessness and powerlessness. Therefore, as part of healing, programmes need to give children back their power and sense of ownership and control. This approach must be more systematic within humanitarian interventions.
- Evidence shows that adolescents have an evolutionary need to belong to a collective, as part of the process of growing up and detaching from parents. This should be translated into programmatic approaches that will respond to this need and direct it towards constructive outcomes. Indeed, extremist groups have been highly successful in exploiting this evolutionary need.
- Neuroscience shows that repetition is not only crucial for learning, but also for the basic neurological development of lower parts of the brain; neglect, violence and abuse hamper such development. Therefore, children who have experienced neglect or trauma in their early years need repetitive activities to develop parts of their brain that are underdeveloped due to the impact of distress and trauma. In MHPSS programming, this would involve a repetition of positive actions that enhance cognitive, emotional and relational skills, together with a variety of positive stimuli.

Once evidence is translated into programmes, then implementation science should help identify the most effective models in each given context. It is the responsibility of the MHPSS humanitarian community, including researchers and implementing agencies, to break this complexity down into easily understandable tools and programmatic elements that can help scale up high quality, contextualized programmes.

⁴ Perry, B. D., & Szalavitz, M. (2017). *The Boy Who Was Raised as a Dog: And other stories from a child psychiatrist's notebook--what traumatized children can teach us about loss, love, and healing*. Basic Books.

THEMATIC AREA 2



Thematic Area 2. Inclusion of people with disabilities in humanitarian response

Co-chairs Sarah Rizk, Humanity and Inclusion Representative, and Julian Eaton, CBM International Senior Mental Health Advisor, summarized the main themes established by the Working Group on Inclusion of People with Disabilities in Humanitarian Response as follows:

1. Links between disabilities and humanitarian emergencies

During natural or man-made crises, people with disabilities may be disproportionately affected due to the breakdown of normal social and formal support systems, and additional accessibility issues associated with disrupted infrastructure. In addition, people affected may acquire additional injuries leading to physical impairment and, in some cases, to long-term disabilities. Widespread distress is a common consequence of emergencies, and psychosocial wellbeing should be considered for all people affected by humanitarian emergencies. Most people recover well, especially if the event is short-lived, but some may have more prolonged and severe mental consequences leading to disabilities, which can be referred to as psychosocial disabilities.

The degree to which people with any disability are negatively affected depends on the barriers to their meaningful participation during the post-emergency phase in general, and in the response process in particular. Attention therefore needs to be paid to ensuring that their needs are understood and that the

proper response to these needs is mainstreamed into interventions. This can best be achieved by ensuring that people with disabilities are part of the process of emergency response and recovery.

2. Changing attitudes

Disability is defined as the interaction of impairment and barriers to participation. In many cases, it is the attitudes of community members that cause social exclusion, neglect and stigma, which can also be institutionalized in law, policy and practice. Moreover, people in power need to understand their duties towards the realization of the rights of all members of the population and to be held accountable accordingly. This is also the case during humanitarian emergencies; hence, in addition to improving technical knowledge and practice on including people with disabilities in humanitarian response, these profound issues will require collective engagement in the long-term if change is to be realized.

3. 'Leave no one behind'

In emergency situations, people with disabilities are likely to be neglected without specific attention paid to their needs. This is even more pronounced if a person is part of another marginalized group, such as women, children and the very poor, or lives in rural areas. They are less likely or able to access care due to various factors (e.g. collapse of support systems they rely on, or the inability to travel further or pay

more for care). When people are exposed to multiple adversities, they may be less resilient and are at increased risk of developing mental health conditions; special attention should be paid to provide psychosocial support during emergencies.

Invisibility is one of the biggest challenges for people with disabilities, who are often not well documented in official statistics, and may not be easily identified in established needs assessment. It is necessary to find innovative ways of determining and understanding their needs, including by routinely disaggregating data by disability. Measuring impact on and outcomes for people with multiple, severe and complex needs should be prioritized on an equal footing with the pursuit of cost-effectiveness and coverage. The principles of reasonable accommodation should be carried over in measuring outcomes of value.

Key Recommendations for Thematic Area 2

Actions were developed and recommendations made based on the priority themes and outputs established in the Working Group. The four priority recommendations were:

1. Prioritize people with disabilities to **lead the mainstreaming of disability inclusion** at both the international and advisory levels, and during field implementation.
2. Create **accessible, targeted and tailored MHPSS interventions** that are inclusive in emergencies (e.g. gender-based violence and disabilities).
3. Create **awareness and mainstream actions** for individuals with physical, psychosocial and intellectual disabilities in the MHPSS sector.
4. Better understand the **unique needs** of individuals with physical, psychosocial and intellectual disabilities, and of their **caregivers** in order to create MHPSS programming that addresses them.

The Convention on Rights of Persons with Disabilities (CRPD) was developed in recognition of the need for inclusion of persons with disabilities, recognizing that while in principle their rights are enshrined in other major rights instruments, they face additional, routine discrimination, and these rights are not observed. There should be a shift towards guaranteeing that people with disabilities are included in humanitarian work. Moreover, there will always be a need to focus specifically on areas where their rights are routinely abused. One particular area is ensuring that proper consent and participation of people with disabilities is part of decision-making regarding care (e.g. during emergency medical treatment such as amputation).

Mental health, psychosocial support, disability and inclusion are areas that should be mainstreamed

but that also require specific interventions. Accordingly, expertise is required to support agencies, governments and civil society, among others.

4. 'Nothing about us without us'

As the MHPSS sector moves towards providing greater support for specific MHPSS interventions for persons with disabilities, these people must be given priority in leading this work at the international and advisory levels, and in field implementation. Capacities will need to be built, and the appropriate local people and their representative organizations, identified. The importance of leadership by people with disabilities and strengthening their agency in the way programmes are designed cannot be overstated. This strengthening will only be effective when individuals and their representative organizations are identified and strengthened in advance of emergencies as part of mainstream preparation, for example, while developing a Humanitarian Response Plan.

ANALYSIS OF RECOMMENDED ACTIONS ACROSS DIFFERENT STAKEHOLDERS

1. Donors and bilateral agencies. Donors must commit to disability inclusion in their work, allocate the appropriate resources, and advocate for inclusive approaches to emergency response. Such commitments are strongest if supported by clear goals and targets.

Expert organizations that work on disability issues should provide support to other agencies, international non-governmental organizations (INGOs), multilaterals, etc. to mainstream disability inclusion in their work, both in policy development and field implementation. Currently, there is a lack of highly experienced people to respond to demand in this area; hence, funds must be earmarked to provide expert support in mainstreaming disability inclusion and to build capacities of people with disabilities to provide their own technical assistance.

2. Implementing agencies. When identified, disability focal points as part of disaster preparedness, they should also be able to advise on mental health and emotional needs. They should ideally be local members of local disabled persons organizations (DPOs) and will need to be supported through capacity development in advance of emergencies, at the onset of emergencies, and in longer-term development. To achieve this, helpful and practical tools are required.

The MHPSS community needs to incorporate disability inclusion into their ongoing work so that MHPSS actors can build knowledge and skills in this area. There is also a need to provide capacity development for the MHPSS actors, which will require expertise, standards, helpful and practical tools, and action sheets (e.g. CBM's Humanitarian



Hands-on Tool app). The IASC Reference Group on MHPSS is best placed to provide the needed capacity development and has already begun to do so.

3. Caring for carers. Implementing Agencies working in humanitarian settings must ensure that they do not overburden caring staff or family carers/volunteers in the systems they put in place. It is empowering and validating for those people with disabilities who are able to contribute to help themselves; however, they should not be overburdened and they may require reasonable accommodation and specific support. In addition, the mental health needs of humanitarian and development workers must be respected and routinely incorporated into planning programmes.

4. Researchers. There are significant differences between the disability and MHPSS communities in the language used with regards to disability. An important element is the degree to which distress and mental conditions are considered disabilities. Hence, formative work on clarifying language and concepts is a critical area that researchers must adopt in the field of MHPSS and disability.

Additionally, indicators need to be clarified and validated for feasible use in an emergency (e.g. during a situation analysis, in measuring needs and burdens, and in measuring outcome/impact). Researchers must help the humanitarian community answer the following questions: How can inclusion of disability be measured in programmes? What is the standard target that agencies should be advised to achieve?

The answers to these questions can inform surveys for basic epidemiology and measuring levels of need. And while the Washington Group is widely adopted to measure levels of disability, it does not sufficiently focus on mental health/psychosocial disabilities. Researchers can help the MHPSS and disability

sectors in: understanding multiple adversities and intersectionality, and how they interact as risk factors for mental distress in emergencies; ensuring that the most vulnerable are not excluded; and developing resources to cover linkages between the MHPSS sector and people with specific disabilities. In addition, there is a need to understand which available resources can be adapted and how to implement them. Humanitarian agencies, with support from researchers, can map and understand what organizations have achieved in the past for this population, and disseminate information on both effective and ineffective techniques.

4. Governments. It is important that governments incorporate disability inclusion into emergency response plans in line with the CRPD (identified as the key principle document by the disability community). Governments can work to ensure collaboration with civil society, including representative organizations of people with disabilities. Donors and INGOs must be committed to the implementation of the emergency response and recognize the government's ownership and unique roles and responsibilities in coordinating local action during an emergency. Governments can also play a key role in improving links between MHPSS and disability/inclusion actors who often work in different departments.

During emergencies, the humanitarian community needs to be pragmatic about where expertise and coordination responsibilities lie depending on various factors specific to the context and emergency, including human resource availability for MHPSS and disability inclusion.



