UNHCR
The UN
Refugee Agency

UNHCR'S MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

FOR PERSONS OF CONCERN

Global Review – 2013

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Acknowledgement

It has been widely documented that the legal, social and financial impacts of being a refugee can be complex and deleterious. It is now coming to the fore that much the same can be said for the psychological impact of being a refugee or internally displaced person. This evaluation reports on how well UNHCR considers and provides for the well-being and mental health of the Persons of Concern to this agency. A perspective on the Mental Health and Psycho-Social Support (MHPSS) to Persons of Concern offers a new way to look at humanitarian assistance. It calls into question the appropriateness, sensitivity, and empathy of humanitarian interventions and demands that humanitarian agencies support avenues for displaced people to address and heal their own trauma. These demands pose a significant challenge for humanitarian organizations since many of the countries we work in do not have well developed mental health infrastructures and therapeutic solutions need to be resourced or developed within the displaced community. In some cases, addressing mental health also requires a technical expertise that has not always been present in the usual roster of humanitarian responders. Yet despite these challenges, the field based staff surveyed for this evaluation overwhelmingly agreed that “MHPSS programs contribute toward the protection of Persons of Concern”.

Nevertheless, MHPSS is an emerging and sometimes ambiguous perspective for UNHCR as well as for many other humanitarian actors. Thus, the evaluation begins with definitions of psycho-social support and examples. As this evaluation discovered, MHPSS activities in UNHCR may exist as an adjunct to other programmes or by another name. Many thanks to Sarah Meyer, the author of this global review, for her expertise and up to date overview on the field of MHPSS in humanitarian interventions. Through her knowledge, sensitivity and persistence she was able to discern UNHCR’s level of engagement in providing MHPSS programmes to Persons of Concern. Sarah was also assisted by Nora McGann, Research Assistant from the School of Foreign Service at Georgetown University. Sincere thanks to the Steering Committee members of this review: Sabine Rakotomalala of Terre des Hommes - Switzerland, Dr. Mark Van Ommeren from the World Health Organization, and Marian Schilperoord and Stefanie Krause of UNHCR. Their advice and guidance were invaluable to this document. Most generous thanks to field based colleagues who informed the review by reporting on the importance and realities of providing MHPSS activities to Persons of Concern. For it stands to reason that a truly durable solution can only be present for an individual who has found a way to cope and create a viable support network in displacement.

Gratefully,
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Acronyms

AGDM	Age, gender and diversity mainstreaming
CBO	Community Based Organisation
ECD	Early Childhood Development
IASC	Inter-agency Standing Committee
IDP	Internally Displaced Person
IOM	International Organisation for Migration
IMC	International Medical Corps
mhGAP	Mental Health Gap Action Program
MHPSS	Mental Health and Psychosocial Support
NGO	Non-Governmental Organisation
PFA	Psychological First Aid
PoC	Persons of Concern
PTSD	Post-Traumatic Stress Disorder
SGBV	Sexual and Gender-Based Violence
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

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Executive summary

Images of individuals and families crossing borders to find safety, after having witnessed violence and destruction, leaving possessions and family members behind, have come to represent the human impact of conflict and disaster. Threats to well-being due to these experiences and subsequent challenges are increasingly understood.

Conflict and displacement brings about a range of stressors and has the potential to negatively impact the mental health and well-being of everyone affected. These impacts – many and varied – have been observed and studied by many humanitarian workers, researchers and policy-makers globally.

Recognising these impacts, the humanitarian community has turned its attention to addressing them and in doing so the field of mental health and psychosocial support in humanitarian operations has developed substantially over the past years, culminating in the Inter-agency Standing Committee [IASC] Guidelines in 2007.

The term MHPSS – mental health and psychosocial support – was introduced and is now widely used to describe the range of activities that are used to treat mental disorders and to improve the well-being of individuals and communities in their conflict or disaster affected environments. This range of activities includes approaches designed to address the psychological and social impacts of conflict and displacement.

UNHCR's Policy Development and Evaluation Service [PDES] commissioned this review in order to assess UNHCR's involvement with MHPSS activities, examine UNHCR's engagement with and adoption of best practices and guidelines, and understand UNHCR's current and potential position in the field of MHPSS activities.

This review presents findings based on policy analysis, results from a survey of UNHCR staff, and interviews with UNHCR staff, MHPSS staff from other international organisations and non-governmental organisations, and academics in the field of MHPSS research.

UNHCR has not thus far played a strong role in visibly supporting MHPSS activities for the agency's Persons of Concern [PoC] – refugees, asylum seekers, internally displaced persons, and stateless people. However, it is clear that UNHCR could do more. Yet, the findings presented in this review demonstrate that across the organisation and its functional sectors, UNHCR has a number of activities that already fall under the spectrum of activities discussed in the IASC Guidelines. In some specific contexts, UNHCR has marshalled expertise and support for quality MHPSS interventions again demonstrating capacity in this field.

UNHCR staff widely recognise the problems in humanitarian contexts that could be addressed through improved mental health and psychosocial activities, including supporting communities' resilience, promoting mechanisms for social support, and offering services to individuals with more specialised mental health needs.

Results from the survey conducted for this review indicate that across core humanitarian response sectors – water, sanitation and hygiene, nutrition and shelter – MHPSS concerns appear to be well-represented within UNHCR. MHPSS activities in the SGBV and protection sector were almost uniformly reported. Patterns of activities in the areas of strengthening families and communities, psychological interventions, mental health activities in primary health care, and specialised mental health activities varied substantially across countries. Findings indicate limitations in provision of clinical mental health services for displaced persons, including limited activities in the field of pharmacological and non-pharmacological management of severe mental disorders and gaps in referral systems to specialised mental health services.

A broad range of UNHCR's key priorities overlap with MHPSS issues – for example, child protection and sexual and gender-based violence [SGBV] prevention and response.

Despite all these existent synergies, UNHCR's current policies and guidelines do not sufficiently link with MHPSS principles. For example, the Community Services section, which is closely aligned to the principles of MHPSS and could be well-positioned to guide the implementation of related programs, has not adopted the MHPSS language or approach.

There are opportunities for UNHCR to engage more strongly and clearly in this field. However, this requires a vision for how the organisation as a whole, and particular sectors within the organisation, will engage within the field of MHPSS activities. For a start, UNHCR can work to improve its understanding and framing of mental health and psychosocial issues, and how these issues fit within its broader mandate.

While the majority of MHPSS activities are delivered by implementing partners, UNHCR staff require familiarity with core principles in the field, such as the Intervention Pyramid contained in the IASC Guidelines, in order to support and monitor quality MHPSS activities.

Key findings and recommendations of this review

FINDING 1: UNHCR has not adequately engaged with MHPSS concepts, definitions and approaches

Recommendations:

1. UNHCR should strongly and clearly articulate its role in the field of MHPSS by developing and issuing a MHPSS strategy

2. UNHCR should promote and adapt the key principles in the field of MHPSS activities, including the Intervention Pyramid, within the organisation and within current policy approaches

3. UNHCR should seek to build internal capacity to develop, implement and support MHPSS activities

FINDING 2: There is a lack of strong assessment of MHPSS needs, and monitoring and evaluation of MHPSS interventions in the humanitarian sector

Recommendations:

4. UNHCR should identify feasible and effective assessment and evaluation methodologies and select commonly implemented MHPSS activities to evaluate, publishing case studies of results

5. UNHCR should play a central role in translating and disseminating research findings to practice and field-settings

FINDING 3: The sectoral nature of UNHCR's work currently limits integration of MHPSS activities across the organisation

Recommendations:

6. UNHCR staff in different sectors should complete a mandatory online course on how to protect and promote the dignity and psychosocial well-being of displaced persons during their daily work.

7. UNHCR should operationalise models for increased collaboration and communication on MHPSS activities, ensuring that Health, Protection and Community Services sectors utilise a MHPSS framework that enables referral systems and linkages between activities

8. UNHCR should clarify the role of Community Services as lead on Level 2 activities (strengthening family and community supports), linking current activities to best practices in the MHPSS field and ensuring Community Services has the resources and expertise to support these activities

9. UNHCR participatory assessments should be used to develop strategies to strengthen family and community self help and social supports.

FINDING 4: Synergies between Protection and MHPSS within UNHCR are not being maximised

Recommendations:

10. UNHCR should frame MHPSS activities as core components of its protection mandate

11. UNHCR should integrate MHPSS principles and approaches into core protection activities

FINDING 5: There is a lack of guidance on how to support MHPSS programs in non-emergency and/or urban settings

Recommendations:

12. UNHCR should lead development of MHPSS guidelines for non-emergency and urban settings

13. UNHCR should assess the role of MHPSS activities in the context of protracted refugee situations impacted by resettlement and/ or repatriation, identifying key interventions that should be supported as a part of ongoing activities or phasing out of humanitarian support

FINDING 6: Clinical mental health services can be increased and strengthened

Recommendation:

14. UNHCR should actively engage implementing partners who have expertise to manage severe mental health problems in adults and children

1. Introduction

Mental health and psychosocial support [MHPSS] activities are now an integral part of any humanitarian response, and as such are recognised as requirements of humanitarian response across a range of contexts and scenarios. For example, in humanitarian emergencies over recent years, including the 2010 earthquake in Haiti, displacement from Libya in 2011, and the on-going humanitarian crisis in Syria, the mental health and psychosocial impacts of conflict, disaster and displacement have been widely recognised, and the provision of a range of interventions to support individuals and communities in dealing with the impacts of conflict and disaster have occurred in the early stages of humanitarian response. As well, in situations of protracted displacement, mental health and psychosocial activities are increasingly recognised as vital interventions to assist communities in drawing on and building resilience to cope with stress associated with long-term displacement.

Until the late 1980s, the primary concern of humanitarian response was provision of services to meet basic material needs of displaced persons. Mental health and psychosocial problems of refugees were rarely, if ever, discussed or addressed. A number of events and processes precipitated interest and investment in mental health and psychosocial concerns in humanitarian settings. In a number of humanitarian crises, including displacement from Cambodia and the crises in Bosnia-Herzegovina and Croatia, mental health and psychosocial issues of affected populations came to the fore. Studies identified extensive needs amongst affected communities, and a large number of activities were implemented to address these needs. Moreover, the emergence and consolidation of an evidence-base demonstrating the mental health and psychosocial needs of displaced persons further expanded focus and attention on these issues. Improved co-ordination and inter-agency collaboration, stemming from the 2005 establishment of the Interagency Standing Committee [IASC] MHPSS Task Force, also contributed toward increased attention to these activities within the humanitarian community.

UNHCR's global protection mandate should include addressing the MHPSS needs of the people they serve for a number of reasons. First, while varying according to context and population, it is clear that conflict and displacement can bring about new mental health and psychosocial issues, and also exacerbate pre-existing conditions amongst people who have been displaced. As the IASC Guidelines summarise, humanitarian emergencies may cause social issues such as family separation, destruction of community structures and social networks, and psychological issues including depression, grief, anxiety and post-traumatic stress disorder [PSTD] related to exposure to trauma and displacement.[1] Addressing these issues in a systematic way, in collaboration and partnership with other agencies and implementing partners, should be a core component of humanitarian response.

In various policies and approaches, UNHCR demonstrates recognition that it has a key role in protecting and improving well-being in providing its mandated activities and mental health and psychosocial programs need to emerge more prominently as component of implementing this unique mandate.

Mental health and psychosocial issues may impact *functioning*. Functioning refers to the ability of an individual to complete daily tasks, including self-care, fulfil relevant social roles, as a member of a household, family and community, and take part in activities, including, for example, attending religious events and providing support for community members.[2]

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1 IASC (2007)

2 Bolton and Tang (2002).

Iraqi refugee child at the Restart centre for rehabilitation of victims of torture and violence taken during a trip to Tripoli. © UNHCR / Amine Osman

Mental health and psychosocial problems may affect functioning in a variety of ways – for example, an individual experiencing symptoms of depression such as lethargy, sleeplessness and loneliness may be less likely to take part in community activities, or a mother feeling frustrated, anxious and hopeless may be less likely to be able to perform important care practices for her child. Efforts to promote self-reliance and livelihoods may be undermined if individuals and families are less likely to engage in such activities due to unmet mental health and psychosocial needs. Therefore, it is evident that symptoms of mental health and psychosocial problems can significantly impact individual, family and communal well-being.

Moreover, there is considerable overlap between protection, and mental health and psychosocial issues. Within the field of actors engaged with MHPSS activities, UNHCR is uniquely situated as an operational agency with primary responsibility for protection. Within core UNHCR policies, such as Age, Gender and Diversity mainstreaming [AGDM], protection is defined as including "physical security and restoration of human dignity," entailing "supporting communities to rebuild their social structures, realise their rights and find durable solutions," and constituted by "material, social, economic, political and legal dimensions."[3]

As such, provision of services to achieve mental and psychosocial well-being is a core protection activity. Moreover, in cases with protection concerns, such as sexual or gender-based violence [SGBV] or child abuse, individuals may have specific psychosocial needs that emerge from protection concerns. Protection activities – for example, family tracing for unaccompanied children – are undoubtedly linked with psychosocial outcomes. MHPSS activities are a way to prevent protection risks and promote community support for vulnerable individuals at risk.

3 UNHCR (2008a); UNHCR (2010).

Mental health and psychosocial support is also inextricably linked to protection. Symptoms of mental distress may be caused by protection concerns – for example, cases of female adolescent suicide in a province in Afghanistan were found to be a result to forced early marriage, indicating how protection concerns can result in serious mental health and psychosocial issues. Conversely, substance abuse problems can lead to increases in violence, including sexual and gender-based violence [SGBV], indicating a way in which addressing mental health and psychosocial issues can result in improved protection.

Promotion of well-being of PoC through integration of MHPSS activities and services into UNHCR's core work is both necessary and timely. However, as this review found, UNHCR is currently not well positioned to support and oversee quality MHPSS programs. There is a lack of consensus within UNHCR on the appropriate role of MHPSS activities in programs, often limiting the potential impact of existing MHPSS programs. UNHCR staff have limited capacity to make the case for MHPSS in their programs, and there is often a disconnect between MHPSS activities in Community Services and Health and Protection.

The question of how UNHCR should be situated as an organisation within the MHPSS field is currently unanswered. There has been considerable debate and contention within UNHCR around whether further engagement with and support of MHPSS activities is appropriate. A central issue that emerged in the course of this review is whether the MHPSS framework would provide any added value to UNHCR, especially in a context where other similar and over-lapping approaches, including community-based protection and AGDM, already exist within the agency.

This debate appears to have limited UNHCR's role, rather than clarified it, and has held UNHCR back from taking practical actions to improve its approach to mental health and psychosocial issues. There are practical actions UNHCR can take to further engage with the approach, in order to achieve the following objectives: 1) quality improvement for programs and activities in the field, 2) co-ordination and communication with implementing partners and other agencies, and, 3) most importantly, improved mental health and psychosocial well-being for displaced persons.