Thematic Area 3. Gender-Based Violence Survivors

Co-chairs Ananda Galappatti, Co-Director of MHPSS.net, HAWAR founder Düzen Tekkal, and Zeinab Hijazi, UNICEF Child Protection in Emergencies Mental Health and Psychosocial Support Specialist, summarized the main themes established by the Working Group on Gender-Based Violence as shown below:

1. Prevention and response

Future design and implementation of GBV prevention and response services should be based on an analysis of the prevalent forms of violence, their impacts on survivors across the life cycle, and factors affecting accessibility within the social, educational, cultural, economic and political context of each setting. The prevention component of services needs to ensure that structural and social interventions are part of a wider programme design. There are current gaps in models, guidance and evidence-based practices for effective GBV prevention (e.g. mitigation of contributing factors such as alcohol and drug use), including guidance on contextualization and adaptation for specific settings (i.e. in particular countries or communities, and in emergency phases). Interventions that already provide evidence of MHPSS benefits for GBV survivors should be encouraged, including those that promote help-seeking and peer support assistance (i.e. non-MHPSS-specific activities, such as group and economic empowerment, and low-intensity psychological interventions).

To implement **sustainable and effective services**, donors need to ensure that all procedures are allowed adequate time and funding for a sound understanding of the prevalent forms of GBV and affected groups (i.e. of girls, boys, women and men). Moreover, policymakers

must promote multi-disciplinary and client-centred models for survivor support and recovery that are responsive to individual needs. The establishment of models for non-formal approaches to justice and reparation for survivor well-being could offer alternative or complementary pathways to formal legal proceedings and forms of justice (see UNFPA Minimum Standards, chapter on Justice and Legal Proceedings). This would include a wide range of measures and approaches that contain forms of justice and reparation that are relevant for survivor well-being, going beyond legal remedies alone.

Implementing agencies should ensure that GBV prevention and response programmes include access to the spectrum of MHPSS services and support, and improve training and the provision of integrated services for MHPSS and GBV actors. GBV actors need to be trained in effective MHPSS intervention delivery together with guidance in and provision of appropriate MHPSS (beyond the provision of PFA and onward referral) for survivors in GBV responses. Given that coverage of focused GBV prevention and response services is often limited, approaches for integrating GBV-sensitive MHPSS should also encompass community-based methodologies that mobilize available formal and informal supports, including those within families and peer networks, to reach survivors, especially those at risk of intimate partner violence. Furthermore, implementing agencies need to produce guidance for MHPSS actors on taking a client-centred approach that acknowledges GBV as an area where entrenched (and contested) social values, norms and belief systems are fundamen-

tally relevant to the experiences of survivors and the responses of their families, communities and service providers (including humanitarian actors). Such an approach would foster intervention techniques that could increase the survivor's healing and create a more culturally informed response. Sensitive and principled strategies for engagement are especially important in contexts where the dominant practices and systems may restrict survivors' access to support or may even be a source of further risk or harm to them.

2. Cross-sectoral integration and inclusion

MHPSS services, referral and integration within GBV prevention and response services must be delivered as part of a broad prevention and response strategy. This would include immediate social, medical, legal, protection, practical and psychosocial support relevant to the survivor's needs. **Policymakers and implementing agencies** should not create stand-alone mental health services for GBV survivors, but rather services that are linked to other sectors, including social, medical, legal and practical support. This would not only address the immediate needs of survivors (e.g. protection/urgent), but also their long-term mental health needs.

MHPSS interventions need to be **accessible, inclusive and tailored to GBV prevention and response services**. There are subgroups within the GBV-affected population that are currently overlooked or that have not been provided with sufficient or accessible MHPSS services (e.g. boys and adult male survivors, individuals with disabilities, ethnic and sexual minority groups, survivors of torture, partners of ex-combatants).

- Implementing agencies should ensure that initiatives account for the specific needs of men and boys while building evidence of the need to respond to these needs (without detracting from efforts to better meet the needs of women and girls).
- Implementing agencies need to strengthen guidance to provide a stronger emphasis on inclusion of individuals with disabilities, and to establish initiatives at multiple levels.
- In order to strengthen and improve interactions and coordination between MHPSS and GBV sectors, especially in key areas that overlap or are complementary (i.e. alcohol and substance misuse), supporting platforms for dialogue between MHPSS and GBV actors may be required, or creating opportunities for an exchange of models and for advocacy at the regional and international levels.

3. Guidance and standards on MHPSS in GBV prevention and response services

Implementing agencies need to adapt available guidance and standards to support the integration and coordination of MHPSS services and approaches in GBV prevention and response. Agencies can also consolidate and communicate knowledge on the impacts of GBV on the individual, family and community

to inform advocacy approaches and materials while ensuring the confidentiality and rights of the survivors. This could be achieved by promoting current global guidance on documenting cases in the context of ongoing conflict that would be safe and accessible to survivors, including for future post-conflict justice and reparations processes. This would ensure the ethical, safe and effective collection and storage of GBV documentation and enable future legal proceedings. Furthermore, it would ensure survivors' right to information on how they may access information pertaining to them in the documentation of GBV cases.

In order to mainstream GBV awareness and tailor MHPSS prevention and response services, **implementing agencies** need to develop tailored guidance for specific sectors with respect to MHPSS and GBV. For example, they should respond to questions such as what MHPSS actors should know about GBV and what health, protection and water, sanitation and hygiene (WASH) actors should know about MHPSS within a broader GBV response. Implementing agencies should also develop and mainstream guidance and training on support to GBV survivors across MHPSS service provision and outreach (including general psychotherapy, counselling and community psychosocial work) while training MHPSS actors on the specific issues facing GBV survivors. Finally, recommendations need to be developed in support of survivors who do not have access – or who are likely to never directly access – formal MHPSS services or GBV prevention and response services. Overall, **policymakers, implementing agencies and researchers** need to better examine evidence for effective GBV prevention while developing evidence-based approaches.

Key Recommendations for Thematic Area 3

Actions were developed and recommendations made based on the priority themes and outputs established in the Working Group, as follows:

1. Ensure that the design and implementation of gender-based violence (GBV) prevention and response services are based on an analysis of the prevalent forms of violence, their impacts on survivors across the life cycle, and factors affecting accessibility to these services within the social, educational, cultural, economic and political context of each setting.
2. Ensure that MHPSS services, referral and integration within GBV prevention and response services are delivered as part of a broad prevention and response strategy.
3. Create accessible, inclusive and tailored MHPSS interventions within GBV prevention and response services.
4. Develop strategies to better operationalize the current guidance and standards to support the integration and coordination of MHPSS services and approaches within GBV prevention and response.



Thematic Area 4. People on the Move: Refugees and Internally Displaced Persons

Co-chairs Inka Weissbecker, Senior Global Mental Health and Psychosocial Advisor for the International Medical Corps, and Amit Sen, Representative of the United Nations High Commissioner for Refugees (UNHCR) summarized the six main themes established within the Refugees and Internally Displaced Persons (IDPs) Working Group, as follows:

1. Coordination

MHPSS coordination should involve national governments and authorities. INGOs and agency coordination leads could develop MHPSS actions and work plans together with government partners, and governments should designate a lead government agency or individual in each country to improve coordination across various ministries. In environments with limited government capacity, or with a government not willing or able to participate, coordination groups should be co-led by relevant United Nations agencies (e.g. WHO, UNHCR, international Organization for Migration, UNICEF) together with INGOs or local NGO coordination groups should make efforts to involve key national and local actors, including informal and volunteer organizations. Coordination leads should also develop soft governance tools that specify key aspects of the MHPSS humanitarian response.

Donor coordination should be strengthened to support complementary humanitarian response and

development programmes. This should include clarifying who is funding what in order to avoid duplication, ensuring that best practice guidelines are followed (e.g. IASC MHPSS Guidelines) while gaps are filled (using the 4Ws to understand MHPSS components that are covered in different geographical areas), and holding regular meetings with relief and development donors.

2. Capacity development

Support broad and long-term capacity development for governments, academic institutions and civil society. Donors, INGOs and implementing agencies should dedicate funding and implement programming that addresses different aspects of capacity development. Capacity development includes in-service training and supervision for current staff and pre-service training for students of universities and other institutions of learning. It also includes training/education through academic training institutions in MHPSS leadership and governance for government and national authorities, including persons in leadership positions.

There should be discussions on and development of a handover strategy at the outset of emergencies to support an effective transition from international actors to local and national actors over time. This requires not only a transfer of activities and resources, but also a 'transfer of vision' and national champions

to guide implementation. It is important to find a balance between providing needed quality services and designing programmes in such a way that facilitates their longer-term sustainability.

INGOs should map and utilize governmental, community-based organizations (CBOs) and community structures in place when planning new MHPSS programmes. They should have a flexible approach and take into consideration current systems and capacities when deciding who should be trained, who should provide services, and what role they play in the overall support to communities in designing and implementing these programmes. INGOs should conduct contingency planning that considers the capacity of national systems to absorb MHPSS services established in emergencies, especially at the outset when funding levels and resources may be highest.

Donors need to recognize that establishing quality, sustainable national MHPSS services and systems is a long-term commitment and that emergencies also present new opportunities to strengthen MHPSS systems. Providing long-term flexible funding (at least five years) would allow broader and more sustainable capacity development.

3. Provision of MHPSS services and activities

Ensure inclusivity and accessibility of MHPSS services and activities by always including all members of the host community and vulnerable persons in MHPSS programming and support, and by developing sustainable solutions to make MHPSS services accessible (e.g. inclusion in insurance schemes and a basic package of health services). Consider how planned MHPSS activities and services can promote and protect human rights, including those of persons with chronic and severe mental disorders and intellectual disabilities.

Track and support the implementation of MHPSS services and scale up effective MHPSS interventions.

INGOs and implementing agencies should use and develop financing tools that track resources used and how they are spent (e.g. in sectors, National expenditures vs. NGO expenditures), and help identify and scale up effective interventions from a public health perspective. INGOs should also develop common accessible tools and adapt them to the local and community context.



Key Recommendations for Thematic Area 4

Actions were developed and recommendations made based on the priority themes and outputs established in the Working Group, as follows:

COORDINATION

- Include and involve national governments and authorities in MHPSS coordination.
- Strengthen donor coordination to support complementary humanitarian response and development programmes.

CAPACITY DEVELOPMENT

- Support broad and long-term multi-sectoral capacity development that includes governments, academic institutions and civil society.
- Recognize that establishing quality, sustainable national MHPSS services and systems is a long-term commitment and that emergencies also present new opportunities to strengthen MHPSS systems.