The method and data sources for this review are:

1. An in-depth analysis of academic literature focusing on MHPSS issues;

2. Review of reports and guidelines from other UN agencies and NGOs, including policy analysis of UNHCR policy guidelines in relevant sectors [see Annex 1 for list of documents consulted];

3. Telephone and in-person interviews with UNHCR staff, individuals responsible for MHPSS programs at other UN agencies and international NGOs, and academics (47 respondents) [see Annex 2 for list of organisations and interviews conducted; see Annex 3 for example of semi-structured interview guide, adapted for each specific interview]. Responses of UNHCR, UN agency and NGO staff are presented anonymously, as this provided respondents an opportunity to speak more openly in interviews;

4. An online survey distributed to Community Services and Protection staff, focusing on attitudes towards MHPSS activities, and mapping of MHPSS activities across all sectors, with 144 responses [see Annex 4].

5. An in-depth analysis of UNHCR's involvement with and support for MHPSS activities in the Syria response (for IDPs in Syria and Syrian refugees in Jordan and Lebanon), including 7 telephone interviews with staff from UNHCR, implementing partners and other NGOs, and review of over 20 needs assessments and program documents.

UNHCR's Policy Development and Evaluation Service [PDES] commissioned this review in order to assess UNHCR's involvement with MHPSS activities, examine UNHCR's engagement with and adoption of best practices and guidelines, and understand UNHCR's current and potential position in the field of MHPSS activities. Rather than providing evaluation of specific UNHCR

MHPSS programs, the aim is to provide an over-arching global review, capturing policy approaches and programmatic initiatives, and mapping UNHCR's engagement with MHPSS approaches and interventions within its operations. The review describes the development of the field of MHPSS activities in humanitarian settings. Given the nascent status of MHPSS activities within UNHCR approaches and activities, analysis of the way in which guidelines, best practices and principles have been adopted and operationalised by other actors is presented. The review focuses specifically on MHPSS activities in humanitarian settings. While resettled refugees often have significant mental health and psychosocial needs, analysis of these issues and activities to address these needs is beyond the scope of this current review.

The findings presented in a global review of this nature contain some important limitations. Data – on mental disorders, psychosocial problems, availability of services, and the nature, size and scope of MHPSS activities – is severely lacking. As is discussed in this review, there are significant limitations throughout the field of MHPSS activities regarding evaluation of the impact of MHPSS programs. As such, while the survey identified the scope and types of programs UNHCR is engaged in, the quality of these programs cannot be assessed through these numbers. Given the small number of completers of the online survey, statistical comparisons between regions or sectors cannot be made. Individuals who are interested in and working on MHPSS issues may be more likely to respond to the survey, potentially skewing the results. Therefore, the survey results cannot be interpreted as representative of attitudes of staff across UNHCR, or reflective of the full spread of programs across the organisation. The evaluation did not include field visits to UNHCR operations, or consultations with refugees, IDPs, asylum seekers or stateless people. As such, the need for and impact of MHPSS activities from their perspective cannot be fully included, and is instead reflected through analysis of other literature and needs assessments that have sought to capture these needs and impacts. Finally, given the way in which expenditure is tracked and MHPSS programs are categorised, it is impossible to determine the scope of financial resources that UNHCR has committed to MHPSS activities.

Section II of the review will provide definitions adopted for this review, as well as discussion of research that has highlighted the need for MHPSS activities in humanitarian settings. Within this discussion, key historical events and influences on the development of MHPSS as a field of practice will be presented, including the IASC MHPSS Guidelines. Section III focuses on the role of UNHCR within this field, presenting findings from a survey of UNHCR's MHPSS operations, as well as providing an overview of UNHCR's role in MHPSS activities in the Syria response. Section III will additionally map UNHCR's policy guidelines and approaches that are relevant to and overlapping with MHPSS activities and principles, exploring the commonalities and differences in approaches in UNHCR policies and the MHPSS approach. Throughout Sections II and III, Program Snapshots are provided – descriptions of MHPSS activities that are implemented in the field, presenting a range of activities that span the scope of interventions and approaches recommended in the IASC Guidelines and demonstrating the range of interventions available to address MHPSS needs.

Section IV outlines the primary findings of this review, identifying issues that are influencing UNHCR's opportunities to ensure quality MHPSS activities and interventions. Framed around the central principle of UNHCR's responsibility to work towards improving well-being as part of its protection mandate, this review provides recommendations to adopt in order to achieve the policy development and program expansion needed to address the pressing mental health and psychosocial issues prevalent in humanitarian settings.

2. Mental health and psychosocial support – development of a field of practice

2.1 Definitions

This review adopts and utilises the commonly accepted definition from the IASC Guidelines, recognising that it has provided a basis for common language and improved communication within this field [see Textbox 1]. However, it is evident that definitions and language in this field has often been contested and confused. Indeed, this review identified concerns prevalent amongst UNHCR staff that the terminology utilised in the field of MHPSS is too technical, confusing and alienating. As such, here the terms "MHPSS" and "psychosocial" are defined and discussed further here. Moreover, the distinction between *a MHPSS approach* and *a MHPSS intervention* is described, in order to frame the ways in which MHPSS can be integrated and implemented throughout humanitarian response.

TEXTBOX 1

Definitions of mental health, psychosocial and MHPSS utilised in this review

Mental health: a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community.[4]

Psychosocial: The term psychosocial is often used in the field of humanitarian response to "emphasise the close connection between psychological aspects of experience and wider social aspects of experience, inclusive of human capacity, social ecology, and culture and values."[5] Psychosocial interventions are designed to address the psychological effects of conflict, including the effects on behaviour, emotion, thoughts, memory and functioning, and social effects, including changes in relationships, social support and economic status.[6]

MHPSS: Any type of local or outside support that aims to protect or promote psychosocial well-being and/ or prevent or treat mental disorder.[7]

Mental health and psychosocial support:

The Inter-Agency Standing Committee [IASC] Guidelines propose that the term mental health and psychosocial support [MHPSS] be used "to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/ or prevent or treat mental disorder."[8] This composite term is now widely used and accepted by practitioners in the field. On one level, this definition reflects a pragmatic approach to collaboration between a wide range of actors working in

4 WHO (2011).
5 Tol, Reis, Susanty, & de Jong. (2010).
6 Galappatti (2003).
7 IASC (2007).
8 IASC (2007).

this field, approaching mental health and psychosocial issues from different perspectives. As stated in the introduction to the IASC Guidelines, "the composite term mental health and psychosocial support (MHPSS) serves to unite as broad a group of actors as possible and underscores the need for diverse, complementary approaches in providing appropriate supports."[9] As such, the composite MHPSS term is an attempt to seek agreement on practice and avoid the conceptual and theoretical debates that have previously divided the field and, in many cases, hindered improved programs and co-ordination.[10]

However, beyond pragmatism, the composite definition is also a framework that is strongly grounded in an integrated approach to the promotion of mental health and well-being, and prevention of mental disorder. The composite term also recognises the connections between (a) programs that may target a broad community-level and focus on building resilience, developing community-support and activating coping mechanisms, and (b) programs that address a smaller percentage of the population, displaying significant mental distress, for whom community-wide activities are not adequate and for whom more specialised support is needed. This reflects one of the core principles of the IASC Guidelines, the need for multi-layered supports, a "layered system of complementary supports that meets the needs of different groups." Broad-based psychosocial interventions provide a basis from which to reduce stigma associated with mental distress or disorder, identify individuals who may be at-risk of developing problems, and provide referrals to appropriate services. Psychosocial programs, for example, women's groups and targeted activities to encourage livelihoods, may act to prevent the onset of symptoms of mental disorders that, if untreated, would require further intervention in the health care system. In a description of a multi-layered MHPSS intervention for children affected by conflict in Burundi, Sri Lanka, Indonesia and Sudan, this process is described as a "continuum of multi-layered care," and ways in which interventions at one level support can interact with interventions at another level highlight the interconnectedness of mental health and psychosocial activities.[11] UNHCR staff interviewed for this project discussed the role of community centers and outreach activities as approaches that address needs of a broad segment of the population, while also providing the opportunity to link individuals with more specialised needs to mental health services.

The field of MHPSS is broad and often complex, because its areas of policy and programs are highly diverse. First, the field of MHPSS is concerned with individuals who suffer from social, psychological and psychiatric problems that pre-exist conflict and displacement, including for example, individuals already suffering from schizophrenia who are displaced. Second, the field is concerned with individuals who experience social, psychological and psychiatric problems induced by emergencies, for example, loss of family members, lack of access to basic services, and symptoms of mental disorders caused by emergency-related traumatic events. Some of these concerns may include anxiety about the future, because the provision of humanitarian assistance, which can enhance and promote mental health and psychosocial well-being, or, be delivered and provided in such a way that it undermines well-being and negatively impacts individual and communal coping mechanisms. These concerns may be on-going in a protracted situation, leading to hopelessness and despair about the future.

9 IASC (2007).

10 Ager (2008).

11 Jordans, Tol, Komproe, et al. (2010); Jordans, Komproe, Tol, et al. (2010).

What does psychosocial mean?

The term psychosocial indicates an approach that accounts for two types of inter-related effects of conflict and displacement: "psychological effects" – defined as those that "affect different levels of functioning including cognitive (perceptions and memory as a basis for thoughts and learning), affective (emotions), and behaviour," and "social effects," including altered relationships, family and community networks, and economic status.[12] According to the IASC, "[t]he term psychosocial denotes the inter-connection between psychological and social processes and the fact that each continually interacts with and influences the other."[13] Terre des Hommes describes psychosocial work as "deal[ing] with the well-being of individuals in relation to their environment,"[14] reflecting the principles underlying psychosocial work: a recognition of the multi-layered impacts of conflict and the need to address the contextual influences on individuals' and communities' well-being and functioning. The psychosocial framework is described by UNICEF as one that works towards "reinforc[ing] well-being, dignity and resiliency" of individuals and communities.[15]

Throughout the history of the field of MHPSS, the meaning of the term psychosocial has been contested. As psychosocial experts Ager, Strang, and Wessells pointed out, the term psychosocial has been used in three distinct ways: 1) as a synonym with mental health (often to avoid using potentially stigmatising language); 2) to "describe a wide and diverse range of programs involving recreational, cultural, informal and sometimes formal, educational activities"; and, 3) to describe approaches that aim towards "enhancing the capacity of a community or individual to engage with their circumstances, and more effectively identify and mobilise resources."[16] It is often the case that the list of interventions considered as "psychosocial" is long, and includes a broad range of approaches and different forms of engaging with individuals and communities. Yet, experts and practitioners interviewed in the course of this review believe that the IASC Guidelines has helped to establish a framework of best practice interventions. While recognising that there is continued debate as to what constitutes a psychosocial intervention, there is now improved consensus around the core principles of the field and efforts to provide interventions following these principles.

In interviews conducted for this review with staff from other humanitarian agencies and actors in the MHPSS field, it was evident that, in order to increase understanding of and support for psychosocial activities, significant policy development, strategic thinking and concerted activities have been required. Some organisations have worked to define psychosocial activities specifically in relation to their mandate – for example, child protection or health programs – and have conducted organisation-wide training in order to promote adoption of psychosocial principles within core programs. Others discussed the role of research and policy guidelines in promoting psychosocial work within their agencies, discussing ways in which they integrate research and evidence on best practices within activities, for example, promoting early childhood development programs within nutrition support activities [see Textbox 2 below].

MHPSS activities are a relatively new and emerging field within the broader field of humanitarian response. Therefore, agencies have found that defining, adopting and integrating the psychosocial approach within core activities has required significant investment in improving understanding and skills associated with psychosocial approaches. It is evident that promoting understanding and support for the psychosocial approach is a challenge for many organisations.

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12 Psychosocial Care and Protection of Tsunami Affected Children: Guiding Principles, http://goo.gl/LyVDT

13 IASC (2007)

14 Terre des Hommes (2008).

15 UNICEF, at http://goo.gl/q3HnS

16 Ager, Strang, & Wessells. (2006).

TEXTBOX 2

Program snapshot: Nutrition and Early Childhood Development [ECD]

The minimum response for MHPSS activities in the food security and nutrition sector in the IASC Guidelines is: "Include specific social and psychological considerations (safe aid for all in dignity, considering cultural practices and household roles) in the provision of food and nutritional support." Beyond this, some agencies – such as International Medical Corps [IMC] and UNICEF – have found that integration of psychosocial activities within nutrition programming improves outcomes of nutrition programs. Children need both nutrition and stimulation to grow and develop. Yet, in emergency contexts mothers may experience depression or other mental health problems, such that they are less likely to care adequately for their children and engage in activities to promote stimulation. Evidence shows that poor mother-child interaction can result in poor child development and growth, such that provision of food alone is inadequate to address the challenges of child malnutrition in emergency settings.[17]

Evidence has shown that early childhood development [ECD] programs integrated within nutrition programming activities can improve growth and developmental outcomes for children. ECD activities include activities that aim to improve mother-to-child interaction, including promoting infant stimulation and play. ECD activities can also work to improve maternal mood, increasing mothers' interaction with children. Most significantly, as IMC has pointed out, "[s]tudies suggest that ECD combined with nutritional interventions has more of a positive effect on child cognitive and physical development than either intervention alone."[18] As such, integration of psychosocial activities is a way to *improve effectiveness* of nutrition programming.

One example, funded by UNICEF and implemented by IMC, consisted of mother and baby group sessions, education for mothers focused on ECD, and home visits, combined with standard emergency nutrition for malnourished babies. Mother and baby groups provided mothers with an opportunity to discuss experiences and learn methods of interacting with their child, and home visits were used to reinforce key behaviours and knowledge. Findings from a controlled intervention, comparing a group of mothers who received both nutrition and ECD activities, and a group who received only nutrition activities, showed that the ECD activities "improve maternal involvement, increase the availability of play materials, and decrease sadness and worry in displaced mothers of malnourished children."[19]

It is important to note that there is increased support for and implementation of combined nutrition and ECD programs for a number of key reasons. Firstly, there is growing literature demonstrating the relationship between integration of psychosocial and nutrition programming and improved outcomes, providing practitioners and advocates with evidence they can marshal to support the integration of psychosocial activities.[20] Secondly, there is specific guidance from the WHO indicating the role of psychosocial approaches in addressing child malnutrition in emergencies, as well as specific guidelines on integrating ECD into nutrition programming.[21] Finally, based on this evidence and guidelines, specific activities, toolkits and training materials have been developed, for example, UNICEF's Care for Development Training Package.[22]

Approach vs. intervention

One debate within the MHPSS field that is relevant to UNHCR's work in this field is whether MHPSS approaches and programs should be separate interventions or integrated within already existing

17 IMC (2012).

18 IMC (2012).

19 Morris, Jones, Berrino, et. al. (2012).

20 Dybdahl, 2001; Morris, et al., 2012; Rahman, Malik, Sikander, Roberts, & Creed (2008)

21 UNICEF & WHO (2012); WHO (2006).

22 UNICEF (2010); UNICEF (2011a).

programs. Williamson and Robinson, focusing on psychosocial programming, argued against the concept of a separate psychosocial sector or set of programs, stating that "[t]he material, biological and psychological aspects of well-being are integrally related, and it is not helpful to try to separate them into separate areas of programming…it is important that *all* interventions with populations affected by armed conflict should be informed by and incorporate a working understanding of the relevance of psychosocial issues."[23] As such, they were arguing for integration of a psychosocial *approach* within all sectors, as distinct from psychosocial *interventions* [see Textbox 3].

TEXTBOX 3

MHPSS approach vs. MHPSS interventions – a definition

The distinction between a MHPSS approach and a MHPSS intervention is a useful framework for thinking about the ways in which UNHCR can engage with and adopt MHPSS activities in an integrated and systematic manner.

The distinction between a MHPSS approach and a MHPSS intervention is drawn from Terre des Hommes' useful framing of psychosocial issues, and its experience integrating psychosocial programming across the organisation.

Terre des Hommes has adopted a framework that highlights the distinction between a psychosocial *approach* and a psychosocial *intervention*, demonstrating potential for integrating a psychosocial approach into a range of activities.

❶ A *psychosocial approach* is defined as "a way to engage with and analyse a situation, build and intervention, and provide a response, taking into account both psychological and social elements, as well as their interrelation."

❷ A *psychosocial intervention* is defined as "composed of one or several activities that aims to increase the coping capacity of children, families and communities, and to reinforce their integration within society."[24]

As such, a psychosocial approach (which is in line with many good humanitarian practices described throughout the Sphere Handbook) can be integrated into any program, and is a way of approaching all components of the program, which has primary objectives in the realm of any sector (e.g. nutrition, shelter, etc). A psychosocial approach, integrated into another program, may ensure that the program also protects dignity and improves psychosocial well-being, as well as achieving its primary objectives – for example, proper nutrition and shelter.

A psychosocial intervention, in contrast, is a program whose primary objective is to improve psychosocial well-being (e.g., group counselling).

The terms MHPSS approach and MHPSS intervention are used in the place of psychosocial approach and psychosocial intervention in this review, to emphasise the need to promote integrated mental health and psychosocial programming within UNHCR. A MHPSS approach is grounded in the principles found in the IASC Guidelines. The distinction between a MHPSS approach and MHPSS interventions brings to light the numerous ways in which UNHCR can engage with MHPSS activities, across multiple sectors.

Integration of a MHPSS approach within existing programs may strengthen them, improve quality and maximise the positive impact of a range of interventions, including water and sanitation, shelter, nutrition and education. However, there are some limitations to this way of engaging with MHPSS

23 Williamson & Robinson (2006).

24 Terre des Hommes (2010).

activities. A salient analogy can be made to that of the role of gender in the humanitarian sector: advocates support the idea of mainstreaming gender concerns, but also recognise the importance of separate programs focused on women's empowerment or protection. The humanitarian sector has sought to address gender issues through mainstreaming – that is, integrating gender analysis and issues within all components of program and policy design, as an "integral dimension of the design, implementation, monitoring and evaluation of policies and programs."[25] Gender mainstreaming is similar to a MHPSS approach, in that it entails integrating gender concerns into all sectors and activities, and is considered to be a process and strategy, rather than a specific intervention. However, critiques of gender mainstreaming have identified the limitations in addressing issues of concern solely through gender mainstreaming. Gender mainstreaming may not address specific disadvantages or challenges men and women face, and specific targeted activities that focus primarily on the goal of gender equality are still needed,[26] and thus is most useful when used to complement interventions, rather than to replace interventions. Similarly, while integrating a MHPSS approach throughout all existing activities is likely to improve quality of response and services, it is also important to address MHPSS needs through specific and targeted activities in some circumstances.

While integrated approaches in humanitarian settings are ideal, the structure of the humanitarian system and humanitarian response makes integration of cross-cutting issues across sectors challenging. If MHPSS needs are only addressed through a MHPSS approach, there is a risk that the issue will disappear from view. For example, in the case of ECD and nutrition, while it is the case that nutrition activities can be improved through incorporating a MHPSS approach into nutrition activities, it is also the case that specific interventions may be needed to address depression amongst some mothers who may not be able to care adequately for their children. As Ager, Strang and Wessells point out, "[i]n some circumstances psychosocial considerations may become a 'cross-cutting issue,' meaning one developed across all projects and programs…Nevertheless, it seems unlikely that such psychosocial concerns will always comprehensively and effectively be met by such means."[27] Integration of a MHPSS approach across sectors can be a way to bring the principles and objectives of MHPSS activities to the fore across all programs. However, it is also evident that MHPSS interventions are needed to achieve key goals and reach groups with specific MHPSS needs. Within UNHCR, there are opportunities for strengthening (and making explicit) a MHPSS approach within core sectors of humanitarian response, while also implementing MHPSS interventions in areas of child protection, response for SGBV survivors, and service provision in the primary health care setting.

25 United Nations Women Watch, at http://goo.gl/f9xFg

26 United Nations Women Watch, at http://goo.gl/bSgBb

27 Ager, Strang, & Wessells. (2006).

2.2 Key influences on the development of the field

Recognition of MHPSS needs in humanitarian settings:

Initial discussions of and approaches to addressing the mental health needs of populations affected by traumatic events, torture and conflict emerged post-World War II, with research focusing specifically on psychiatric problems of resettled refugees from Europe, adopting a clinical approach to treatment needs of these refugees.[28] There was practically a non-existent recognition of and response to the mental health and psychosocial needs of refugees in humanitarian contexts in this period.[29]

A number of humanitarian emergencies brought MHPSS issues to the fore, highlighting MHPSS needs of those affected by conflict and displacement, and increasing attention to the role of MHPSS activities within humanitarian responses. Recognition of MHPSS needs of refugees in humanitarian contexts grew alongside reports on the mental health problems of Cambodian and Vietnamese refugees in camps in Thailand, and these reports influenced the prioritisation of MHPSS response in complex emergencies.[30] The humanitarian response to the crises in Bosnia-Herzegovina and Croatia was a turning point in terms of inclusion of and emphasis on the MHPSS component of humanitarian response.[31] A large number of humanitarian organisations developed and supported activities to address mental health and psychosocial needs, building on national-level response that developed in early stages of the crisis.[32] Some of these activities, including programs supported by the European Commission Humanitarian Office [ECHO}, UNICEF, the International Organisation for Migration [IOM] [33], and the International Federation for the Red Cross, showed emerging understanding of the need for non-psychiatric, community-based interventions to address psychosocial needs, recognising the need to address mental health and psychosocial problems beyond post-traumatic stress disorder [PTSD], and the need to provide integrated services, addressing community and family supports as well as individual symptoms.

The 2004 tsunami was also an important influence on the development of the MHPSS field. The psychological impact of the tsunami was widely recognised.[34] As child protection expert Mike Wessells pointed out after the tsunami, the event shifted the view that psychosocial needs of individuals and communities should be addressed only once basic needs were met. He wrote, "[m]ore than any one single event, the 2004 Asian tsunami brought home to people worldwide the enormity of the psychosocial needs that emergencies create,"[35] showing a "global audience" a "glimpse of the enormity of suffering associated with psychological anguish, social disruptions and forced life transformations caused by the disaster."[36] Recognition of this led to greater acceptance of the argument that mental health and psychosocial needs were concomitant with other needs, and affected other priorities, such as food, security and physical health. The increasingly widespread nature of this understanding is perhaps reflected in media reports of the current Syrian refugee crisis, which have focused heavily on the MHPSS needs of refugees and IDPs fleeing violence.[37]

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28 Ager (1993); Agger (2002).

29 Harrell-Bond (1988); Ratnavale (1981).

30 Mollica & Jalbert (1989); Mollica, Donelan, Tor, et. al. (1993); Mollica, McInnes, Poole & Tor (1998).

31 Agger (2002).

32 Agger & Mimica (1996).

33 IOM (2000).

34 Kostelny & Wessells (2005); Silove & Zwi (2005).

35 Wessells (2009).

36 Wessells & van Ommeren (2008).

37 For example, "Tortured, traumatised, scarred: the children caught up in Syria's war," The Guardian, September 24 2012, at http://goo.gl/0w01V; "Rape is shredding Syria's social fabric," cnn.com, December 5 2012, at http://goo.gl/bjBix; "Syria: Refugees' trauma," BBC Health Check, Dec 24 2012.

Conceptual developments

Alongside the increase in MHPSS activities within humanitarian response, theoretical and conceptual work in the field advanced understanding of the impact of conflict and displacement on individuals and communities. These efforts fed into principles that now form the basis of the IASC Guidelines, and have informed policy and practice in the field.

An early discussion of the impact of the refugee experience on mental health is Ager's 1993 paper discussion of stressors and ameliorative factors impacting refugees' mental health across different phases of displacement: pre-flight, flight, reception and resettlement.[38] Ager's analysis focused on the balance between recognition of the negative mental health impacts of stressors, and the strengths and resiliency of individuals and communities in the face of such stressors, recommending a focus on rebuilding and strengthening social networks.

The Psychosocial Working Group [PWG], a collaboration between academic institutions and humanitarian agencies established in 2000, worked toward developing and improving consensus on goals and best practice in the field. For example, the PWG developed a conceptual framework, defining psychosocial well-being with respect to three domains – human capacity, social ecology, and culture and values, all of which can be influenced by the experience of conflict and displacement. Events and conditions wrought by conflict and displacement may challenge these domains, while available economic, environmental and physical resources can be marshalled to address these challenges.[39] This drive towards a common framework of understanding for the field of MHPSS has now culminated in the IASC Guidelines, described below. Core principles included in the PWG Conceptual Framework and working papers – including commitment to human rights in MHPSS work, participation, do no harm, and building on existing resources – were disseminated in various ways, including publications in journals such as *The Lancet* and *Intervention*,[40] and were included among the core principles in the IASC Guidelines.

This early conceptual and theoretical work influenced the field in multiple ways, including influencing thinking about core principles, improving consensus around best practices, and working on definitional issues to improve communication and collaboration amongst actors in the field. This conceptual work confronted debates and disagreements concerning the ways to conceptualise the impact of conflict and displacement, as well as the appropriate goal and focus of MHPSS activities. As such, this work improved understanding of the breadth and dimensions of psychosocial work, while further delineating underlying principles that should guide interventions. The PWG's work is also notable for its emphasis on the need to design interventions that address locally perceived needs and build upon already existing resources and support systems, emphasising a perspective that "recognize(s) that individuals, families, groups and communities actively deploy the resources available to them in order to shape their world"[41] [see Textbox 5]. A notable limitation of the PWG's work was the lack of focus on the area of clinical mental health, leading to neglect of the topic of how to support people with severe mental disorders in humanitarian settings.

Influences of research

Published academic literature has contributed to an emerging evidence-base regarding the extent and type of impact of conflict and displacement on mental health and psychosocial well-being. Research literature has identified impacts through quantitative studies that have documented mental disorder and mental health symptoms, primarily depression, anxiety and PTSD. The number of quantitative surveys focused on PTSD, depression or both among displaced or conflict-affected populations grew from 25 in the 1980s, to 73 in the 1990s and 83 in the 2000s,[42] reflecting growing

38 Ager (1993).

39 Psychosocial Working Group (2003).

40 Mollica, Cardozo, Osofsky, et. al. (2004); Strang & Ager (2003).

41 Strang and Ager (2003).

42 Steel, Chey, Silove, et. al. (2009).

interest in the issue, and increasing use of standard quantitative methods in challenging field settings. For example, one study compared the prevalence of mental disorders in conflict-affected populations in Algeria, Cambodia, Ethiopia and Palestine.[43] The findings showed PTSD prevalence ranging from 15.8% (Eritrean refugees in Ethiopia) to 37.4% (Algerian peri-urban area exposed to massacres). The number of conflict-related events experienced was significantly related to PTSD in all four samples; apart from this, the four samples showed different relationships between traumatic events, risk factors and mental health outcomes, indicating the importance of understanding and accounting for contextual factors that influence mental health and psychosocial well-being in humanitarian settings [see Textbox 4].

TEXTBOX 4

What are the most important influences on well-being in humanitarian settings?

Multiple studies focused on depression, anxiety and PTSD amongst conflict-affected populations have found a strong association between exposure to trauma and mental health symptoms.[44] However, it is also evident that stressors that are generated by conflict and displacement, such as inadequate housing, unemployment and changes in family structure – sometimes termed as "daily stressors" – are important influences on mental health status, if not more important and pressing than the impact of trauma.[45] For example, Rasmussen et al.'s study of Darfuri refugees in Chad showed that daily stressors – lack of access to basic resources and perceptions of lack of safety – were better predictors of adverse mental health outcomes than trauma experience during war.[46] One study demonstrated the role of stigma in influencing child soldiers' integration in Sierra Leone, with findings showing that current experience of stigma was more highly associated with mental health than previous exposure to trauma.[47] Recent research in Jordan and Nepal has identified the role of unmet needs in mediating the relationship between previous trauma and current distress, indicating that efforts to address current unmet needs may have a significant impact on distress.[48]

The question of what factors comprise the most important influences on the mental health and psychosocial well-being in humanitarian settings is of particular relevance to UNHCR's work. While this is an active debate in the research literature, the fact of the multiple and often common risks and stressors present in camps and urban displacement environments, including risks of sexual and gender-based violence and inadequate livelihood opportunities, is widely recognised by UNHCR. UNHCR staff interviewed for this review discussed numerous stressors present in displacement settings, including waiting in line for long periods for food assistance, inadequate or culturally inappropriate housing and shelter, and lack of access to education. Moreover, procedures associated with protection activities – including registration and resettlement interviews – were described as potential triggers for increased distress.

Mental disorders and psychosocial distress in humanitarian settings may be related to individual's experiences of traumatic events, or may be related to mental disorders that pre-existed displacement. However, it is also evident that basic protection and assistance activities, if not designed and implemented in a timely and quality manner, can have detrimental impacts on mental health and psychosocial well-being. Conversely, core assistance activities – such as shelter, nutrition and education – have the potential to have widespread positive impacts on mental health and psychosocial well-being, and specialised protection activities, including prevention and response to SGBV, can promote psychosocial well-being and prevent distress and mental disorders.

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43 de Jong, Komproe, & Van Ommeren (2003); de Jong, Komproe, Van Ommeren, et al. (2001).

44 Murthy & Lakshminarayana (2006).

45 Miller, Omidian, Rasmussen, et. al. (2008).

46 Rasmussen, Nguyen, Wilkinson, et. al. (2010).

47 Betancourt, Agnew-Blais, Gilman, et. al. (2010).

48 Jordans, Semrau, Thornicroft & van Ommeren (2012).

Systematic reviews, comparing and contrasting findings in the literature and synthesising findings across a range of studies, have shown that a range of risk factors exist for adverse mental health outcomes and poor psychological health. Reviewing a body of epidemiological surveys of traumatic events, PTSD and depression amongst refugee populations, Steel – a clinical psychologist whose research focuses on mental health impacts resettled refugees, refugees in humanitarian contexts, and asylum seekers – found that taking into account the substantial differences in methodology between the studies, torture was "the strongest substantive factor associated with PTSD," while cumulative exposure to potentially traumatic events had the strongest association with depression.[49] Another influence on mental health outcomes was displacement or living in a refugee camp, which resulted in increased symptoms of mental disorder, compared to resettlement in a third country. Another review identified social and economic factors, such as being unemployed, poor living conditions, and demographic factors, such as being female, associated with poor psychological health in conflict-affected populations.[50] In a synthesis of surveys of displaced and non-displaced populations, conducted globally and across five decades, Porter and Haslam found that post-displacement factors, such as restricted economic opportunity and living in institutional accommodation, was associated with poorer mental health outcomes.[51] These systematic reviews provide insight into a number of aspects of the research literature; firstly, there is a growing body of evidence focusing on mental health of refugees in humanitarian settings. Secondly, analysis of these studies provides insight into a number of important risk factors and outcomes. Finally, however, methodological differences between the studies have limited direct comparability and there are a number of unresolved issues in terms of sampling, measurement and diagnostics.