PROVISION OF MHPSS SERVICES AND ACTIVITIES

- Ensure accessibility of MHPSS services and activities for all.

- Track and support the implementation and scale-up of effective and cost-effective MHPSS interventions.

STAFF CARE

- Recognize that staff and volunteers are also affected by emergencies and need adequate support systems.

RESEARCH AND MONITORING EVALUATION, ACCOUNTABILITY AND LEARNING (MEAL)

- Ensure accountability and oversight when conducting research.
- Monitor programmes and ensure flexibility to meet the needs of the affected populations in line with the 'do no harm' principle.

INTEGRATING MHPSS IN DIFFERENT SECTORS

- Ensure that MHPSS considerations are included in programming by other sectors.

4. Staff care

Staff and volunteers are also affected by emergencies and need adequate support systems. **INGOs and local organizations** need to address gaps in staff care by using a broad and inclusive approach that includes, as much as possible, all MHPSS providers, such as volunteers, as well as other staff working in humanitarian emergencies, together with local actors. Working conditions (including roles, responsibilities, safety and evacuation policies) that affect the mental health and psychosocial well-being of staff need to be addressed, and a budget allocated for staff care.

5. Research and monitoring evaluation, accountability and learning (MEAL)

Researchers need to ensure accountability and oversight when conducting research, and adhere to ethical standards and considerations, including the 'do no harm' principle (e.g. see Inter-Agency Standing Committee (IASC) Guidance on Ethical Considerations in carrying out MHPSS research). This includes safety planning and referral to services where necessary (e.g. for those with suicidal ideation, those who have acute mental health problems). **Researchers** also need to share findings with national agencies and authorities, other organizations and agencies, and affected communities (e.g. research finding summary in local language, meetings to share and discuss findings).

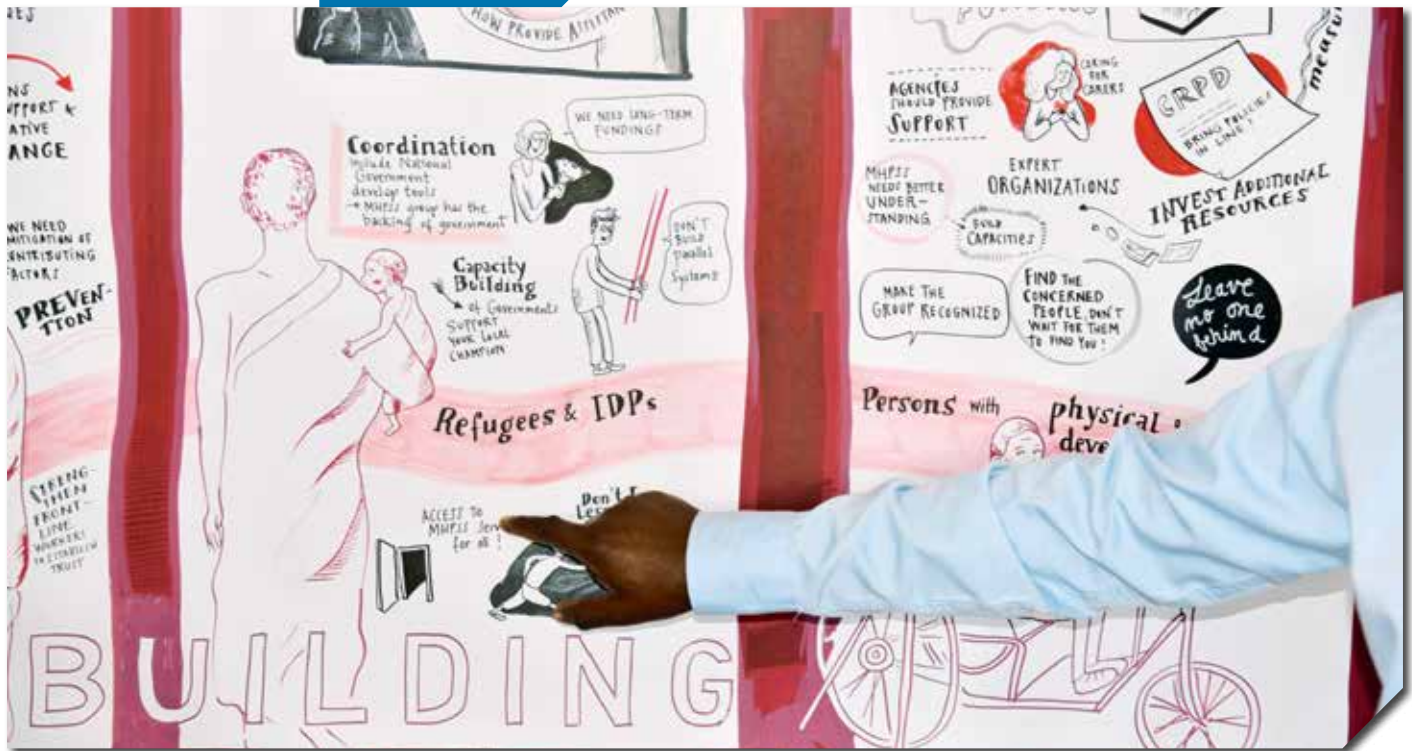
Donors, researchers and INGOs need to collectively monitor programmes and ensure flexibility to meet the needs of affected populations while ensuring the 'do no harm' principle. What does and does not work should be openly acknowledged and shared. Moreover, promising practices should be replicable, and interventions adapted within communities to the local culture and context. Funding should be made available and process evaluations and monitoring must be carried out in order to identify problems. In addition, flexibility should be ensured in project budgets to make programme adjustments based on findings, if needed.

6. Integrating MHPSS in different sectors

MHPSS-related considerations must be included in programming by other sectors. **INGOs and agencies** should develop brief summaries and checklists for defining MHPSS for different sectors, including their roles, what should be taken into consideration, and what is beyond their capacity.



CONSULTATION



THE WIDER CONSULTATION PROCESS

The expert meeting and its recommendations were the starting point of a wider consultation process that gave other MHPSS experts, not present in Berlin, the opportunity to provide their feedback and input.

During this participatory process, the recommendations were presented to, inter alia, representatives of German civil society on 18 October 2018, and to participants at the first open forum on Mental Health and Psychosocial Support organized by the IASC RG on MHPSS in emergency settings, on 31 October 2018 with government and civil society partners in Amman, Jordan. In a video message, Elke Löbel, BMZ Commissioner for Refugee Policy, encouraged all participants to engage in the process.

In the follow-up, an online survey provided space to comment on the recommendations as well as on the focus and structure of the thematic areas. Moreover, respondents to the survey could indicate any additional thematic areas or other marginalized groups that were not included in the first round of recommendations. Respondents had the opportunity to propose changes to and amend the text of the recommendations.

By the end of November 2018, various MHPSS practitioners from around 50 United Nations agencies, civil society organizations and governments had participated in the drawing up of recommendations on how to improve and sustain longer-term MHPSS services in protracted conflicts and crises.

We would like to take the opportunity to have your valuable input and guidance on strategies and approaches. We will work hard to integrate these recommendations in our future policies and programming, and advocate at the international level for making psychosocial support an integral part of any development-oriented crisis response.



Watch Elke Löbel's Video Message here:
<https://tinyurl.com/yazngxux>

Detailed action-oriented recommendations can be found in Annex 1.



CONCLUSIONS AND WAY FORWARD

The recommendations detailed in this report provide guidance on improving MHPSS across four key thematic areas: children and adolescents; refugees and IDPs; persons with disabilities; and survivors of GBV. The recommendations also address gaps in knowledge and action for groups including donors, policymakers (e.g. government and United Nations agencies), implementing agencies and researchers, which are essential to making shifts in the current MHPSS dialogue and implementation. The recommendations include specific guidance and actions to these groups in their respective roles to contribute to the wider provision of quality MHPSS services in protracted and post-conflict settings.

BMZ and UNICEF are committed to improving long-term structural MHPSS in situations of armed violence and forced displacement. Scaling up development-oriented responses will be at the core of strategic partnerships in the area of MHPSS.

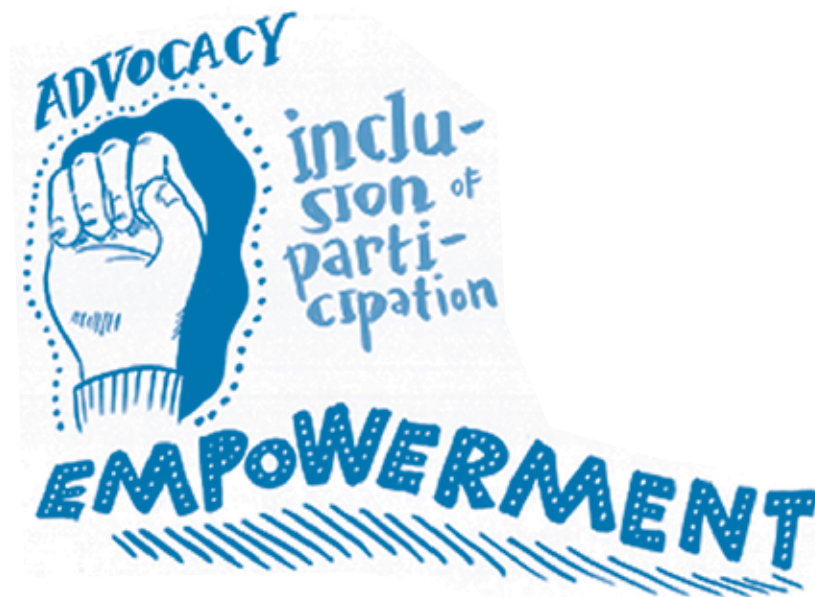
We need to find a way to increase in scale without giving up on quality – we need to ‘scale up’ and we need to ‘scale deep’.

BMZ and UNICEF will engage in communities of practice to share lessons learned and build on collaborations within the framework that emerged from the expert meeting. BMZ will dedicate additional human resources within its implementing structure in order to further develop the issue of MHPSS on a policy level and within the framework of its implementation. Together with their partners, the co-hosts of the expert meeting will support greater coordination on learning and evidence building through the development of a research agenda and strategies based on identified gaps and priorities.

BMZ and UNICEF will advocate for more dialogue on MHPSS with like-minded donors, governments, United Nations agencies and civil society organizations. The recommendations that concluded the expert meeting and its follow-up consultation can contribute to this ongoing dialogue by providing impetus on long-term, development-oriented responses to MHPSS challenges. BMZ and UNICEF are looking forward to continuing these efforts together and invite others to join them.

ANNEX 1.

**WORKING GROUP OUTPUTS
FOR FUTURE CONSULTATIONS,
BY THEMATIC AREA**



Thematic Area 1: Children & Adolescents

Working Group Co-Chairs: Hani Mansourian, UNICEF and Child Protection Alliance representative; Leslie Snider, Director of the Global Collaborative for Child and Family MHPSS (hosted by Save the Children)

Specific Actions and Recommendations

Priority Area	Recommendations	Specific actions across different stakeholders
Social Ecological Framework	Ensure that the social ecology of the child serves as the framework for all MHPSS interventions (with a focus on carers and care environments)	POLICYMAKERS AND DONORS - Ensure that funding is targeted to MHPSS programmes that incorporate the broader social ecological environment of children (with a focus on carers and community structures, resources, and the local context and environment). - Prioritize and fund multisectoral approaches. - Provide longer-term funding to ensure a long-term focus on response, recovery and maintenance of the mental health and psychosocial well-being of children and families. IMPLEMENTING AGENCIES - Shift MHPSS programming to systematically incorporate the social ecological environment of children to improve their well-being and prevent more severe impacts of distress and trauma (e.g. increased community and family engagement with basic psychosocial interventions, such as safe spaces for children, adolescents and youth; integrated psychosocial models with education services; engagement of and support to teachers and youth leaders; community-based public mental health care models; community-based MHPSS models in urban settings). - Emphasize community-initiated approaches over externally imposed models. - Ensure that MHPSS approaches work through a range of delivery platforms that are relevant to children and adolescents in different circumstances (e.g. children out of school, children in the workforce) and for different types of help-seeking behaviours (e.g. different types of help seeking for adolescents, former child combatants) - Work with researchers to synthesize available evidence and translate it into programmatic approaches and a clear theory of change in contexts and communities experiencing severe adversity. - Build and maintain structures and partnerships that facilitate functional referral systems across all layers of the IASC MHPSS intervention pyramid. RESEARCHERS - Identify key elements of success in the most effective models of MHPSS programming in different contexts and with different population groups (e.g. children/families on the move, child/adolescent-headed households). - Identify key risk factors for children to inform preventive MHPSS approaches. - Identify the short- and long-term impacts on children and adolescents who faced severe adversity in different circumstances in order to better understand how environmental and other factors shape outcomes (e.g. children/families who have not fled, are in detention, are resettled or experience a change in their usual support networks). INTER-AGENCY FORUMS - Seek a clear agreement at the global and country levels across sectors on how they contribute to MHPSS outcomes, including sectors that are not traditionally considered part of MHPSS, such as livelihoods.



Priority Area	Recommendations		Specific actions across different stakeholders
Capacity development	Build MHPSS capacity within communities among:	MHPSS workforce	POLICYMAKERS AND DONORS ▪ Fund long-term training initiatives that build the MHPSS workforce at all levels, including a specialized workforce to address the specific needs of children, adolescents and families who have experienced severe adversity (e.g. psychiatric nurses and psychologists) and/or who have pre-existing mental, neurologic and substance abuse disorders. ▪ Institutionalize capacity-building models through certification programmes (including intensive, quality training) for social workers, para-social workers, volunteers, psychologists and others. ▪ Prioritize funding for promotion and establishment of staff care/self-care structures, including in state institutions, such as social services. IMPLEMENTING AGENCIES ▪ Implement longer-term training initiatives that incorporate coaching and supervision for MHPSS staff and volunteers at all levels, linked with competency frameworks (see the Inter-agency forums recommendation below). ▪ Ensure that capacity-building initiatives are incorporated into current structures with a focus on resources/gaps in the local context to build long-term engagement and sustainability. ▪ Consider an incentive system linked with capacity-building programmes in low- and middle-income countries to allow staff working in different layers of the IASC MHPSS intervention pyramid to choose the training/competency they need (e.g. modular training that builds on basic competencies over time). ▪ Promote and establish staff-care/self-care structures. RESEARCHERS ▪ Identify, evaluate, document and share lessons learned from successful models for building the workforce through capacity development specific to the needs of different settings and available resources (e.g. outcomes of capacity developed through task-shifting). ▪ Expand implementation science research together with implementing partners to evaluate learning from capacity-building models in different contexts. INTER-AGENCY FORUMS ▪ Develop an inter-agency, evidence-informed competency framework for staff working at different layers of the IASC MHPSS intervention pyramid (in collaboration with researchers). ▪ Advocate for and assist in the institutionalization of capacity development in the continuum from preparedness to recovery to response.



Priority Area	Recommendations		Specific actions across different stakeholders
Capacity development	Build MHPSS capacity within communities among:	Carers and community members	POLICY MAKERS AND DONORS - Provide longer-term funding that includes rigorous and evidence-informed capacity development for carers, which includes self-care/staff care mechanisms for carers. IMPLEMENTING AGENCIES - Target specific capacity-building initiatives to parents and other caregivers (e.g. teachers), family members, and the children and adolescents themselves, including volunteers and youth leaders. - Equip carers of children who require specialized MHPSS interventions, with knowledge, skills and resources to: - ensure inclusive opportunities for their children's learning, and engagement with the cultural and social life. - interface effectively with mental health care systems (e.g. work with treatment providers to ensure adherence to treatment protocols; advocate for adequate care for their children). - Emphasize and address in implementation protocols the importance of providing support to distressed caregivers through socio-culturally appropriate models of engagement (e.g. support groups; focused support or treatment for caregivers with specialized needs; support for parenting in situations of severe adversity). RESEARCHERS - Design and implement human-centred models of MHPSS programming and evaluation (i.e. design approaches and tools together with children and families who would be their primary users) with implementing organizations to ensure that interventions are relevant to the particular needs of children, adolescents and families with specific needs and in their relevant contexts. INTER-AGENCY FORUMS - Provide opportunities for shared learning and inter-agency collaboration in innovative models of capacity development for carers and community members, including cross-sectoral thematic areas (e.g. children with disabilities, young mothers, girls and boys impacted by GBV).



Priority Area	Recommendations	Specific actions across different stakeholders
Coordination and Accountability	Improve inter-agency and inter-sectoral coordination as well as accountability to children, families, and communities	POLICYMAKERS AND DONORS ▪ Prioritize funding to multi-sectoral programming initiatives. ▪ Ensure that all sectors include MHPSS considerations and indicators in their programming and sectoral plans. ▪ Ensure that monitoring and evaluation strategies for funded/supported projects incorporate opportunities for stakeholder feedback, especially from beneficiaries, to provide input into and perceptions of MHPSS interventions. IMPLEMENTING AGENCIES ▪ Build on synergies with other sectors and plan multi-sectoral interventions in collaboration with other sectors/agencies, starting with a roadmap from Who is doing What, Where and Until When (4Ws) mapping and other assessments. ▪ Together with other implementing agencies, assess MHPSS needs and resources across the four layers of the pyramid and develop an integrated response plan addressing the needs of all groups and clearly defining agencies' tasks and responsibilities. This may include joint fund appeals and the sharing of available technical resources, such as high-level skill specialists. Where there is a national MHPSS group, it should lead and coordinate this assessment. ▪ Develop an easy-to-understand and engaging a theory of change⁵ for MHPSS approaches to engage multiple sectors. ▪ Harmonize data collection tools and information across agencies for children and adolescents (e.g. disaggregation by age/developmental stage). ▪ Include children and families in sharing feedback and generating lessons learned on programme outcomes and effectiveness in monitoring and evaluation strategies. RESEARCHERS ▪ Develop implementation protocols to feasibly measure the impact of multi-sectoral mainstreaming of MHPSS across sectors, such as education, disability, water, sanitation and hygiene (WASH) and child protection. INTER-AGENCY FORUMS ▪ Advocate with high-level and/or global forums (e.g. IASC MHPSS RG) to identify ways to hold sectors accountable for incorporating MHPSS in their programming and sectoral plans (e.g. through definition of indicators, the allocation of resources). ▪ Ensure an adequate focus on children and adolescents (and families) within the IASC MHPSS RG. ▪ Raise awareness on, and link the IASC MHPSS RG with, current child and adolescent reference and coordination mechanisms, e.g. the Global Child Protection Area of Responsibility (Global CP AoR) and Alliance for Child Protection in Humanitarian Action). ▪ Enhance coordination and partnerships between forums in order to avoid duplication and fragmentation of actions. ▪ Ensure that global coordination and advisory groups provide relevant, user-friendly support and guidance to the field as needed.
Improving MHPSS services, actions and provision	Translate available evidence on the healthy development of children and youth into programmatic language and guidelines while systematically pursuing implementation research to improve the effectiveness of programmes.	POLICYMAKERS AND DONORS ▪ Break down the categories of the most vulnerable children for a better understanding of their unique needs for MHPSS and other services (e.g. urban refugee children and families, young mothers, child and adolescent heads of households, children on the move). ▪ Fund lateral sharing and capacity development in innovative design models for the most vulnerable children, including adolescents. ▪ Ensure that MHPSS programmes utilize the most effective delivery platforms for children and adolescents within communities (e.g. to reach children and adolescents who are out of school).



⁵ A theory of change explains how activities produce a series of results that contribute to achieving the intended impact or outcome (UNICEF CB MHPSS Operational Guidelines, 2018).