Research has also identified the need to engage with local idioms of distress and culturally-specific expressions of mental health and psychosocial problems. For example, in addition to quantifiable risk and protective factors, research has discussed the role of religion and coping, proper burials and mourning rituals, the role of economic activity, and the role of community belonging in influencing psychosocial well-being amongst conflict-affected populations.[52] Specific contextual and cultural factors shape expressions of mental distress; for example, a study of South Sudanese refugees in Cairo demonstrated the extent to which physical and mental health are intertwined with individuals' refugee experiences, with cultural dislocation, loss of family and friends, and difficulties living as a refugee in Cairo manifesting in forms of pain described in physical and psychological terms.[53] Qualitative studies suggest that while the amount of violence to which individuals and communities are exposed clearly impacts mental health outcomes and psychosocial well-being, there is also a need to investigate the ways in which individuals and communities perceive the violence and its impacts, and to assess culturally acceptable forms of coping and expressing distress.

Specific mental disorders – such as PTSD, anxiety and depression – are associated with difficulty functioning, which can directly impact physical health, social functioning, livelihoods and household well-being. Symptoms such as anger and aggression can result in increased household and communal violence; feelings of hopelessness and fatigue may increase isolation of already vulnerable individuals. Recent NGO-led MHPSS needs assessments describe some of these issues. For example, a MHPSS needs assessment of Syrian refugees in Northern Lebanon in 2011 showed that refugees' most commonly cited problems included lethargy, sleeping disturbances, loneliness, anger, and feeling empty. Refugees described these problems as affecting relationships with children, social interactions and health, and resulting in problems with functioning, including self-neglect, decreased participation in daily activities, and decreased capacity to care for children.[54] An IOM study of Iraqi refugees in Syria and Jordan in 2007 found widespread sleep problems, nightmares, appetite problems, fatigue, anger and anxiety amongst displaced families, with uncertainty of legal status, lack of ability to work, and lack of ability to plan for the future commonly

49 Steel, Chey, Silove et. al. (2009).

50 Roberts & Browne (2011).

51 Porter & Haslam (2005).

52 Batniji, Van Ommeren & Saraceno (2006).

53 Coker (2004).

54 IMC (2011).

cited as key influences on psychosocial well-being.[55] Taken as a whole, this body of research demonstrates that mental health and psychosocial issues are of great relevance and importance to the humanitarian community in their efforts to improve protection and well-being of PoC.

TEXTBOX 5

Resources and resilience

Within the field of MHPSS, some academics and practitioners have expressed concerns that some approaches and interventions are based within a "deficits" model, assuming that people affected by conflict or disaster are all helpless and traumatised. This approach would actually increase harm and disempower individuals and communities.[56] These researchers have advocated for the adoption of a resilience approach, defined as an approach that "emphasises the importance of self-help, social mobilisation, and collective empowerment."[57] While it is understandable, and important, to identify the needs of affected populations, using also a resilience approach would allow UNHCR to identify key protective factors and systems already in place in affected communities that can be developed and enabled through support and assistance. Focus not only clinical mental health problems, but also on resilience is justified by the fact that in many humanitarian contexts, the majority of individuals exposed to trauma do not develop psychiatric conditions, symptoms of mental disorders often reduce over time without clinical interventions, and forms of community support and local resources may be effective in addressing mental health and psychosocial problems in humanitarian contexts.[58]

Researchers focusing on MHPSS in humanitarian settings have identified important factors influencing resilience and evidence of resources marshalled in the face of extreme adversity. For example, Betancourt's studies of reintegration of child soldiers in Sierra Leone have identified the importance of social support and family and community structures, showing that community acceptance was an important protective factor that is significantly associated with reduced depression and improved pro-social behaviours amongst children over time.[59] A longitudinal study of Palestinian and Israeli children found that positive parenting and high self-esteem acted as protective factors for children exposed to trauma, leading to lower PTSD symptoms.[60] A recent systematic review of resilience amongst children and adolescents living in conflict-affected settings found support for a "perspective of resilience as a complex dynamic process driven by time- and context-dependent variables," indicating a need for interventions that provide key supports for children and youth – in particular, parental support and monitoring – but that are tailored to specific contexts in order to address the context-specific dynamics of resilience.[61]

Recognition and analysis of these influences such as this allow for targeted interventions and supports to improve already existing positive influences on resilience and identify gaps that may negatively impact psychosocial well-being. Some UNHCR activities – such as participatory assessments and community-based protection approaches – seek to identify resources and build on resilience factors. However, the nature of funding and design of MHPSS interventions within UNHCR – and, broadly, within the field – is that activities largely respond to and target particular "vulnerabilities." As such, including of a resilience perspective may be a challenging activity for UNHCR.

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55 IOM (2008).

56 Betancourt & Khan (2008); Wessells (2009).

57 Wessells (2009).

58 Miller, Kulkarni, & Kushner (2006); Jones (2008).

59 Betancourt, Borisova, Williams, et. al. (2010); Betancourt, Brennan, Rubin-Smith, et. al. (2010).

60 Dubow, Huesmann, Boxer, et. al. (2012).

61 Tol, Song & Jordans (2013).

2.3 Emerging consensus – The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

The Guidelines, developed in 2007, have had a considerable conceptual and practical impact on definitions and practices in the field. The Guidelines represent an important step towards generating consensus around minimum standards of MHPSS in emergencies, reflecting a political achievement that enables greater coordination in a field of practice with considerable theoretical and political disagreements.[62] The Guidelines primarily sought to increase consensus around the main principles underlying MHPSS activities, thus promoting improved coordination and collaboration between agencies working on MHPSS issues.

The Guidelines are based on six key principles: human rights and equity; participation; do no harm; building on available resources and capacities; integrated support systems; and multi-layered supports. The Guidelines are then comprised of a matrix of interventions under the categories: common functions, core mental health and psychosocial supports, and social considerations in sectors, with each function containing key steps in three phases of response: emergency preparedness, minimum response, and comprehensive response. This organisation of the Guidelines mirrors previous versions of IASC Guidelines on different topics, with the addition of a new set of activities, "community mobilisation and support." These key activities include the following minimum responses actions:

5.1 "Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors;

5.2 Facilitate community self-help and social support;

5.3 Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices; and

5.4 Facilitate support for young children (0–8 years) and their care-givers."

The inclusion of community mobilisation and support, at the same level as activities such as health and education, emphasises the key principles of participation and ensuring that implementation of MHPSS activities is done in a way that builds on local resources and support networks.[63]

Perhaps the single most influential component of the Guidelines has been the Intervention Pyramid [Figure 1], reflecting the principle that MHPSS actors should coordinate to provide multi-layered supports, encompassing different levels and kinds of need for supports. The Intervention Pyramid is described by the co-chairs of the IASC MHPSS Task Force at the time of Guideline development as "a 'home' for different sorts of MHPSS activities, emphasises their complementarities, and underscores the importance of coordination and referrals across levels."[64] These varying levels of intervention are designed to meet the needs of different groups of affected people – basic services and security should be provided to all people in a manner that is safe and protects their dignity; community and family supports are required for those who will be able to maintain psychosocial well-being if provided with key community and family supports; focused, non-specialised supports are necessary for those "who additionally require more focused individual, family or group interventions by trained and supervised workers"; and specialised services for those who are suffering more severe symptoms and have impaired daily functioning.

The pyramid approach is reflective of similar models in public health prevention and promotion work. For example, similar pyramids focused on public mental health suggest activities at a population-level be implemented in order to prevent mental disorders and promote positive mental

62 Ager (2008).

63 Wessells & van Ommeren (2008).

64 Wessells & van Ommeren (2008).

health, an approach that maps conceptually and practically with Level 1 activities in the Intervention Pyramid.[65] These activities, while firmly within the realm of psychosocial approaches, are connected to the more clinically-focused, targeted mental health interventions. For example, universal, broad-based interventions provide a basis from which to reduce stigma associated with mental distress or disorder, identify individuals who may be at-risk of developing problems, and refer them to appropriate services.

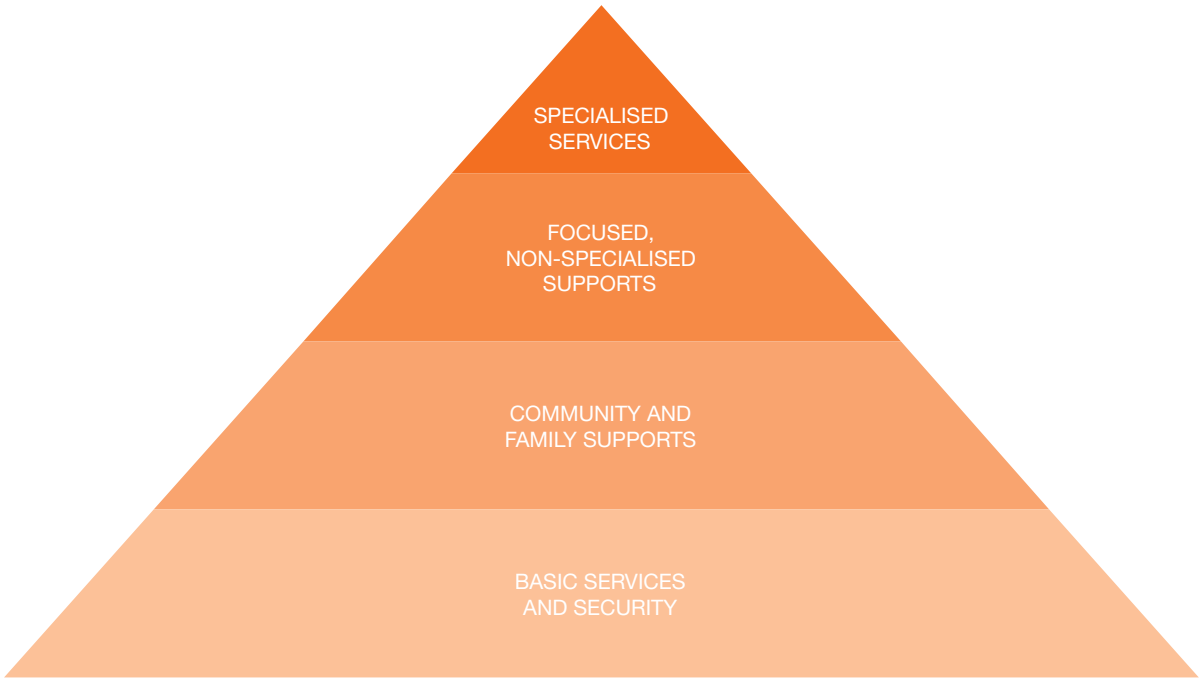

Figure 1: IASC Guidelines Intervention Pyramid

Within the Intervention Pyramid, the following levels of activities are represented:

Level 1: Social considerations in basic services and security: This level encompasses core humanitarian actions designed to meet basic physical needs, including food, shelter, water and health care, and security needs. Responses at this level should integrate social and cultural considerations into these services, including activities that protect local people's dignity, strengthen local social supports and mobilise community networks. Inclusion of this level in the Guidelines indicates recognition that modes of delivery of key humanitarian services have significant implications for mental health and psychosocial well-being of affected persons in a humanitarian context. *Example: UNHCR incorporates social considerations into planning of appropriate shelter and site planning, for example, ensuring communal space and safe layout to prevent protection risks.*[66]

Level 2: Community and family supports: This level is for the smaller number of people who may need support accessing key community and family supports in order to maintain good mental health and psychosocial well-being. Examples of activities at this level are: family tracing and reunification, assisted mourning and communal healing ceremonies, supportive parenting programs, formal and non-formal educational activities, livelihood activities, women's groups and youth clubs. *Example: UNHCR Nepal has supported Youth Friendly Centres in refugee camps for Bhutanese youth between 18-25, providing space for educational and social activities, as well as establishing a Mentor-Mentee system for youth to reach out to vulnerable youth in the community*.[67]

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65 Miles, Espiritu, Horen, et. al. (2010).

66 Interview, UNHCR staff member, July 30 2012.

67 Interview, UNHCR staff member, August 28 2012.

Level 3: Focused, non-specialised supports: This level is directed at the still smaller group of people who require additional support, whether individual, family or group interventions, for example, social and livelihood programs for survivors of SGBV. This level of support is delivered by trained and supervised workers, and includes psychological first aid [PFA] and basic mental health care in primary health care settings. *Example: UNHCR Yemen supports screening, assessment and treatment of refugees in primary health care settings, including referrals for psychosocial support, counselling, or psychiatric treatment if needed.*[68]

Level 4: Specialised services: This level is directed at the small percentage of the population for whom mental health and psychosocial issues impair daily functioning and cause significant suffering. This includes psychological and psychiatric support for segment of the population who have severe mental disorders, such as referral to specialised services where possible. *Example: UNHCR Ethiopia sends psychiatrists on regular visits to refugee camps, to support training, review medication, and for direct consultation on cases of severe mental illness.*[69]

The levels of the Intervention Pyramid also demonstrate ❶ the distinction between a MHPSS approach and a MHPSS intervention, ❷ the necessity of both approaches and interventions in order to comprehensively meet MHPSS needs across levels of severity of symptoms and disorders, and ❸ the potential for approaches and interventions to the mutually reinforcing. For example, where social considerations are taken into account in site and shelter planning (a Level 1 intervention), presence of communal safe spaces and culturally appropriate shelter can reinforce Level 2 interventions addressing social isolation through establishment of support groups for individuals with specific vulnerabilities, while a Level 3 intervention focusing on addressing maternal depression may be reinforced by a nutrition intervention at Level 1, addressing malnutrition of infants while simultaneously encouraging infant stimulation through mothers' groups.

TEXTBOX 6

Program snapshot: Community spaces

One approach to providing MHPSS activities is provision of services, activities and support through community centers. One example of this is Casa de Derechos [House of Rights], a community center that is a joint effort between UNHCR, the Municipality of Desamparados and other implementing partners, in San Jose, Costa Rica. Of the 20,057 refugees in Costa Rica, the majority are Colombian, and have resided in urban areas for more than 8 years.[70] UNHCR's operation is focused on local integration of refugees, and as such, supports a number of activities, such as Casa de Derechos, that provides services and activities to achieve this durable solution.

The center provides a range of services and activities, including microfinance, public health outreach, legal services and support groups to refugees and the local community. 'Diversity groups' of members of the refugee population have been established to support youth, men and women to discuss common problems and interests.[71] The center hosts a number of programs provided by other agencies and partners, including a legal aid clinic, a program focusing on youth and vocational training, and a labour rights program.