Priority Area	Recommendations	Specific actions across different stakeholders
Improving MHPSS services, actions and provision	Translate available evidence on the healthy development of children and youth into programmatic language and guidelines while systematically pursuing implementation research to improve the effectiveness of programmes.	IMPLEMENTING AGENCIES - Focus on the unique needs of male and female adolescents within the design of MHPSS interventions, as well as on their particular risks (e.g. interface with the police, unlawfully detained, adolescents tortured while imprisoned, risk behaviours) through the implementation and sharing of innovative models of psychosocial support as well as clinical treatment. - Ensure that the most vulnerable children are meaningfully included and their needs addressed throughout all MHPSS programming. - Support the active and meaningful participation and leadership of children and adolescents (including the most vulnerable) in the design and implementation of MHPSS interventions. - Ensure that not only children's vulnerabilities but also their strengths are recognized and incorporated into MHPSS interventions. RESEARCHERS - Research, document and disseminate information on the impacts of detention on adolescents, focusing on situations of protracted detention, sub-standard conditions and torture. - Utilize human-centred design models in the assessment and planning of implementation science research and in effective service delivery for the most vulnerable children and adolescents (e.g. children with disabilities, children as caregivers). INTER-AGENCY FORUMS - Focus on the most vulnerable children and adolescents, and facilitate working groups and inter-agency and academic partnerships to address their needs in challenging contexts. - Advocate within organizations to prioritize the use of MHPSS programming funds to support to children, adolescents and families (e.g. unearmarked funds from donors).
Other Considerations	Cross-cutting recommendations	A long-term perspective: MHPSS programmes need a long-term perspective in line with stages of child development, and funding must incorporate them when scaling up. Prevention: MHPSS service provision and programming must adopt a rigorous approach to prevention that includes addressing the root causes of distress and trauma. Prevention is also associated with fostering non-violence (e.g. peaceful societies), transitional justice and dealing with the past. Scaling up: The dilemma between quality and scale remains but with diligence and systematic approaches to scaling up, scale can be achieved with a minimal loss of quality. Scaling up of a programme may prove successful but often only under a controlled set-up. Staff care: All programmes and funding mechanisms must consider the well-being of staff and volunteers who provide MHPSS to children and adolescents. Continued mentoring and coaching are necessary both to ensure quality in service delivery and to promote and foster staff well-being. Caregiver well-being: Addressing the distress of caregivers through supportive interventions (including providing direct psychosocial support to caregivers and parenting support/skills) is essential to child and adolescent well-being. Human-centred design: Children and adolescents, caregivers and community members should be effectively engaged in the design of MHPSS programmes within their contexts to meet their unique needs. Standards for MHPSS funding: Donor standards for MHPSS funding should take into consideration the need for sufficient time to operationalize MHPSS interventions and to sustainably build on-the-ground capacity. Integrated MHPSS services: Imported stand-alone programmes should be avoided. Existing services, especially community-led activities/ initiatives and peer support, should be built on and integrated across the four layers of the IASC MHPSS intervention pyramid (e.g. between psychosocial support and livelihoods, and focused and non-focused MHPSS).

Thematic Area 2: INCLUSION OF PEOPLE WITH DISABILITIES IN HUMANITARIAN RESPONSE

Working Group Co-Chairs: Sarah Rizk, Humanity and Inclusion Representative; Julian Eaton, CBM Senior Mental Health Advisor

Specific Actions and Recommendations

Priority Area	Recommendations	Specific actions across different stakeholders
Capacity development	Prioritize people with disabilities to lead mainstreaming disability inclusion at both the international and advisory levels, and during field implementation.	POLICYMAKERS AND DONORS - Ensure that agencies, international non-governmental agencies, multilaterals, etc. mainstream disability inclusion in their work (in policy development, services organization and field implementation). - Commit to more awareness and inclusion in the areas of MHPSS and disability by having disability inclusion in a checklist of criteria for funding of programmes. - Advocate for inclusive approaches to emergency responses for people with disabilities. IMPLEMENTING AGENCIES - Hire members of the local community or organizations of disabled persons. - Provide capacity development in advance of emergencies and in inclusive disaster risk reduction prior to and in emergencies and in longer-term development. - Map and understand what organizations have achieved in the past for this population and disseminate information on techniques that were ineffective and effective. - Train MHPSS practitioners and local community members to recognize and reach out to those at risk and the most vulnerable. Ensure the inclusion of individuals who are experiencing all levels of distress. RESEARCHERS - Establish standards (i.e. indicators and targets) that would serve as a basis for advising agencies on implementing measures that can inform surveys for basic epidemiology and measuring levels of need.



Priority Area	Recommendations	Specific actions across different stakeholders
Inter-agency coordination and cross-sector accountability to MHPSS services	Create accessible, targeted and tailored MHPSS interventions that are inclusive in emergencies (e.g. gender-based violence and disabilities).	POLICY MAKERS ▪ In every sector/platform, hire individuals with physical, psychosocial and intellectual disabilities to ensure their meaningful representation and participation when defining strategies and funding, and monitoring programmes. IMPLEMENTING AGENCIES ▪ Improve coordination between MHPSS and disability/inclusion actors who are often working in different departments. ▪ Develop/adapt resources that cover the relations between the MHPSS sector and people with specific disabilities. In addition, there is a need to understand which available resources can be adapted and how to implement them. ▪ Improve coordination and sector responsibilities depending on various factors specific to the context and emergency, including the availability of human resources for MHPSS and disability inclusion in emergencies. RESEARCHERS ▪ Apply learning and adapt guidelines that provide evidence-based support so that government and other humanitarian responders will have tools to meet the practical needs of people with disabilities in health and other sectors; for example, adapt the Mental Health Gap Action Programme (mhGAP) or Psychological First Aid (PFA). ▪ Develop guidelines and document good practices on specific topics (e.g. MHPSS support for people with disabilities/survivors of gender-based violence (GBV); lessons learned on the inclusion of people with disabilities in MHPSS in emergencies). ▪ Clarify language and concepts, differentiate the degree to which distress and mental conditions are considered disabilities. ▪ Disaggregate data by disability.
Funding	Create awareness and mainstream actions for individuals with physical, psychosocial and intellectual disabilities in the MHPSS sector.	CROSS-CUTTING ACTIONS ▪ Earmark funding for expert support in mainstreaming inclusion. [Donors and implementing agencies] ▪ Adequately budget support for carers. [Donors and implementing agencies] ▪ Earmark funding to support the mental health needs of MHPSS actors/humanitarian workers. [Donors and implementing agencies] ▪ Fund and implement specific research to address questions related to the needs of people with disabilities. [Donors and researchers] ▪ Fund research in implementation science for mainstreaming inclusion. [Donors and researchers]



Priority Area	Recommendations	Specific actions across different stakeholders
Improving MHPSS services and service provision	Better understand the unique needs of individuals with physical, psychosocial and intellectual disabilities and of their caregivers in order to create MHPSS programming that addresses these needs.	POLICY MAKERS ▪ Incorporate disability and inclusion into emergency response plans in line with the United Nations Convention of the Rights of Persons with Disabilities (CRPD). ▪ Collaborate with civil society organizations, including representative organizations of people with disabilities. IMPLEMENTING AGENCIES ▪ Create disability focal points as part of disaster preparedness and response who would advise on mental health and emotional needs. ▪ Ensure that the most vulnerable populations are not overlooked through by including people with disabilities and their caregivers when conducting situation analyses, implementing programmes, carrying out monitoring and evaluation, and research. ▪ Prevent overburdening staff or family carers/volunteers in the systems, and ensure appropriate and reasonable accommodation and support for people with disabilities. RESEARCHERS ▪ Improve understanding of multiple adversities/intersectionality and how they interact as risk factors for mental distress in emergencies. ▪ Conduct research regarding access to and gaps in services for people with disabilities in humanitarian response. ▪ Create tools to differentiate the degree to which distress and mental conditions are considered disabilities. ▪ Create indicators that are feasible for use in emergency – for situation analysis, needs/burden measurement and outcome/ impact measurement. ▪ Create tools to measure inclusion of disability in current and future programmes.
Other considerations	▪ Links with GBV: People with disabilities, especially girls, and people with intellectual disabilities are at significantly high risk of abuse. It should be recognized that they are less likely to report abuse, especially when they have impairments linked to communication, and that physical injury and disability (not only emotional trauma) are a potential consequence of GBV (e.g. fistula; injuries as a result of violence). They should therefore be a specific focus of GBV prevention and support. ▪ In post-emergency reconstruction and recovery, it is essential that good principles of universal design are applied to ensure that new physical infrastructure, as well as services, meet the needs of people with disabilities.	

Thematic Area 3: Gender-Based Violence Survivors

Working Group Co-Chairs: Ananda Galappatti, Co-Director of MHPSS.net; HAWAR founder Düzen Tekkal; Zeinab Hijazi, UNICEF Child Protection in Emergencies Mental Health and Psychosocial Support Specialist

Specific Actions and Recommendations

Priority Area	Recommendations	Specific actions across different stakeholders
Prevention and response	Ensure that the design and implementation of gender-based violence (GBV) prevention and response services are based on an analysis of the prevalent forms of violence, their impacts on survivors across the life cycle, and factors affecting accessibility within the social, educational, cultural, economic and political context of each setting.	POLICYMAKERS AND DONORS - Promote multi-disciplinary and client-centred models for survivors' support and recovery that are responsive to individual needs. - Explore and establish models for non-formal approaches to justice and reparation for survivors' well-being that may offer an alternative or complementary response to formal legal proceedings and forms of justice (see UNFPA Minimum Standards, chapter on Justice and Legal Proceedings). - Include support for a wide range of measures or approaches to enable access to forms of justice and reparation that are relevant for survivor well-being, going beyond conventional legal remedies. - Ensure that procedures allow for sufficient time and that budgets allocate enough funding to guarantee a sound understanding of the prevalent forms of GBV and diverse affected groups, including those that are often hidden or underserved. IMPLEMENTING AGENCIES - Ensure that GBV prevention and response programmes include access to a wide spectrum of MHPSS services and support. - Ensure that provision of MHPSS for survivors within GBV responses goes beyond Psychological First Aid (PFA) and referral by enhancing relevant GBV actors' capacity to support the provision or integration of appropriate MHPSS interventions within GBV prevention and response services. - Train GBV actors to deliver appropriate MHPSS interventions, and develop and promote community-based approaches to mobilize formal and non-formal support to survivors in contexts where GBV actors are not present. - Produce guidance for MHPSS actors on taking a client-centred approach that acknowledges that GBV is an area where entrenched and contested social values, norms and belief systems are fundamentally relevant to the experiences of survivors and the responses of their families, communities and service providers, including humanitarian actors. CROSS-CUTTING ACTIONS - Ensure that structural and social interventions for prevention form part of wider programme design. - Ensure that programmes assess forms of violence and their age-related impacts. - Ensure that responses to GBV are informed by the life cycle perspectives of survivors. - Design programmes that support accessibility to services given the social, cultural and political context. - Promote interventions (including non-MHPSS-specific activities such as economic empowerment) for which there is already evidence of MHPSS benefits for GBV survivors, including those that promote help-seeking and peer support.