The focus on multiple, integrated activities came from recognition from UNHCR and other actors that Colombian refugees often had a range of mental health and psychosocial issues such that "it's going to be quite difficult for them to integrate because maybe they have so many other issues that they need to resolve somehow before getting to the point where they

68 UNHCR (2011c).

69 Interview, UNHCR staff member, August 27 2012.

70 UNHCR Costa Rica, at http://goo.gl/LQaS3

71 Interview, UNHCR staff member, August 22, 2012; UNHCR (2011a).

can actually apply for a job and go to the job interview and actually get the job or use micro credit effectively."[72] The center also responds specifically to the needs of urban refugees in this context, given in San Jose, "[r]efugees don't have any places where they would naturally get together. So we needed to establish those bases for them. They might not know any other refugees. So, it's about trying to facilitate those basic processes."[73]

A review of UNHCR Costa Rica's implementation of UNHCR's urban refugee policy presented a number of findings on Casa de Derechos, including, "There has been a positive response amongst refugees, migrants and nationals to their mutual interaction at the Casa de Derechos. The centre has allowed people to confront stereotypes and learn skills to live together in greater harmony," and that there is a "high degree of satisfaction" with the vocational training program provided at Casa de Derechos.[74]

There is a specific focus within the center on survivors of SGBV, who are able to access counselling and support groups. An evaluation of UNHCR's AGDM activities described this program as "a model for dealing with SGBV cases," given staff are well-trained in provision of legal and psychosocial support, and partner organisations refer SGBV survivors to the center for support.[75] As such, the center provides both Level 2 and Level 3 activities from the Intervention Pyramid, providing focused and specialised support to SGBV survivors, and activating social support networks amongst refugees through provision of a place to meet and interact, as well as provision of other services to facilitate local integration.

Use of the Guidelines in the MHPSS field

Use and dissemination of the IASC Guidelines by various actors in the humanitarian sector has taken many different forms. In a recent example, the IASC Guidelines have been used to guide MHPSS response to the Haiti earthquake. The IASC Guidelines were used in Colombia, resulting in establishment of co-ordination groups, identification of priority needs and possible responses in specific municipalities, increased awareness of MHPSS issues amongst Government and non-governmental actors, and integration of key principles into local policies.[76] In UNHCR's activities, UNHCR Ethiopia used the Guidelines for training and capacity-building.[77] A key activity has been capacity-building, using the Guidelines as the basis of training in multiple settings. Moreover, the Guidelines have been adapted for use in national policies, for example, in the Philippines,[78] or used as the basis of guidance used to respond to the specifics of particular emergencies, such as in Kenya.[79] Training and capacity-building continues to play a significant role in dissemination of the Guidelines, for example, World Vision and the War Trauma Foundation are supporting a training on the IASC Guidelines for MHPSS practitioners and leaders from Myanmar, Nepal, India, Pakistan, Bangladesh, Sri Lanka, and Afghanistan, to train individuals who can play a key role advocating for the Guidelines in the South Asia region.

Staff from agencies in the humanitarian sector interviewed for this review offered various reflections on the impact of the Guidelines on their work and the field more broadly. Firstly, increased and improved communication was evident to many. The Guidelines have offered and clarified definitions and principles around MHPSS activities, providing a common language whereby individuals from different agencies working in a field-setting can collaborate to map activities, identify interventions as fitting into certain levels of the Intervention Pyramid, identify gaps in services using this common

72 Interview, UNHCR staff member, August 22, 2012.
73 Interview, UNHCR staff member, August 22, 2012.
74 UNHCR (2011a).
75 Groves (2012).
76 Echeverri & Castilla (2008).
77 Schilperoord, Buffoni & Kouyou (2008).
78 Melville & Rakotomalala (2008).
79 Horn & Strang (2008).

Libya / Misrata / Women and a child from Misrata walk through Tripoli.
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framework, and assess the collective humanitarian response [see Textbox 7 below]. For example, a respondent from an international agency cited an example of all agencies working on MHPSS activities in a humanitarian situation meeting together to map their activities against the Intervention Pyramid, and realising that the response was heavily skewed towards clinical responses, prompting a shift in allocation of resources and attention.

The Intervention Pyramid has helped to promote a sense of integrated, holistic response. The use of the composite term, MHPSS, has encouraged practitioners focused on mental health work to consider the role of psychosocial and community-based activities in improving mental health, and practitioners focused on psychosocial work to consider referrals and linkages to clinical services where appropriate. As Wietse Tol noted in an interview, the Guidelines "incorporate views from both the psychiatric and psychosocial paradigms. So now we have this public health framework with primary, secondary and tertiary preventive interventions and the psychosocial practitioners seem comfortable at the bottom of the pyramid and the specialised mental health professionals seem more comfortable at the top but at least they realise that they're all part of the same pyramid working towards the same goal. So, I think it's been a very helpful exercise."[80]

80 Interview, July 26 2012.

TEXTBOX 7

The 4Ws: mapping MHPSS activities

The IASC MHPSS Reference Group developed the 4Ws tool, to map *who* is *where, when,* doing *what* in the field of MHPSS activities. As listed in the guide, the tool can serve the following purposes:

1. Providing a big picture of the size and nature of the MHPSS response
2. Identifying gaps in the MHPSS response to enable coordinated action
3. Enabling referrals by making information available about who is where, when, doing what
4. Informing appeal processes (e.g. Consolidated Appeal Process)
5. Improving transparency and legitimacy of MHPSS through structured documentation
6. Improving possibilities for reviewing patterns of practice and for drawing lessons for future response.[81]

In summary, the 4Ws mapping tool "enables actors to identify and respond to gaps in services and foster collaboration, coordination, referral and accountability."[82] The 4Ws tool was developed after the IASC Guidelines, and has provided a means for co-ordination and communication as endorsed by the Guidelines, as well as a way of understanding the focus, scope and approach of MHPSS activities in a number of humanitarian settings. The "what" is divided into activities that are community-focused, such as safe spaces, strengthening family and community supports, and information dissemination, and person-focused, including individual counselling, psychological first aid, pharmacological and non-pharmacological management of mental disorders, and in-patient mental health care.

4Ws mapping exercises have been conducted in Haiti,[83] Dadaab (Kenya), Nepal, Jordan,[84] and Libya.[85] Findings and impacts of the process have been varied. In Haiti, the information was used for advocacy and influenced broader humanitarian response. In Syria, a 2011 4Ws focused on MHPSS activities for Iraqi refugees showed geographic inequities in services.[86] Mapping in Libya showed that activities were disproportionately focused on specialised mental health services, and the process resulted in improved linkages between actors providing services in the field.[87]

Analysis of multiple 4Ws processes concluded, "it appears to be a useful instrument to encourage collaboration between MHPSS actors, identify gaps and overlap in service delivery, develop a common language of implementation and programming, and strengthen the sense of community among MHPSS practitioners in the field."[88] One limitation of the process is that it does not capture program quality. It only captures the existence of MHPSS activities, and not their outcomes or impact.

81 IASC MHPSS Reference Group. (2012).
82 O'Connell, Poudyal, Streel, et. al. (2012).
83 MHPSS Working Group - Haiti. (2010).
84 Baca, Fayyad, Marini & Weissbecker (2012).
85 Fitzgerald, Elkaied & Weissbecker (2012).
86 O'Connell, Poudyal, Streel, et. al. (2012).
87 Fitzgerald, Elkaied & Weissbecker (2012).
88 O'Connell, Poudyal, Streel, et. al. (2012).

The 4Ws tool was also used to map 160 programs globally, identifying the most commonly implemented programs in humanitarian contexts from 2007-2010, finding that the most commonly implemented activities include counselling for individuals, families and groups; facilitation of community support to vulnerable individuals; child-friendly spaces; provision of information; and psycho-education. These results led to the conclusion that MHPSS activities are primarily implemented "outside of national mental health, protection and education systems, and with little emphasis on evidence-based practices."[89] The increasing use of the tool and reports of the utility of the exercise in improving co-ordination and information-sharing is encouraging, and represents a step towards further establishment of best practices and principles in the MHPSS field.

Another impact of the Guidelines that was described in the course of this review was the increased use of inter-sectoral MHPSS co-ordination groups, instead of a separate psychosocial group and separate mental health group, which has significantly reduced conflicting priorities and approaches, and improved collaboration. Moreover, a number of key informants discussed the role of the Guidelines as an internal advocacy tool within organisations with multiple priorities and programs, as a way to 1) promote particular principles, 2) bring programs into line with principles promulgated in the Guidelines, and 3) draw further attention to and support for MHPSS activities within a larger organisation. One practitioner at an international organisation stated that the IASC Guidelines "[g]ave all of us, people like me, an instrument to use to reinforce my discourse inside the organisation. So whenever someone shows me a program focused only on PTSD, I can call them and say – "Listen, this is not only against our internal guidance, but it's also actually against the Guidelines rules."[90] The fact that the Guidelines are endorsed at the level of the IASC gives individual staff in agencies increased leverage in arguing for support for MHPSS activities. Respondents also discussed ways in which they have used the Guidelines to improve quality or change the orientation of specific programs. For example, one respondent discussed using the Guidelines as a tool to re-orient a program that had been heavily trauma-focused and not responsive to community needs, towards a community-based approach, based on principles in the Guidelines.

The Guidelines offer a set of principles – telling actors "what" to do, rather than "how" to do it. They do not aim to offer programming details, but rather represent a tool for co-ordination, advocacy, and developing policy. Many respondents described translation from principles in the Guidelines to practices in the field as a challenge. The presence of the IASC Guidelines has not eliminated MHPSS activities that deviate from the IASC principles – for example, short-term trainings on trauma or programs focused psychological debriefing. However, it is clear that the Guidelines have significantly impacted the MHPSS field, in terms of 1) consolidating principles, 2) creating a common language and, 3) providing tools to actors seeking to coordinate and promote MHPSS activities. Despite this, respondents from within and outside UNHCR, consistently described UNHCR's engagement with the Guidelines as limited and lacking, as is discussed further in Section III.

The field of MHPSS activities is characterised by improved consensus and co-ordination, while still developing best practices and working towards increased operationalisation of principles in the IASC Guidelines. One particular challenge in the field that is highly relevant to UNHCR – how to best evaluate MHPSS programs – is discussed below in Textbox 8, as limitations in evaluation of MHPSS activities has a significant impact on understanding of and support for MHPSS within the humanitarian sector broadly.

89 Tol, Barbui, Galappatti, et. al. (2011).

90 Interview, staff member international agency, July 23 2012.

TEXTBOX 8

The challenge of evaluation

There are multiple challenges in the field of evaluation of MHPSS activities. A MHPSS expert from one of UNHCR's implementing partners noted, "donors are always saying – what about the outcomes? Mental health – it's not like a vaccination campaign where once the child is vaccinated, they're OK. I think that is one of the reasons that organisations or even donors stay away from mental health because they feel like they can't measure it, they can't somehow pin it down. So I think we even have the bigger responsibility there to really show impact."[91] Firstly, it is often difficult to capture the impact of programs given the lack of baseline data. For example, child friendly spaces are often assessed using methods that do not compare children's well-being to a time-point prior to the emergency, or prior to the establishment of the child-friendly space, as this data rarely exists.[92] As such, evaluations can only draw limited conclusions as to the impact of the specific activity implemented. These evaluations are unable to distinguish broader trends in improved psychosocial well-being due to time lapsed from the emergency, or other improved social conditions, compared to the actual impact of the intervention itself.

Secondly, the question of availability of appropriate, feasible and effective research methods emerged throughout this review and is present in the research literature. This issue applies to the selection of appropriate indicators or outcome measures to assess mental health and psychosocial issues. There is a wide range of measures, for both child and adult populations, that have been developed and utilised in Western settings to assess functioning and common mental disorders such as depression and anxiety. However, utilising these measures without any adaptation risks assessing for symptoms and disorders that are not locally relevant or prevalent. Yet, there is a growing literature attesting to the value of piloting, adapting and developing measures that are contextually specific. Selecting and adapting appropriate measures of symptoms of mental disorders and psychosocial distress is one of the most challenging components of evaluation in this field, however, mental health researchers are often expert in the field of instrument development and measurement, and research methodologies are developing that can address the challenges of measuring mental health symptoms in humanitarian settings.

As a field, there have been notable advances in evaluation of MHPSS interventions. For example, high-quality randomised controlled trials of specialised interventions have been implemented and findings have strongly influenced the field, both in terms of adoption of particular interventions and in terms of influencing beliefs about the feasibility of randomised controlled trials in field settings.[93] However, methods to assess more commonly implemented interventions in the field of MHPSS in humanitarian settings lag behind. For example, MHPSS activities may not constitute a single activity, or intervention, that can be evaluated, potentially resulting in evaluations overlooking important impacts of activities. Evaluation methods to capture the impact of diffuse and broad interventions are also needed in order to adequately capture the true scope of the impact of MHPSS activities.

Monitoring and evaluation systems set up in order to assess UNHCR Syria's MHPSS program are illustrative of the ways in which various tools and approaches can be incorporated into MHPSS activities in order to understand outcomes and impact. From the beginning of the activities in the Syria program, a strong evaluation component was integrated, based on specific funding for evaluation and collaboration with an academic institution. The evaluation methods included development of quantitative measures to assess specific symptoms expressed by refugees, a survey to assess impact of activities, and in-depth interviews to identify negative and positive coping strategies within the community. In addition to process and output measures – for example, monitoring of numbers and types of beneficiaries and activities, UNHCR Syria's

91 Interview, staff member international agency, July 19 2012.

92 Ager & Metzler (2012).

93 Bass, Neugebauer, Clougherty, et. al. (2006); Bolton, Bass, Neugebauer, et. al. (2003); Rahman, Malik Sikander, et. al. (2008).

MHPSS program developed a contextually relevant survey instrument to enable comparison of baseline to post-intervention results, for example, for case-management clients, enabling an assessment of symptoms of distress and functioning prior to case management and after.

These methods have generated data concerning the impact of the program, for example, showing the impact of case management on clients' symptoms or the forms of social support that refugees drew on in order to cope with stress. This has enabled UNHCR to adapt and inform the program based on these findings. Moreover, this data has provided a tool for advocacy. Using the evaluation results, program staff are more able to make the case for the effectiveness and necessity of the program as a part of the response to humanitarian crisis in Syria.

Throughout this review, academics, UNHCR staff, and MHPSS practitioners from other organisations identified the issue of implementing high-quality monitoring and evaluation activities as a challenge in the field of MHPSS. The case of UNHCR Syria's program activities indicate the potential for integrating monitoring and evaluation systems within programs. Moreover, as discussed further in Section IV, UNHCR has a set of assessment and monitoring tools that can form the basis of improved activities in this area.

Having presented definitions of MHPSS and identified the primary influences on the development of a field, this review will turn to the question of where UNHCR fits within this field, mapping its current activities, presenting specific examples from field settings, and analysing relevant UNHCR's policy guidelines and approaches.

A boy plays football amid the destruction in Siddiqine.
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3. UNHCR and MHPSS: mapping activities and policies

Data collected in the course of this evaluation is presented here, in order to identify the current role of UNHCR in MHPSS activities, and identify gaps and challenges in this role. Findings from an online survey mapping current UNHCR activities and attitudes towards MHPSS activities are presented here. Further, a description of UNHCR Syria's MHPSS program, and emerging themes and issues in MHPSS response in neighbouring host countries (focusing on Jordan and Lebanon) is provided. Finally, current policies and guidelines are analysed, and principles to guide UNHCR's approach to MHPSS are identified.

3.1 Survey findings

145 respondents provided input into the online survey, with responses coming from 55 countries.