Priority Area	Recommendations	Specific actions across different stakeholders
Cross-sectoral Integration and Inclusion	Ensure that MHPSS services, referral and integration with GBV prevention and response services are delivered as part of a broad prevention and response strategy.	CROSS-CUTTING ACTIONS ▪ Include immediate social, medical, legal, protection, practical and psychosocial support. ▪ Address medium- and long-term needs for services, and support inclusive and participatory structural and social change for GBV prevention. ▪ Do not create stand-alone mental health services for GBV survivors. Ensure that all services are appropriately linked to other services including social, medical, legal and practical support, especially support to compensate for economic losses and to ensure economic self-reliance. ▪ Ensure that services meet the immediate (e.g. protection/urgent) and long-term (e.g. therapeutic) mental health needs of survivors.
	Create accessible, inclusive and tailored MHPSS interventions within GBV prevention and response services.	IMPLEMENTING AGENCIES ▪ Strengthen current guidance to provide a stronger emphasis on the specific needs of working with individuals with disabilities. ▪ Establish initiatives at multiple levels to strengthen linkages between MHPSS and GBV sectors, including on key areas of overlap or complementarity (i.e. alcohol and substance abuse), such as by supporting platforms for dialogue between MHPSS and GBV actors, or by creating opportunities to exchange models and promote advocacy at the regional and international levels. ▪ Ensure that initiatives account for the unique needs of men and boys, but not at the cost of addressing the needs of women and girls. ▪ Support the need for building evidence on effective responses to men and boys who are survivors of GBV.



Priority Area	Recommendations	Specific actions across different stakeholders
Guidance and standards on MHPSS within GBV prevention and response services	Elaborate strategies to better operationalize the current guidance and standards to support the integration and coordination of MHPSS services and approaches within GBV prevention and response.	IMPLEMENTING AGENCIES ▪ Comply with current guidelines and minimum standards for holistic GBV programming. ▪ Develop and mainstream guidance and training on support to GBV survivors across MHPSS provision and outreach services, including general psychotherapy, counselling and community psychosocial work. ▪ Train MHPSS actors on the specific issues and needs facing GBV survivors and how to adapt MHPSS interventions to take GBV into consideration (client-centred approach). ▪ Develop tailored guidance for specific sectors on MHPSS and GBV (i.e. What should MHPSS actors know about GBV? What should health, protection and WASH actors know about MHPSS within a broader GBV response?) ▪ Engage the GBV Area of Responsibility (AOR) in the development of minimum standards for GBV prevention and response in order to integrate MHPSS services and approaches. Support an update of these standards to better represent a broader spectrum of possible MHPSS services. ▪ Promote current global guidance on documenting GBV cases in the context of ongoing conflict, which should be safe and accessible to survivors, including for future post-conflict justice and reparations processes, such as by: – ensuring the ethical, safe and effective collection and storage of GBV documentation to enable future legal proceedings, if necessary; – ensuring survivors' rights to information on how they may access their own documentation. CROSS-CUTTING ACTIONS ▪ Address the lack of models, guidance and an evidence base for effective GBV prevention (e.g. mitigation of contributing factors such as alcohol and drug use), including guidance on contextualization and adaptation for specific settings (i.e. particular countries or communities or emergency phases) by: – expanding research to better examine evidence for effective GBV prevention; – developing evidence-based models and approaches for GBV prevention; – exploring how mental health interventions may further contribute to GBV prevention. ▪ Develop recommendations for reaching survivors who are likely never to directly access formal MHPSS or GBV prevention and response services. ▪ Consolidate and communicate knowledge on individual, family and community impacts of GBV to inform advocacy approaches and materials.
Other Considerations	▪ Produce guidance for GBV and MHPSS actors on the provision of staff care for service providers, with sensitivity to the particular risks and stigma that may be associated with efforts in combatting GBV. ▪ Incorporate guidance on prevention and support for humanitarian staff who may be subject to GBV. ▪ Strengthen links between MHPSS and GBV actors and support platforms (e.g. CP Alliance, GBV AoR, IASC MHPSS RG, etc.) for regular dialogue and mutual learning.	

Thematic Area 4: People on the Move: Refugees and Internally Displaced Persons

Working Group Co-Chairs: Inka Weissbecker, Senior Global Mental Health and Psychosocial Advisor with International Medical Corps; Amit Sen, UNHCR Representative

Specific Actions and Recommendations

Priority Area	Recommendations	Specific actions across different stakeholders
Coordination	Involve national governments and authorities in MHPSS coordination.	POLICYMAKERS - Designate a lead government agency/focal point in each country to improve coordination across various ministries. <i>(Governments to coordinate and decide)</i> IMPLEMENTING AGENCIES - Develop MHPSS Action and Work Plans together with government partners. <i>(INGOs/agency coordination leads)</i> - In environments with limited government capacity (e.g. where the government is not willing or able to participate), designate other key agencies and organizations as the co-leads. <i>(INGOs/agency coordination leads)</i> - Develop soft governance tools that specify key aspects of the MHPSS humanitarian response. (e.g. when and how to obtain government approval for new MHPSS projects). <i>(INGOs/agency coordination leads in collaboration with governments)</i>
	Strengthen donor coordination to support complementary humanitarian response and development programmes.	DONORS - Improve donor coordination in order to clearly identify who is funding what in order to avoid duplication, and ensure that gaps are filled. <i>(Humanitarian and Development Donors in coordination with governments) by:</i> - Using the Who is Doing What, Where and Until When (4Ws) mapping to understand MHPSS components that are covered in different geographical areas; - Hold regular meetings and communication among both relief and development donors to coordinate and continue strengthening of MHPSS. <i>(Donors)</i>



Priority Area	Recommendations	Specific actions across different stakeholders
Capacity development	Support broad and long-term multi-sectoral capacity development that includes governments, academic institutions and civil society	IMPLEMENTING AGENCIES - Map and recur to governmental, community-based organizations and community structures when planning new MHPSS programmes. (<i>INGOs</i>) - Use a flexible approach and systems considerations in deciding who should be trained and provide services (e.g. community health workers, counsellors, volunteers, peer support workers), and how they fit into the current system. (<i>INGOs</i>) - Conduct contingency planning that considers the capacity of national systems to absorb MHPSS services established in emergencies, especially at the outset when funding levels and resources may be highest. (<i>INGOs</i>) CROSS-CUTTING ACTIONS - Dedicate funding and implement programming that addresses different aspects of capacity development (in addition to in-service training and supervision), including: - capacity development of governments and national authorities in MHPSS including leadership and governance (e.g. seconding technical MHPSS experts (including from the World Health Organization) at the government level, building technical capacity and providing resources for national-level MHPSS champions); (<i>Donors, INGOs/agencies</i>) - capacity development through academic training institutions (e.g. updating training curricula, academic partnerships between universities). (<i>Donors, INGOs/Agencies, Academia</i>) - Find a balance between providing needed quality services and designing programmes in such a way that they can be sustained in the longer term. This requires donor support for long-term funding and government willingness to invest in MHPSS, which is not always a given in emergencies. Consider that the system may need to be reformed and restructured, which can take many years or even decades. (<i>INGOs, donors, governments</i>) - Start discussions on and development of a handover strategy at the outset of emergencies to support the effective transition from international actors to local and national actors in the long term. This requires not only a transfer of activities and resources, but also a 'transfer of vision' and national champions to guide implementation. However, consider that a full comprehensive handover may take years in some countries and needs comprehensive capacity development (see point 1). (<i>Donors, INGOs/agencies</i>)
	Recognize that establishing quality, sustainable national MHPSS services and systems is a long-term commitment and that emergencies also present new opportunities to strengthen MHPSS systems	DONORS Provide long-term flexible funding (for at least five years) to allow for broader and more sustainable capacity development. (<i>Donors</i>)



Priority Area	Recommendations	Specific actions across different stakeholders
Provision of MHPSS Services and Activities	Ensure accessibility of MHPSS services and activities for all	CROSS-CUTTING ACTIONS ▪ Always involve in MHPSS programming and support all actors, including the host community and vulnerable groups. (<i>Donors, INGOs</i>) ▪ Develop sustainable solutions to make MHPSS services accessible (e.g. inclusion in insurance schemes, basic package of health services) (<i>Donors, Governments</i>)
	Track and support the implementation and scale-up of effective and cost-effective MHPSS interventions	IMPLEMENTING AGENCIES ▪ Use and develop financing tools that track spending (e.g. across MHPSS and non-MHPSS sectors, national vs. NGOs) and help identify and scale up effective interventions from a public health perspective. (<i>INGOs/Agencies</i>) ▪ Develop common accessible tools and adapt them to the local field and community context. (<i>INGOs</i>)
Staff Care	Recognize that staff and volunteers are also affected by emergencies and need adequate support systems	DONORS ▪ Specifically include staff care when allocating resources and budget lines. (<i>Donors</i>) IMPLEMENTING AGENCIES ▪ Address gaps in staff care by using a broad and inclusive approach that includes as much as possible all MHPSS providers, such as volunteers and other staff working in humanitarian emergencies, together with local actors. (<i>INGOs</i>) ▪ Address elements of working conditions (including roles, responsibilities, safety and evacuation policies) that affect the mental health and psychosocial well-being of staff. (<i>INGOs</i>) ▪ Budget for staff care needs and resources. (<i>INGOs</i>)



Priority Area	Recommendations	Specific actions across different stakeholders
Research and monitoring evaluation, accountability and learning (MEAL)	Ensure accountability and oversight when conducting research	RESEARCHERS - Ensure adherence to ethical standards and considerations such as the 'do no harm' principle (e.g. see IASC MHPSS Guidance on Ethical Considerations in Conducting Research). This includes safety planning and referral to services where necessary (e.g. for those who are suicidal and those who have acute mental health problems). (<i>Researchers</i>) - Share research findings with and involve national agencies, authorities, academic institutions and other organizations and agencies, and affected communities (e.g. summarizing research findings available in local languages, setting up meetings for sharing and discussing findings). (<i>Researchers</i>)
	Monitor programmes and ensure flexibility to meet the needs of affected populations in line with the 'do no harm' principle.	DONORS - Ensure flexibility in project budgets and the support of programmatic change and adaptation when required. (<i>Donors</i>) IMPLEMENTING AGENCIES AND RESEARCHERS - Openly acknowledge and share lessons learned and what does and does not work with others. (<i>Researchers, INGOs</i>) CROSS CUTTING ACTIONS - Fund and include process evaluations and monitoring to discover problems and make necessary adjustments to programmes. (<i>Researchers, INGOs, Donors</i>) - Take into consideration that promising practices should be replicable and interventions within the communities adapted to the local culture and context. (<i>Researchers, INGOs, Donors</i>)
Integrating MHPSS in different sectors	Ensure that MHPSS considerations are included in programming by other sectors	IMPLEMENTING AGENCIES Develop brief summaries and field checklists on what MHPSS should be for different sectors, including their roles in the provision of MHPSS, what they should consider, and what goes beyond their capacity. (<i>INGOs/Agencies</i>)

Cross-Cutting Actions and Recommendations across the four Thematic Areas

Priority Areas	Specific actions and recommendations across different stakeholders
Donors and policymakers	
Capacity development	• Create a global roadmap defining priorities, challenges, solutions, and collaborations of MHPSS programming with sectors/agencies. • Support the creation and use of learning and dialogue platforms/forums with donors and policymakers. • Collaborate with local communities and increase community empowerment. • Link formal and informal systems driven by the local community and population. • Approach local communities, agencies, governments as groups who have resources and agency. • Improve advocacy for donors funding of MHPSS capacity development and value long-term capacity training. • Create an open discourse regarding short- vs. long-term capacity training.
Coordination	• Improve inter-agency coordination and cross-sectoral accountability of stakeholders to communities supported through MHPSS services, delivery, and mainstreaming efforts. • Develop an inter-agency, evidence-informed competency framework for staff working at different layers of MHPSS interventions (in collaboration with researchers). • Establish routine, ongoing monitoring of results achieved by MHPSS humanitarian efforts and promote in-depth evaluations to uncover problems and recommend solutions.
Funding	• Allocate resources for high-quality and meaningful MHPSS research. • Establish funding protocols that combines research with service provision. • Provide long-term funding in overall MHPSS programming in response, recovery, and maintenance of mental health and psychosocial well-being. (<i>Donors</i>) • Provide long-term funding in research and programme evaluation. (<i>Donors</i>) • Provide long-term funding for carers and MHPSS staff. (<i>Donors</i>)
Implementing Agencies	
Capacity development	• Identify, activate and strengthen local capacity, and promote the meaningful and inclusive engagement of children, families, marginalized groups and the entire community. • Strengthen support within current structures, including functional referral systems and capacity among professional and non-specialist providers of quality MHPSS care. • Improve training and MHPSS interventions to meet the needs of local staff and population. • Foster accessible, impactful, culturally appropriate and sustainable MHPSS services by involving beneficiaries and key stakeholders in the community at all stages of project design, assessment, implementation, and monitoring and evaluation. • Improve MHPSS capacity within communities among the MHPSS workforce as well as among carers and community members. • Create awareness, promote advocacy, and mainstream neglected populations in the MHPSS sector and across all platforms. • Mainstream IASC MHPSS guidelines across all humanitarian and development sectors, including protection, health and nutrition, education, WASH and shelter systems. • Ensure that MHPSS approaches work through a range of delivery platforms relevant to the target population in different circumstances.



Priority Areas	Specific actions and recommendations across different stakeholders
Improving Interventions	▪ Construct culturally adaptive MHPSS interventions. ▪ Improve and create specialized interventions and inclusion. ▪ Emphasize community-initiated approaches over externally imposed models. ▪ Integrate peacebuilding components into MHPSS programme. ▪ Rebuild perspectives and increase people's agency and self-sufficiency across the four layers of the IASC MHPSS intervention pyramid.
Researchers	
Coordination and capacity development	▪ Address the current lack of models, guidance and an evidence base for effective MHPSS programming ▪ Monitor programmes and ensure flexibility to meet the needs of the affected populations and apply the 'do no harm' principle. ▪ Map and understand what organizations have achieved for specific populations and document both the ineffective and effective techniques. ▪ Review overall, current evidence-based practices of MHPSS services for each thematic Working Group. ▪ Document and field-test current MHPSS interventions.
Development	▪ Create MHPSS tools that can help identify the kind of intervention needed while ensuring discretion and safety for the individuals being helped. ▪ Create accessible MHPSS interventions that are specialized and inclusive to all populations. ▪ Research and develop innovative approaches to address changing needs. ▪ Develop common accessible tools and adapt them to local field and cultural context of communities ▪ Develop research strategies that investigate the link between effective and quality programming, and the creation of a healthy and productive workforce and supportive working environment.

IMPRESSIONS



Get Together 3 July 2018

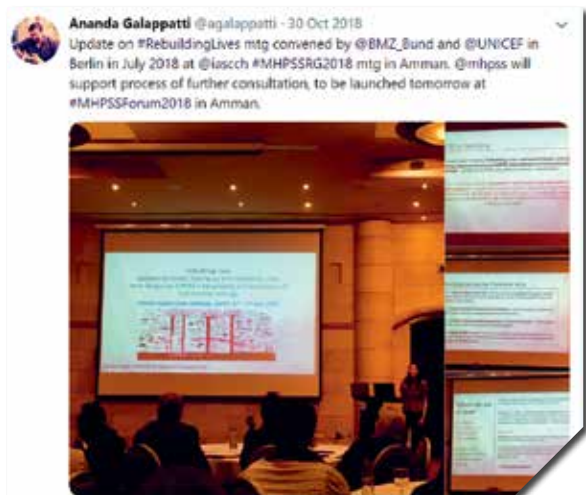


Press Conference
5 July 2018



Participants at the expert meeting watched the live stream of the press conference with UNICEF Executive Director Henrietta H. Fore and Federal Minister Gerd Müller. The press conference also included a statement on the expert meeting by Cornelius Williams.





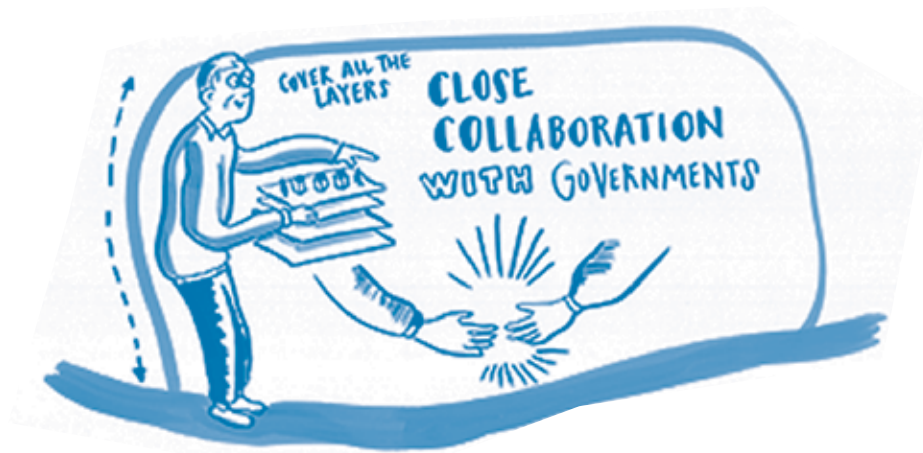
Visit to the Reichstag 4 July



ANNEX 2

ANNEX 2.

DETAILED SUMMARY OF NEEDS FROM THE HAGUE AND WILTON PARK





© UNICEF 2015

Link to the Conference Report:
<https://tinyurl.com/y5noop39>

THE HAGUE SYMPOSIUM 2015

In May 2015, UNICEF convened **The Hague Symposium** with the Government of the Netherlands, bringing together a wide range of humanitarian and academic partners in order to review current interventions in the mental health and psychosocial field. The Symposium primarily focused on adolescents growing up in conflict settings who are experiencing long-term repercussions to their physical, mental health, and psychosocial well-being. The Symposium concentrated on a review of evidence and practice within the scope of MHPSS for children affected by armed conflict and displacement, in consideration of key factors including cultural adaptation, contextualization, resilience and the social ecological approach to designing and implementing MHPSS interventions.

There were five major needs identified in the symposium:

1. To focus on children, adolescents and families

Exposure to violence together with other adverse childhood experiences (e.g. neglect, abuse, malnutrition), can negatively impact brain structure and function, hormonal and immune systems. Hence, the fundamental link between attachment and the organization of the brain, and the importance of attachment and development were emphasized according to the level of resilience that could be fostered, with other important elements such as

cultural adherence, social cohesion, material resources, identity, and having some kind of support or mentor figure in a child's life to decrease risks of vulnerability.

Recommendations in this specific need were as follows:

- Promote activities that children and parents enjoy that can foster mutual support in programmes and interventions.
- Formulate how to build life skills that are relevant to a child's needs in a more creative and culturally adaptive manner.
- Develop an inter-agency approach to children's coping and protection skills, and build awareness within the family system and the community as a whole.