Table 1: Respondents, by region

Region	Number of responses (%)
Africa	53 (37%)
Asia	37 (26%)
Americas	12 (8%)
Europe	18 (12%)
MENA	25 (17%)

Table 2: Attitudes towards MHPSS

Question	Response	%
MHPSS programs contribute towards protection of Persons of Concern	Strongly agree	59%
	Agree	37%
	Disagree	4%
	Strongly disagree	0
Partnerships with implementing partners are an effective means of implementing MHPSS programs	Strongly agree	41%
	Agree	52%
	Disagree	6%
	Strongly disagree	1%
The impact of MHPSS programs are easy to identify	Strongly agree	19%
	Agree	46%
	Disagree	34%
	Strongly disagree	1%
There are clear monitoring and evaluation systems in place to assess the impact of MHPSS activities in my operational areas	Strongly agree	9%
	Agree	27%
	Disagree	53%
	Strongly disagree	11%
MHPSS activities are integrated into other programs in my operational area	Strongly agree	10%
	Agree	49%
	Disagree	30%
	Strongly disagree	10%

Findings from this survey indicate that amongst respondents, there is overwhelming agreement that MHPSS activities provide for protection of PoC and partnership with implementing partners is an effective means of provision of MHPSS activities. 65% of respondents agreed or strongly agreed that the impacts of MHPSS activities are easy to identify. Some respondents provided insight into some of the difficulties UNHCR staff experience in identifying the impacts of MHPSS activities. Results indicate that the nature of MHPSS issues – for example, that symptoms may be difficult to recognise or primarily located in thoughts or feelings that are difficult to assess – leads to difficulty in identifying impacts of programs, for example, one respondent stated, "The results or impact of mental health programs is one of the most difficult areas to measure or see the impact." Another respondent reported,

> *"Often because of the nature of the MHPSS, the impacts are internal and not external and also qualitative rather than quantitative. However, they* [MHPSS activities] *go a long way in assisting the beneficiaries directly and the impact is easy to identify for the clinicians and practitioners working directly with the beneficiaries and for the case workers who have had prior contact with the beneficiary."*

Other respondents identified lack of resources or capacity to assess impacts as barriers. One respondent stated,

> *"There is limited time, resources and capacity in general to measure outcomes. The focus of reporting is on output UNHCR programme and reporting (e.g. objectives, indicators do not appropriately reflect MHPSS programme components)."*

The importance of identifying methods to assess impacts of MHPSS activities for UNHCR is further discussed in Section IV [see *Challenge 2].*

64% of respondents either disagreed or strongly disagreed that there are clear monitoring and evaluation systems in place to assess the impact of MHPSS activities, indicating recognition of the significant gaps in UNHCR's capacity to assess the impact of MHPSS activities, which is also discussed in Section IV. One respondent wrote,

> *"Although the impact of MHPSS support is real, the tools to assess the impact are not established, hence many people are unable to see the added value of such important interventions, specially during the emergency phase. The community services officers normally face great challenges to get the required support for such interventions."*

Another respondent discussed the barriers to monitoring and evaluation of MHPSS activities:

> *"Impacts can only be measured if you have robust M & E systems in place and quantitative data is gathered alongside qualitative data from the beginning of the program. This is difficult if you have an implementing partner who may not have these data management systems set up. Impact also implies a baseline is taken at intake, which is easier to do for mental health case management (look at client functioning and individual goal attainment) than for psychosocial support - e.g., refugees attending an outreach counselling centre."*

Finally, 40% of respondents disagreed or strongly disagreed that MHPSS activities are integrated into other programs.

Table 3 displays responses to the question: "The need for MHPSS programs is identified through…" Most commonly, respondents reported relying on participatory assessments, reports from implementing or operational partners, and requests from community-based organisations or refugee groups to identify MHPSS needs. Only 33% of respondents reported relying on requests or reports from Headquarters, which may likely reflect that MHPSS needs are better identified at the field-level through the reported methods. Respondents also indicated other methods of identification, including direct requests from refugees and identification of individuals in regular operations, including reception days and interviews.

Table 3: Responses to the question: "The need for MHPSS programs is identified through…"

Identification method	%
Participatory Assessments	85%
Reports from Implementing or Operational Partners	79%
Requests from Community Based Organisations and/ or Refugee Groups	76%
Requests or recommendations from Headquarters	33%
Other	27%

MHPSS mapping

The survey [see Annex 4] included a section mapping the MHPSS activities of various sectors. This mapping was designed to capture the presence of both MHPSS *approach* and MHPSS *interventions* within UNHCR – for example, assessing the presence of inclusion of social and cultural issues within WASH activities while also capturing the presence of direct MHPSS interventions, such as in-school support for students experiencing psychosocial and mental health difficulties or the non-pharmacological (not using drugs) management of mental disorders. Moreover, it was designed to span sectors and areas of operation across UNHCR, rather than focusing only on Health and Community Services activities. As is the case with the 4Ws mapping activity, the survey was not able to capture the *quality* of the activity, and, moreover, the extent to which the activity is understood by staff as a MHPSS activity and is guided by MHPSS principles.

It is important to note that this form of mapping does not address reasons why certain activities may not be present – in some cases, this may be due to a gap in programming, whereas in other cases this may be due to the context – for example, that UNHCR does not work in the shelter sector, or that educational activities are primarily provided through the Government. Moreover, lack of a reported activity from a certain country does not indicate that this activity does not exist in the country, but that respondents who completed the survey did not report these activities.

Area/ sector	Activity	Country										
		Chad	Ecuador	Ethiopia	Kenya	Malaysia	Pakistan	South Sudan	Sudan	Syria	Tanzania	Yemen
Water and sanitation and hygiene promotion												
Inclusion of social and cultural issues in WASH activities		•		•	•		•	•		•	•	•
Community participation in planning and implementation		•		•	•	•	•	•	•		•	•
Using the community members to monitor and give feedback on WASH activities		•		•			•	•	•		•	•
Nutrition												
Programs to encourage mother-child bonding and interactions		•		•	•		•				•	•
Programs directly aimed at improving mothers' psychosocial well-being to improve feeding practices (i.e. baby friendly tents)		•	•	•	•	•					•	•
Integration of early childhood development activities with health and nutrition interventions		•		•							•	•
Activities to maximise participation in the planning, distribution and follow-up of food aid		•		•			•	•	•	•	•	•
Inclusion of social and cultural considerations in distributing food assistance		•		•			•		•	•	•	•
Shelter												
Use of a participatory approach to site or settlement planning		•		•	•		•	•	•	•	•	•
Site and settlement designs that include social and cultural considerations		•		•	•		•	•		•	•	•
Inclusion of communal spaces and safe spaces in site design		•		•	•		•	•		•	•	•
Approaches that maximise privacy, ease of movement and social support				•	•		•	•		•	•	•
Support for people who are unable to build their own shelters		•		•	•		•	•	•		•	•
Education												
Promotion of both formal and non-formal education		•	•	•	•	•	•		•	•	•	•
Measures to create Safe Learning Environments		•		•	•	•	•		•	•	•	•
Training for teachers on awareness of psychosocial issues, including recognising psychosocial distress		•			•	•	•	•		•	•	•
Inclusion of life skills development in education		•			•	•		•	•	•	•	•
Play and sports-focused activities		•	•		•	•		•	•	•	•	•
In-school support for students experiencing psychosocial and mental health difficulties					•					•	•	•
Options for referral pathways for children experiencing psychosocial or mental health issues		•			•	•	•		•	•		•
Inclusive education for children with diverse needs e.g. children with disabilities, ethnic minorities, children living with HIV/ AIDS		•	•		•	•	•		•	•	•	•
Support groups for teachers		•				•	•					
Mechanisms for community consultation/ participation in education		•		•	•	•	•	•	•	•	•	•
Focused activities for young people		•	•	•	•	•	•		•	•	•	•

Area/ sector	Activity	Country										
		Chad	Ecuador	Ethiopia	Kenya	Malaysia	Pakistan	South Sudan	Sudan	Syria	Tanzania	Yemen
Protection												
	Apply an Age, Gender and Diversity perspective to all protection and assistance interventions	•	•	•	•	•	•	•	•	•	•	•
	Activities to protect survivors of human rights violations from stigmatisation and discrimination	•	•		•	•	•	•	•	•	•	•
	Training on the psychosocial impacts of human rights violations for staff and officials (can be embedded in other training programs)		•		•	•		•	•	•	•	
	Mechanisms for reporting abuses and exploitation	•	•	•	•	•	•	•	•	•	•	•
	Multi-sectoral participatory assessments from an Age, Gender and Diversity perspective	•	•	•	•	•	•	•	•	•	•	•
	Local protection groups to improve the communal protection capacity (for example, Protection Working Groups or similar committees).	•	•		•	•	•	•		•	•	•
	Responses to protection threats based on consultations with Persons of Concern	•	•	•	•	•	•	•	•	•	•	•
	Community-based protection responses (for example, supporting local dispute resolution mechanisms, local support mechanisms for persons most at risk)	•	•		•	•	•	•	•	•	•	•
	Activities to increase affected people's awareness of their rights and their ability to assert these rights	•	•		•	•	•		•	•	•	•
	Complementary provision of psychosocial support and legal protection support for survivors of human rights violations	•	•		•	•	•			•	•	•
	Psychosocial and mental health orientations/ trainings for legal protection workers				•		•	•		•		•
	Psychosocial training for staff involved in refugee status interviews		•			•	•			•		
	Services for persons with specific needs	•	•	•	•	•	•	•	•	•	•	•
SGBV												
	System for confidential referrals, including psychosocial support	•	•	•	•	•	•	•	•	•	•	•
	Psychological first aid for post-incident care	•	•		•	•	•	•	•	•	•	•
	Link with health services for basic mental health care	•	•		•	•	•	•	•	•	•	•
	Approaches to activate psychological and social support for survivors and their families	•	•		•	•	•	•	•	•	•	•
	Community-based approaches for the reduction of stigma	•	•	•	•	•	•	•		•	•	•
	Community-based approaches to prevent and respond to SGBV	•	•		•	•	•	•	•	•	•	•
	Information for survivors on how to stay safe and access appropriate services	•	•	•	•	•	•	•		•	•	•
Strengthening communities and families												
	Capacity building for community-based social support groups including community centres	•	•	•	•	•	•	•	•	•	•	•
	Programs strengthening parenting and family supports		•		•	•	•			•	•	•

Area/ sector	Activity	Country										
		Chad	Ecuador	Ethiopia	Kenya	Malaysia	Pakistan	South Sudan	Sudan	Syria	Tanzania	Yemen
	Programs to support families to care for family members with specific needs such as persons with disabilities or older persons	•			•	•	•	•		•	•	•
	Child friendly spaces	•	•		•	•	•	•	•	•	•	•
	Improving community responses to vulnerable groups	•	•	•	•	•	•	•	•	•	•	•
	Structured social activities	•		•	•	•	•	•	•	•	•	•
	Structured recreational or cultural activities	•	•		•	•	•	•	•	•	•	•
	Early childhood development activities	•			•	•	•		•	•	•	•
	Provision of conditions for indigenous traditional, spiritual or religious practices, including communal healing practices				•	•	•			•	•	•
Psychological interventions												
	Basic counselling for individuals, including psychological first aid	•	•		•	•	•	•	•	•	•	•
	Basic counselling for groups and families	•	•		•	•	•	•		•	•	•
	Support groups with people with similar problems				•	•	•	•		•	•	•
	Interventions for alcohol/ substance abuse problems	•			•	•	•		•	•	•	
	Psychotherapy				•	•	•			•	•	
	Individual or group psychological debriefing	•			•	•	•			•		
	Art therapy groups (includes, theater, dance, music)	•	•		•	•	•			•	•	
Mental health services in the existing primary health care system												
	Non-pharmacological (not using drugs) management of mental disorders	•	•			•	•			•	•	•
	Pharmacological management of mental disorders	•			•	•	•			•	•	•
	Identification of people with mental disorders and subsequent referrals to services by community workers	•			•	•	•		•	•	•	•
Specialised mental health care												
	Non-pharmacological management of mental disorder by specialised mental health care providers	•	•			•	•			•	•	•
	Pharmacological management of mental disorder by specialised health care				•	•	•			•	•	•
	Referral to specialised mental health services	•	•		•	•	•		•	•	•	•
	Inpatient mental health care				•	•	•			•	•	•

Table 4: Mapping of activities across 11 countries[94]

The mapping indicates that across core humanitarian response sectors – water, sanitation and hygiene, nutrition and shelter – MHPSS concerns appear to be well-represented. Activities in the SGBV sector were almost uniformly reported, reflecting the role of MHPSS response in SGBV activities and protection activities were also well-represented.

94 Mapping of MHPSS related activities is presented for countries for which there were 4 or more complete responses – Pakistan (8), Chad (7), Malaysia (7), Yemen (7), Syria (6), South Sudan (6), Sudan (6), Kenya (5), Ecuador (5), Tanzania (4), and Ethiopia (4). Activities that were endorsed by two or more of respondents from the country are included in the table.

Patterns of activities in the areas of strengthening families and communities, psychological interventions, mental health activities in primary health care, and specialised mental health activities varied substantially across countries. For example, respondents from Syria reported activities across all these sectors, while respondents in South Sudan reported limited activities in these areas, particularly in focused mental health activities. As noted above, these differences likely indicate multiple factors, including the level of access to basic mental health services in the country and region, access to speciality care, context of the refugee operation (emergency, urban, protected, etc) and funding available for MHPSS activities. The above mapping provides an initial snapshot of a number of countries, while further research at field-level could shed light on factors behind these patterns.

Table 5 shows activities endorsed by less than 30% of all survey respondents, to provider a broader view of some of the less well-represented activities across all sectors and areas.

Table 5: Activities less represented in survey responses

Area/ sector	Activity	%
Nutrition	Programs to encourage mother-to-child bonding and interactions	25
Nutrition	Programs directly aimed at improving mothers' psychosocial well-being to improve feeding practices (i.e. baby friendly tents).	25
Nutrition	Integration of early childhood development activities with health and nutrition interventions	27
Education	In-school support for students experiencing psychosocial and mental health difficulties	25
Education	Support groups for teachers	16
Protection	Psychosocial and mental health orientations/ trainings for legal protection workers	27
Protection	Psychosocial training for staff involved in refugee status interviews	18
Strengthening communities and families	Provision of conditions for indigenous traditional, spiritual or religious practices, including communal healing practices	28
Psychological interventions	Art therapy (includes theater, dance, music)	28
Mental health services in the existing primary health care system	Non-pharmacological (not using drugs) management of mental disorders	30
Specialised mental health care	Non-pharmacological management of mental disorder by specialised mental health care providers	30
Specialised mental health care	Inpatient mental health care	29

The presence of activities in the areas of mental health care in primary health care services, and specialised mental health care, reflects themes that emerged in in-depth interviews with UNHCR staff. For example, UNHCR staff in Ethiopia discussed the challenges in providing psychiatric care in rural camp-based settings, given there are few psychiatrists nationally, and the low-quality of scarce mental health services for Ethiopians. As such, it may be the case that without strong national mental health services to draw upon, activities in these two areas are often more limited and constrained due to resources and capacity, rather than due to lack of commitment of UNHCR to support these services.

Overall, activities in these two areas were less reported by all respondents [see Table 6 below]. This is in contrast to activities in SGBV or education, where the majority of activities were reported by more than 70% of respondents.

Table 6: Activities in mental health services in the existing primary health care system and specialised mental health care

Activity	% reporting activity
Non-pharmacological (not using drugs) management of mental disorders	30%
Pharmacological management of mental disorders	36%
Identification of people with mental disorders and subsequent referrals to services by community workers	63%
Non-pharmacological management of mental disorder by specialised mental health care providers	30%
Pharmacological management of mental disorder by specialised health care	33%
Referral to specialised mental health services	63%
Inpatient mental health care	29%

Survey results indicate that across UNHCR's sectors and areas of operation, there are multiple opportunities to integrate a MHPSS approach and to develop and support MHPSS interventions.

TEXTBOX 9

Program snapshot: Outreach volunteers

Another approach to addressing MHPSS needs is through the use of outreach volunteers. This approach has been used by the Psychosocial Services and Training Institute Cairo [PSTIC] and supported by UNHCR Cairo.

In December 2013, UNHCR reported 77,890 refugees and asylum-seekers in Egypt, the majority of whom are from Somalia, Sudan, and increasingly, Syria.[95] Extreme poverty, insecurity and lack of social support impact their well-being and protection. Research and programs in Cairo has found that "many refugees in Cairo are isolated and live there without their usual family and community supports. Mental health issues are often stigmatised so rarely discussed and refugees are not commonly knowledgeable about these issues and how to offer effective support; nor do they know where to seek support if it is needed."[96] In an effort to address these challenges, the PSTIC was established in 2009 and is currently an implementing partner of UNHCR Cairo. The specific goals of the PSTIC are to "increase the psychosocial and mental health support presently offered to refugees," with a specific goal of offering quality MHPSS services in refugees and asylum seekers' own language, according to their own culture and traditions.[97]

In order to improve MHPSS activities and services for refugees and asylum seekers, PSTIC launched a 9-month training program for them to become Psychosocial Workers, who are trained in the following skills and issues:

- Community based psychosocial needs assessments;
- Psycho-education as a method to increase the knowledge and capacities of communities to prevent and respond to psychosocial and mental issues;
- Facilitation of community support groups;
- Community based crisis intervention;
- Psychosocial support and basic counseling for individuals and families;

95 UNHCR Egypt 2013 Country Operations Profile, at http://goo.gl/VBphZ

96 Baron at www.aucegypt.edu/GAPP/cmrs/psychosocial/Overview.aspx

97 Psychosocial Training Institute in Cairo, at http://goo.gl/ylXQD

- Conflict mediation for use with families or community members;
- Advocacy on the behalf of the psychosocial or mental health needs of refugees; and
- Referral to professional psychological or mental health and other services.[98]

Psychosocial Workers are selected by their communities, receive intensive training, and on-going supervision. Through the range of skills and activities that Psychosocial Workers learn, they are able to integrate these activities and approaches within existing programs, such as health, social welfare, and legal services, as well as acting as an intermediary between refugees and UNHCR. Psychosocial Workers are from the communities, and so there is an already-established level of trust and understanding, an important factor in identifying refugees and asylum seekers with MHPSS needs and ensuring that they access the necessary services and supports. Psychosocial Workers are able to listen to concerns and problems, identify solutions and services, and refer protection cases to UNHCR through their outreach activities. The approach seeks to "facilitate protection and to help them get access to the services that they need and to mobilise their communities so that their communities are aware enough and skilled enough that they can help them."[99]

The participatory approach of PSTIC's training program has been found to be empowering to both Psychosocial Workers and the broader community of refugees and asylum seekers. It is also an effective approach to identifying protection cases, given Psychosocial Workers conduct home visits and engage with communities on a daily basis. Overall, the program has been found to have empower the "communities' capacity for self-help, …ensur[ing] cultural relevance and sensitivity in the delivery of services, and enhanc[ing] the identification of people in need." Moreover, the program has engaged with local resources, connecting with Egyptian psychiatrists who provide supervision to the Psychosocial Workers, which is a cost-effective way to provide high-quality services, as well as a way to ensure network of mental health professionals are involved with the program.

3.2 In-depth analysis: MHPSS and the Syria response

Context

Unrest in Syria since April 2011 has led to displacement within Syria, and to neighbouring countries, Jordan, Lebanon, Turkey, Iraq, and Egypt. At the time of writing, displacement within Syria and to neighbouring countries is continuing and increasing, and UNHCR's website featured a number of stories focusing on the needs of refugees fleeing to neighbouring countries.[100] UNHCR reported the following numbers of refugees in neighbouring countries in February 2013:[101]

- Jordan: 269,110 refugees
- Iraq: 92,523 refugees
- Lebanon: 287,571 refugees
- Turkey: 182,621
- Egypt: 18,245 refugees

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98 Psychosocial Training Institute in Cairo, at http://goo.gl/ZeS3r

99 Interview, international expert, July 26 2012.

100 "As conflict affected Syria's health sector, many sick and injured seek treatment outside," February 21 2012 at http://goo.gl/Fokxe; "UNHCR humanitarian aid convoy reaches displaced people in northern Syria," February 1 2013, at http://goo.gl/FjNWC

101 UNHCR (2013).

The scale of influx is immense, with over 100,000 Syrians crossing borders since the start of February. There are up to 3 million internally displaced within Syria, with a significant increase in displacement due to a deteriorating security situation and targeting of specific sites after April 2012.[102]

Multiple needs assessments have documented the significant MHPSS needs of Syrian IDPs and refugees and brought to light the significant and ongoing MHPSS needs in the region.[103]

Specific contextual factors have influenced MHPSS components of the response. A number of staff from UNHCR and implementing partners noted that the response has built upon services and systems, including co-ordination groups, which were already operating as part of the response to Iraqi refugees in the region. In Syria, specifically, a lack of existing partners resulted in UNHCR Syria directly implementing the program described below. While in displacement in the Syria response is not all urban, the predominance of urban refugees is still a challenge, and findings from the experience addressing MHPSS needs of Iraqi refugees in urban settings have informed current approaches.[104]

Throughout the region, agencies such as IMC and Center for Victims of Torture [CVT] have developed strong expertise and experience in providing MHPSS activities in the region, enabling them to build upon experience with the Iraqi refugees and develop a more comprehensive and co-ordinated approach to Syrian IDPs and refugees. Moreover, UNHCR Syria benefitted from the expertise of two MHPSS experts who were hired on United Nations Office for Project Services [UNOPS] contracts, a service that allows UN agencies to hire individuals with specific expertise to implement complex projects. The role and importance of the expertise of these two individuals has been noted by the majority of respondents in interviews focused on UNHCR's role in MHPSS activities in Syria.

UNHCR Syria program response

Development of MHPSS in Syria was based on findings from participatory assessments conducted by UNHCR, as well as reports and results from other surveys and needs assessments.[105] MHPSS activities in Syria were directly implemented by UNHCR until mid 2012, when activities started to be handed over to the Syrian Arab Red Crescent [SARC], a process that was finalised by the end of 2012. UNHCR Syria continues to provide training and support to SARC, including for monitoring and evaluation.

UNHCR Syria's program consisted of MHPSS case management, community-based psychosocial outreach, and a psychosocial centre. Moreover, a major component of the program has been extensive capacity-building, including training of psychologists, psychiatrists and social workers, resulting in improved understanding of psychosocial concepts and practices, as well as development of curricula and training materials based on international standards and appropriate to the context in Syria.[106]

UNHCR Syria's MHPSS program focuses on community-based psychosocial support, both at a community centre and through outreach volunteers. The community centre, located in an areas identified has having high needs, was developed in response to reported social isolation and needs for communal safe space. Activities held at the centre focus on recreation and skills development, and include peer support groups for specific groups, sewing activities, handicrafts, and psycho-education. Outreach workers are refugees who are volunteers, and are trained and supervised to offer mobile support throughout communities, who conduct follow-up through home visits and

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102 IDMC (2012).

103 World Federation for Mental Health (2013).

104 Quosh (2011).

105 For example, Ventevogel (2008).

106 Quosh (2011).

provision of mobile services. The community centre has experienced closures and many refugees and IDPs currently have limited access, given security issues in surrounding areas.

Overall, this component of UNHCR Syria's MHPSS response aimed to activate community supports, address social isolation and barriers to accessing services and support. As such, it formed the basis of a holistic and integrated approach to address MHPSS needs in Syria. The use of similar models for MHPSS activities, implemented by UNHCR partners, is described in Textboxes 6 (Program snapshot: Community spaces) and 10 (Program snapshot: Outreach volunteers).

Another core component of the program is MHPSS case management, which involves identification of individuals with severe mental disorders or specific vulnerabilities, and provision of a Case Manager whose role includes assessment of needs and resources, linking the client to services and supports, and ensuring follow-up. A more detailed description of MHPSS case management as implemented by IMC is described in greater depth in Textbox 10 below. Similar to IMC's model, UNHCR Syria's program sought to facilitate a continuum of care between layers of support and services, linkages to a range of services, including comprehensive needs assessments, development of a specific client plan, and referrals to a range of other appropriate available services.

Across UNHCR Syria's activities, the different components of the program can provide links to other parts of the program – for example, outreach volunteers can refer individuals with specific needs to the community centre, or case managers can refer clients to activities at the community centre or link clients to more specialised services, such as counselling.

Strong monitoring and evaluation approaches throughout the project entail that results of the program can be assessed and lessons learned applied to other UNHCR operations. Monitoring and evaluation methods used in UNHCR Syria's MHPSS program are discussed in Textbox 8. Comments received in the survey for this review from respondents based in Syria noted the unique components and impact of the program. One respondent wrote:

> *"A lot has been done on promotion of community participation and empowerment…The outcome of the project exceeded our expectation not only in reaching out and assisting refugees in need of protection and assistance, but it offered a unique method for addressing psychological disorder among the targeted groups."*

While UNHCR Syria's role as direct implementer of the program makes this particular program unique within UNHCR, there are several findings that can be applied to UNHCR's MHPSS activities, some of which include:

- the need for intensive internal and external capacity-building activities focused on MHPSS concepts and skills;
- the strength of integrated systems and activities that provide a continuum of care; and
- the need for outreach and other methods of identification of persons with specific needs, particularly in an urban setting.

Currently, there are significant operational challenges in shifting MHPSS activities from a response focused on Iraqi refugees to one focusing on Syrian IDPs.

MHPSS response in host countries

Given the rapidly changing and evolving crisis and displacement to neighbouring countries from Syria, it is difficult to obtain and present a comprehensive picture of MHPSS response overall at the present time, and UNHCR's role within that response.

Based on conversations with UNHCR staff and implementing partners in the region, and focused on Jordan and Lebanon, the following points are a partial perspective on the nature of the response and UNHCR's role within it:

- Working Groups, which were established for the response for Iraqi refugees and now functioning primarily for Syrian refugees, have provided an important space for co-ordination, communication and promotion of MHPSS activities. In Jordan, strong leadership of the Working Group had led to increased knowledge and understanding of MHPSS concepts and activities across the humanitarian sector. One implementing partner staff member reported: "Five years ago, no one understood what MHPSS meant, and no one understood what the levels of the pyramid meant. Today, it's really hard to find an organisation that at least isn't familiar with the levels of the pyramid."[107] As such, UNHCR is in the position to be able to partner with a number of strong implementing partners who have expertise and capacity in a range of MHPSS activities.

- The Working Groups actively use the IASC Guidelines and other tools to advocate for MHPSS. For example, the Working Group in Jordan issued a Guidance Note outlining key principles, terminology and the Intervention Pyramid. The Guidance Note commits a number of international agencies, national organisations and international NGOs (including UNHCR) to guidelines such as active inter-agency co-ordination and information sharing, co-ordination of services and referrals, and provision of information to affected populations. UNICEF and IMC developed guidelines on social considerations in shelter and site planning, camp safety, food distribution, and water and sanitation in Za'atri camp, Jordan.

- Based on findings from components of the MHPSS response for Iraqi refugees, it is evident that working with Government Ministries and primary health care providers is feasible and effective.[108]

- UNHCR is supporting MHPSS case management in Jordan but has withdrawn support for MHPSS case management in Lebanon. Changes in staffing, prioritisation of other health concerns within the Health Unit, and lack of strong capacity to understand MHPSS approaches are possible reasons for this. However, UNHCR Lebanon is supporting an assessment of IMC's training of primary health care providers to identify mental health problems, which is an important measure in ensuring quality of training and skills, and supports specialised mental health services for persons with severe mental disorders.

- There is scope for UNHCR Jordan and Lebanon to draw on expertise developed in design and implementation of UNHCR Syria's MHPSS activities, and use of dedicated missions or structured information-sharing activities may be appropriate in order to disseminate findings and facilitate knowledge transfer

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107 Interview, February 18 2013.

108 Hijazi, Weissbecker & Chammay (2011).

TEXTBOX 10

Program snapshot: MHPSS case management

IMC currently implements MHPSS case management for Syrian refugees in Syria, Turkey, Lebanon and Jordan, and is supported for these activities by UNHCR in Jordan and was supported in Lebanon until end 2012. IMC has developed and utilises this approach, as refugees "have multiple and complex needs and require a comprehensive mental health and case management approach which identifies, supports and protects those who are vulnerable and promotes stability and recovery."[109] IMC states that the approach is a way to "optimise client functioning by providing services in the most efficient and effective manner to whose with multiple needs," ensuring that referrals are used to build "a comprehensive network of services for each client." Thus, MHPSS case management activities may operate at Level 2, 3 or 4 of the Intervention Pyramid, depending on the needs of the individual client. IMC's program description emphasises the way in which MHPSS case management can span multiple levels of the Intervention Pyramid, stating "IMC Case Managers are trained in using the guidelines to ensure appropriate up and down referral between levels of care, making use of formal as well as informal support systems and advocating for accessible and comprehensive services."[110]

In IMC programs, MHPSS case management involves establishing a Case Management team to address the needs of a client. Primary Health Care [PHC] providers receive training from IMC in identification of mental disorders and psychosocial distress. As such, PHC clinics can be utilised as a site of referral, as well as a site of service provision, providing for two-way referral that ensures that clients' needs are identified and addressed. An individual client may be referred to an IMC Case Manager through identification by a PHC provider or community health worker, and the Case Manager will identify the specific needs of the client, complete an environmental assessment and safe assessment, and develop a specialised plan, which may include counseling, social support, or legal services, providing a "wrap-around system of support."[111] A Case Management Team, which includes a psychiatrist, psychologist, Case Manager (a trained social worker or nurse), and PHC provider or community health worker, meet and discuss the case weekly, ensuring appropriate adjustments to the plan and reviewing the client's progress. The MHPSS case management model provides an example of multi-sectoral, integrated care that addresses multiple mental health and psychosocial needs that may be experienced by an individual. Its use of two-way referral and referral between levels of care is based on IASC principles of co-ordination and provision of a multi-layered system of care.

IMC is currently working with UNHCR Headquarters' Health Unit to develop a comprehensive training package on MHPSS case management, using the model that IMC has implemented in Jordan, Lebanon and other countries, and UNHCR's experience with direct implementation in Syria.

3.3 UNHCR policy guidelines and MHPSS

Throughout the course of this review, it was clear that many UNHCR staff members recognise the severe and ongoing impact of violence, displacement and deprivation on individuals and communities, the scale of unmet need for MHPSS services amongst PoC, and the importance of UNHCR's support for MHPSS activities. However, there is a lack of explicit engagement with MHPSS approaches and interventions within UNHCR's own policies. The following analysis of UNHCR's policies relevant and applicable to MHPSS activities seeks to identify key areas of overlap and intersections between current UNHCR policy approaches and the MHPSS framework.