Discussions on adolescents included the critical transition from childhood into adulthood, and how the environmental context can compromise it, putting many at high risk of being subjected to harmful cultural practices such as child marriage and recruitment into armed forces, or of being displaced forcefully or out of safety concerns. Helping adolescents and youth become aware and be active in their agency was a major focus. The recommendations were as follows:

- Create benchmarks for adolescents and youth in MHPSS programming.
- Integrate considerations of context on youth and adolescents in the current guidance materials being implemented by all sectors in humanitarian response.

In terms of families in conflict settings, discussions stressed the importance of re-establishing positive parenting strategies in order to help increase caregivers' resilience. Thus, caregivers or mentors would be able to meet developmental and recovery needs of the affected children while assisting and supporting the family as a whole. Awareness of and advocacy for the role of fathers in children's upbringing were also emphasized, together with the cultural and fundamental sex and gender differences. Finally, families with disabilities face social isolation, stigma, and overall weak social cohesion due to being overlooked or outcast. Discussions also stressed the need to create more awareness and provide psychosocial education on disability in general. The specific recommendations that emerged for families in conflict settings were as follows:

- Develop parenting/family programmes specifically for unaccompanied and separated children, and children who have been associated with military forces.
- Consolidate research and create effective parenting programmes from research findings.
- Include support to parents when referrals are made in accordance with child protection standards.

2. To increase community empowerment

In order to enhance community empowerment and engagement, humanitarian agencies need to view communities as groups that have the capacity and resources to heal themselves and that need not rely (solely) on external interventions and support.

A crucial understanding and awareness of the possibility of harming a society and its local power structures was noted as a priority, since it is important to build and understand the power relationships that currently, uniquely operate in each setting. When co-existence is not effective, this may lead to more exclusion or marginalization of stigmatized or undermined groups (i.e. individuals with physical and mental disabilities, women, etc.). Recommendations from these discussions are as follows:

- Link formal and informal systems driven by the local community and population.
- Document examples of community empowerment and engagement in humanitarian emergencies.
- Create an alliance and open dialogue with the community in order to understand how they resolve their own issues.

3. To link MHPSS, education and child protection

Creating a multi-layered, intersectoral system with MHPSS, education, and child protective services would strengthen resilience and reduce developmental and societal risk factors for children and adolescents. Discussions on the effects of youth in conflict settings were divided into two kinds of risk factors: developmental and societal. With respect to developmental risk factors, stress from experiencing violence, separation from family, displacement, and forced military or marriage can permanently damage brain development and lead to depression, anxiety and slower cognitive, emotional and social development. With respect to societal risk factors, due to exposure to violence and other traumatic events, adolescents were put at a higher risk of being recruited into armed forces and child marriage, labour and sex trafficking, street violence, substance abuse, sexual and gender-based violence (SGBV), as well as committing suicide and homicide. Since youth did not have guaranteed safety at home or with their families, the roles of mentors and teachers were discussed, as well as how mental health problems can be reduced, yielding better outcomes and involving fewer risk factors when learning environments are improved. The topics discussed were inaccessibility to training programmes, stress management, higher-level education, protection, and general psychosocial support for teachers, and how often this inaccessibility led to teachers being unable to support their classrooms.

Recommendations from these discussions included:

- Contribute to and strengthen the Child Protection Working Group Task Force on Psychosocial Support.
- Review overall evidence and practice of MHPSS for children.
- Develop an inter-agency training package for teachers on how to provide psychosocial support in the classroom.
- Document and field-test good practices on education and MHPSS interventions.
- Recognize and implement proper psychosocial innovations in schools

4. To integrate peacebuilding components into MHPSS programmes

During the Symposium, research presented on Bosnian children who were fostered in conflict zones highlighted a correlation between wellbeing and understanding the political context that greatly affected the physical and mental health state of the children. Discussions also focused on emphasizing MHPSS programmes and engaging with youth in peacebuilding, the difference between advocacy and physical protest, and awareness of current versus intergenerational traumas. It was concluded that there needs to be a way to create safe spaces for youth to express themselves and learn how to navigate their opinions so as to protect their rights and their environment. The recommendations that emerged are as follows:

- Map tools and practices by documenting activities that involve overlooked/neglected groups.
- Develop a definition for peacebuilding and MHPSS to serve as a foundation for their integration and narrow the gap between the two fields.
- Collect examples of good practice at the intersection of MHPSS and peacebuilding.
- Engage stakeholders in peacebuilding and conflict resolution in school-based MHPSS.

5. To develop innovative approaches for changing needs

Creating resourceful approaches for changing needs in the MHPSS field was discussed and dialogue was opened on low- and high-intensity interventions, and on the effectiveness of child-friendly spaces in each setting. The contrast between low-intensity interventions that do not require specialists or trained individuals, versus high-intensive interventions that require skilled providers revealed the issues regarding sustainability, overall effectiveness, and even the awareness and promotion of staff care in the field. The recommendations that emerged from these discussions are as follows:

- Collect evidence on what interventions work and in which circumstances.
- Continue to strengthen agency capacity for rigorous project evaluations to broaden the evidence base.
- Encourage research initiatives on addressing the longer-term trajectories of children affected by conflict.
- Identify the means to provide technical mentoring and emergency resources for multiple agencies.
- Improve training and supervision strategies to meet the needs of a changing workforce.
- Identify strategies to reduce isolation and burn-out of practitioners working in the field.



© The Save the Children Fund 2018

Link to the Conference Report:
<https://tinyurl.com/y2sjuvhz>

WILTON PARK DIALOGUE 2018

In January 2018, the Wilton Park Dialogue, in partnership with the UK Department for International Development (DFID) and Save the Children, convened over 50 MHPSS experts to discuss the present challenges in responding to the mental health needs of children and adolescents affected by conflict internationally and, in particular, in the Middle East. Despite the existence of common frameworks for MHPSS responses in general, there was a lack of specific child-focused interventions and there were no international guidelines in a humanitarian response setting.

Experts at Wilton Park aimed to build on recommendations from The Hague Symposium, Growing Up in Conflict: The impact on children's mental health and psychosocial well-being.

Overall, the objectives of the Wilton Park Dialogue were as follows:

- Discuss and evaluate good practice in MHPSS for children and adolescents during and after conflict, lessons learned globally and innovations in new programming.
- Share effective approaches in ensuring that programmes are multi-sectoral, coordinated and integrated with humanitarian missions;
- Address issues regarding the implementation of MHPSS programmes that include but are not limited to age and gender sensitivities, stigma and accessibility to difficult-to-reach regions, as well as strengthening national capacity, specifically in the Middle East.

- Create a global roadmap defining the priorities of, the challenges in, the solutions to, and necessary collaborations in, MHPSS programming for children and adolescents in conflict zones.

Implementing multi-sectoral programming and coordination were discussed as key to achieving these objectives. If carried out correctly, MHPSS interventions could sustainably support sectors such as education, health and nutrition. The main goal is to have an integrative and supportive collaboration rather than competition across sectors, donors and organizations. This is vital considering that, currently, there is limited funding globally, despite an increase in a number of agencies delivering MHPSS interventions. Recommendations that emerged from these discussions include:

- Rename MHPSS coordination groups in countries as MHPSS Technical Advisory Groups, which would support all clusters with technical input and coordination to help ensure consistency of standards and quality of all MHPSS work in a cross-sectoral manner.
- Ensure that level 3 emergencies have MHPSS Technical Advisory Groups.
- Lobby for an MHPSS child/adolescent focused thematic group under the Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support (IASC RG MHPSS) to focus on developing packages, tools, standards and training.

- Encourage open and ongoing communication among donor platforms.
- Set up a database of MHPSS technical experts to provide surge capacity and deployable technical support.

The second objective of the Dialogue, established to improve MHPSS for children and adolescents in conflict settings, was to engage youth and advocate on behalf of young populations who are often ignored or undermined on a global and community level (i.e. persons with disabilities, young females).

This objective promotes a platform for youth to allow them to feel safe, engaged and supported, and to invest in them and their communities. The platform would also teach them about their neurobiology and their responses to threat and trauma. Recommendations that emerged from this discussion are as follows:

- Ensure MHPSS community identifies how current humanitarian standards, policies and structures contribute to the exclusion of various child and adolescent groups and their lack of engagement in community.
- Invest in youth experts and empower youth's agency of their own lives in humanitarian contexts.
- Empower youth to be a positive force in their community.

As with youth engagement and support, there is a vital need to create more interventions and support for caregivers in humanitarian settings. The Dialogue emphasized the need to change the narrative on caregivers, focusing on their well-being, rather than how knowledgeable or helpful they are in their context, which would relieve the stress, negative coping mechanisms, risky behaviour, and levels of substance and self-harm. The language and training methods used for caregivers should mirror the language and approach of their community (i.e. families, workers, teachers, the elderly) in order to share common knowledge and terminology, and decrease the stigma of MHPSS in their setting. It was recommended to diversify the concept of a caregiver beyond parental roles and include other members of an individual's nuclear family, as well as mentor figures in the community.

The final objective established in the Wilton Park Dialogue was to strengthen the national capacity of MHPSS practitioners in a humanitarian aid setting. In the past, there has been a lack of adequate monitoring, evaluation or proper training to ensure enough supervised, experienced, and well-trained MHPSS practitioners to continue to effectively provide for populations outside of an individual agencies' manualized, short-term MHPSS programme. Recommendations that emerged from this objective are as follows:

- Continue to identify gaps between MHPSS practitioners and donors.
- Develop collaboration with local communities to create an age- and gender-sensitive intervention plan that is long-term, as opposed to training staff from a manualized two- to four-month programme.
- Establish a stand-by mechanism for senior child and adolescent MHPSS experts to support emergency responses and long-term national capacity.
- Collaborate with tech companies and create progressive models and training that could be accessible to workers working in remote locations.
- Create an inter-agency MHPSS staff training package on children and adolescents.
- Increase advocacy among donors for funding MHPSS capacity development and supporting long-term capacity training and for ensuring ongoing and long-term technical support and supervision.
- Ensure that capacity development includes leadership, management, proposal writing, clinical and counselling skills, supervision and coaching.