109 IMC (2012).

110 IMC (2012).

111 IMC (2012).

Timor-Leste / IDP emergency / A boy watches as vehicles burn as a result of arson in Dili.
© UNHCR / N. Ng / June 2006

UNHCR works in multiple spheres in which MHPSS issues are fundamental. There are a number of areas of UNHCR's work that are directly connected with MHPSS approaches and interventions, and below policy guidelines in the areas of SGBV, child protection, education, and community-based approaches are analysed.

The role of UNHCR's Health Unit is clearly central to MHPSS activities. The Health Unit's MHPSS activities are currently guided by the IASC Guidelines, while a number of other frameworks, tools, and guidelines are in development. For example, UNHCR is supporting the development of Mental Health Gap Action Program [mhGAP] Intervention Guide specifically for humanitarian settings, a tool that could be used for priority setting and practical guidance for implementation of interventions in the field. The Health Unit is also supporting the development of Operational Guidelines for

MHPSS, mirroring Guidelines that currently exist in areas such as, for example, refugee protection in urban areas, referral health care, and health insurance schemes. These policies and guidelines have not yet been issued, and as such, UNHCR's current engagement with the IASC Guidelines is addressed in this section.

Other core areas of work, including shelter, water and sanitation and livelihoods, as well as core protection activities, such as registration and refugee status determination interviews, have implications for MHPSS work, and an MHPSS approach can be integrated across all sectors. However, it is beyond the scope of this review to assess the role of MHPSS activities within policies from all sectors.

Sexual and gender-based violence

SGBV is an area with clear connections to MHPSS activities. SGBV survivors may have significant mental health and psychological needs that can be addressed in multiple ways, including at the community level, through targeted interventions, or in health care settings. Impacts of sexual violence can include mental disorders, such as PTSD and depression, and stigma, including discrimination and rejection from family and community.[112] Provision of mental health, psychosocial and anti-stigma interventions in response to these needs is a key component of SGBV response to prevent mental health or psychosocial problems, and promote well-being.[113]

Psychosocial response for survivors of SGBV is evidently understood within UNHCR as a core activity. UNHCR's *Focus* indicators for SGBV response link "quality of response" to the activity of counselling, with performance indicators of number of persons counselled and number of counselling sessions. Within UNHCR's key SGBV policy document, the 2011 *Action against Sexual and Gender-Based Violence: An Updated Strategy,* psychosocial care is identified as one of the key areas of multi-sectoral approach to addressing SGBV, alongside health and legal sector responses. It is defined as providing survivors of SGBV "with the support and tools needed to deal with personal trauma, stigma and personal exclusion from their families and community."

Identification of the psychosocial component of SGBV response is consistent with the *IASC Guidelines for Gender-Based Violence Interventions in Humanitarian Settings.*[114] In the IASC GBV Guidelines, provision of community-based psychological and social support is included as an area of health and community services, and includes recommended activities such as providing emotional support, encouraging positive coping skills and organising social reintegration activities. However, in contrast, UNHCR's SGBV Guidelines include recommendations for psychosocial response, without delineating types of interventions, capacities of staff required for such a response, and connections between psychosocial responses and broader protection measures. The implication of this is not that UNHCR is failing to implement these activities, but that these activities are not grounded in a broader vision and strategy based on consensus principles found in the IASC Guidelines. In interviews with UNHCR staff conducted for this review, concerns were raised as to the quality of counselling provided as a component of SGBV response. The definition, approach, and training required to provide appropriate counselling as a component of UNHCR's SGBV response requires considerable work, and would benefit from engagement with the MHPSS framework and principles.

While throughout UNHCR's 2011 SGBV strategy document there is limited additional reference to MHPSS approaches, there is clear overlap between SGBV strategy, specifically response for survivors, and MHPSS interventions. Examples of this overlap include the following recommendation actions, including in different sections of the strategy:

- Provide children with social and life skills training to raise awareness about their rights, to help them make better life choices and protect themselves against exploitation;
- Ensure the inclusion and participation of Persons of Concern with disabilities in the development of customised programs designed to protect them from SGBV and response to SGBV where it occurs.

All SGBV activities in the survey apart from one, addressing stigma, were reported to be implemented by over 60% of respondents. Survey results show that 73% of respondents reported that the link for SGBV survivors with health services for basic mental health care exists and 75% reported community-based approaches to prevent and respond to SGBV were also in place. MHPSS activities are prevalent within SGBV response, and some activities and systems may be in place upon which to build more comprehensive MHPSS activities. Quality, focus, and implementation of SGBV programs could be improved through thoroughly engaging with relevant principles from the field of MHPSS activities.

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112 WHO & UNFPA (2011).

113 WHO & UNFPA (2011).

114 IASC (2005).

Child protection

Psychosocial work is central in the field of child protection. Exposure to conflict and displacement are understood to pose significant long-term risks to children's health, development and well-being. Conditions such as impoverishment, lack of access to basic services, and changes in social structures experienced in displacement settings can be harmful to children. Child protection and psychosocial well-being were widely described by child protection and psychosocial experts consulted for this evaluation as inextricably linked and mutually reinforcing. Child friendly spaces, a widely implemented intervention in emergency settings, often have dual objectives of child protection and improving psychosocial well-being. Protection risks may lead to mental health and psychosocial problems amongst children, and children experiencing psychological and mental health issues, and lack of psychosocial support, may be exposed to increased protection risks.

Given these interconnections, as well as discussions with UNHCR staff members working on these issues who recognised this overlap, the absence of explicit engagement with MHPSS approaches and interventions in the 2012 policy document, *A Framework for the Protection of Children*[115], is particularly striking. Within this document, particular risks to children – discrimination, neglect, violence, abuse and exploitation – are presented, all of which are known risks for short and long-term psychosocial distress and create potential for mental disorders amongst affected children. However, in the *Framework*, as with the SGBV strategy, psychosocial work is mentioned throughout without specifically engaging with what this means for the types of interventions selected, the types of programs or approaches undertaken, or the capacity of staff required to implement these responses. Within the *Framework*, psychosocial services for children are referenced as a component of prevention and response within two of the six goals: Girls and boys are safe where they live, learn and play; and Girls and boys with specific needs receive targeted support.

Other goals, outcomes and suggested activities that are relevant to MHPSS approaches include:

- Children and adolescents are increasingly able to find solutions and positive coping strategies that address their problems *[Outcome under Goal 2 – Children's participation and capacity are integral to their protection]*
- Children are actively engaged through activities and education that build their skills and capacities *[Outcome under Goal 2 – Children's participation and capacity are integral to their protection]*
- Girls and boys who have experienced sexual violence access age-appropriate, confidential services *[Outcome under Goal 5 – Girls and boys with specific needs receive targeted support]*

These goals and outcomes are clearly linked with the MHPSS framework, and as is the case with SGBV policy, it is evident that improved linkages could be made between the child protection sector and MHPSS language, concepts and principles, such as building on available resources and capacities to strengthen supports, provision of integrated systems of support, and provision of a multi-layered and complementary system of care.

Education

Education in emergencies is widely recognised as an important influence on child and adolescent development and well-being. Formal and informal educational settings can contribute to a sense of normalcy, a regular schedule, the opportunity for adult role models, and space for socialising with peers. UNHCR's 2012-2016 *Education Strategy* identifies the psychosocial benefits of education, recognising that education, particularly in emergencies, "provides life-sustaining physical, psychosocial and cognitive protection."[116] A myriad of key activities listed within the *Strategy* – including teacher training, inclusion and social cohesion in schools, early childhood education and development, sports activities, life skills and specific psychosocial support strategies implemented within schools and learning spaces – are activities that fit within the framework of

115 UNHCR (2012).

116 UNHCR (2012b).

MHPSS interventions. Connections with MHPSS approaches, in particular, the Intervention Pyramid, include recognition of schools as "important sites through which to identify children at risk of abuse, sexual and gender-based violence, and forced recruitment, for example, and to connect them to appropriate services." This suggests opportunities for utilising schools as mechanisms for identification of protection risks. Moreover, this suggests the potential to leverage investment in education and activities within the education sector to create, enhance and strengthen referral mechanisms for children who require more specialised services to address psychosocial distress.

As such, education activities and frameworks within UNHCR that provide a strong basis for MHPSS activities, however, could be framed more explicitly as linked to the broader MHPSS framework and linked to the Intervention Pyramid. Moreover, some of the education sector activities that were less commonly reported in the survey – for example, training for teachers on awareness of psychosocial issues, including recognising psychological distress [32%], in-school support for students experiencing psychosocial and mental health difficulties (25%), and support groups for teachers (16%) – have the potential to significantly improve children's psychosocial well-being through simple and straightforward interventions in formal and non-formal education contexts.

TEXTBOX 11

Alcohol and substance-use

There are a number of central issues relevant to MHPSS that have received considerably less attention, both in terms of research efforts and implementation of interventions in the field. One specific area is that of alcohol and other substance-use. The role of alcohol and other substance-use and its association with trauma, stress and ongoing psychosocial problems is well-established, however, limited research has focused on the issue of alcohol and substance-use in humanitarian settings. Ezard et al., using rapid qualitative methods to assess alcohol and substance use in settings of protracted displacement in Kenya, Liberia, Uganda, Iran, Pakistan and Thailand, found that alcohol and substance-use was commonly linked to stressors associated with displacement, such as lack of livelihood opportunities and widespread poverty, and perceived as causing gender-based violence and other social problems, as well as linked to risky sexual behaviours.[117] Recent research has identified the role of alcohol and substance-use as a result of ongoing stress, leading to domestic violence and child abuse in post-conflict settings in Afghanistan and Sri Lanka[118] or associated with suicide and suicide attempts in refugee camps in Nepal.[119]

Alcohol and other substance-use is a significant issue in many humanitarian settings, and can be used as a form of coping, leading to harmful use or dependence. Alcohol and other substance-use can be linked to risky health behaviours, including HIV-risk behaviours, and is associated with violence. The financial burden of high levels of consumption of alcohol or other substances can reduce household well-being. As such, addressing alcohol and other substance-use must be a priority activity in MHPSS response.

In 2008, UNHCR and WHO released the Rapid Assessment of alcohol and other substance-use Field Guide.[120] This tool enables an assessment that draws on multiple sources of data, engages a range of community members and other stakeholders, and covers contextual factors, including norms surrounding alcohol and substance use, impacts of alcohol and other substance use, patterns of usage, and availability of existing services to address alcohol and other substance use.

117 Ezard, Oppenheimer, Burton, et. al. (2011).

118 Catani, Schauer & Neuner (2008).

119 Schinina, Sharma, Gorbacheva and Mishra (2011).

120 UNHCR & WHO (2008).

The IASC Guidelines list "Minimise harm related to alcohol and other substance use" as a minimum standard action for the Health Sector, and suggests a number of actions, including facilitating educational, recreational and income-generating activities, non-medical approaches to addressing acute stress (i.e. Psychological First Aid), brief interventions by community health workers, prescription of non-addictive medication alternatives, where appropriate, and management of acute withdrawal in clinics and hospitals. The UNHCR/WHO Field Guide suggests that interventions "involve multiple integrated strategies requiring individual, community and policy-level interventions; information and means for behavioural change; changes to service delivery; and community and high-level political engagement, as appropriate." Alcohol and substance-use interventions are not commonly supported. UNHCR has played a constructive role in supporting research and field guide development in this area. It is important that further engagement with MHPSS activities continue to support, advocate for, and fund alcohol and substance-use prevention and treatment activities.

Community-based approaches

UNHCR currently frames a number of activities and approaches that fall within the psychosocial realm as "community-based approaches" or "community development approaches," and as such, describing and exploring the elements of this approach and accounting for the connections to MHPSS activities, is central in understanding UNHCR's current approach to MHPSS.

UNHCR's commitment to a community-development approach is articulated in a number of documents: the 2001 ExCom Conclusion, "Reinforcing a Community Development Approach," the 2006 *Tool for Participatory Assessment* and the 2008 *A Community-Based Approach in UNHCR Operations.* Within these documents, the overlap with principles in the IASC Guidelines and approaches utilised in the MHPSS field more broadly is evident. In the 2001 ExCom Conclusion, the challenges wrought by displacement are recognised as bringing "dramatic changes in lifestyle, social and economic status, gender roles and in life expectations," and the Conclusion states that, in seeking to meet the needs of refugees, "it remains essential to bear in mind that in any emergency situation, factors such as belonging to a caring family or community and maintaining well-known traditions and culture are equally crucial to sustaining the community."[121] The Conclusion emphasises that by engaging refugees in their own communities, and by shifting from a focus on individuals to communities, UNHCR can effectively reinforce the dignity and self-esteem of refugees, while also increasing the cost-effectiveness and sustainability of UNHCR's programs.

The 2006 *Tool for Participatory Assessment* suggests that structured dialogues with Persons of Concern can help identify community capacities and resources, and that the role of UNHCR is "to support the building, rebuilding and strengthening of communities' capacities to respond to protection risks and to make decisions over access to and use of resources."[122] This document further describes the role of community-based approaches to refugees, and elucidates the role of participation and its connection to protection.

The 2008 *Community-Based Approach in UNHCR Operations* outlines that a community-based approach stands in contrast to an individual, case-management approach, shifting to "building on the knowledge, skills and capacities of people of concern and their communities."[123] The 2008 document states:

> *"A community-based approach is a way of working in partnership with Persons of Concern during all stages of UNHCR's programme cycle. It recognises the resilience, capacities, skills and resources of Persons of Concern, builds on these to deliver protection and solutions, and supports the community's own goals. The approach is not limited to a particular function or sector of work. It should guide all UNHCR staff and partners in their work with Persons of Concern."*

121 UNHCR (2001).

122 UNHCR (2006).

123 UNHCR (2008).

The 2008 document explains that community-based approaches are multi- and cross-sectoral and integrated across UNHCR's areas of work. Moreover, the 2008 document proposes that a community-based approach can be a way in which to identify protection concerns and ensure referrals to specialised services if needed.

Many of the activities identified as core activities with community-based approaches include attempts to engage individuals and communities in promoting their own well-being, activities to draw upon and strengthen communities' resources and resilience, and the use of participatory assessments as a technique through which to identify individuals and groups that may need more targeted attention. These are primarily Level 1 and 2 activities in the Intervention Pyramid. Moreover, community-based approaches, similarly to many MHPSS activities, are viewed as multi and cross-sectoral, an approach to working with communities, rather than being conceptualised as the purview of a specific sector. As such, community-based approaches may include both MHPSS *approaches* and MHPSS *interventions.*

The Community Services sector is the area in which UNHCR's activities most significantly overlap with MHPSS activities. Much of what Community Services currently seeks to support and achieve can be considered MHPSS. This indicates the considerable opportunity for community-based approaches to the form the basis of a more comprehensive and integrated approach to MHPSS activities within UNHCR. However, currently, these activities are not considered within the framework of MHPSS. MHPSS experts consulted for this review commented that UNHCR's utilisation of a different framework and language in the Community Services sector, without linking it to the MHPSS framework, has resulted in missed opportunities to utilise and leverage the broader linkages between community-based approaches, which are situated in the Community Services sector, and other Protection and Health approaches to MHPSS. The potential for community-based approaches to form the basis of a more comprehensive approach is diminished by UNHCR framing these approaches primarily as community-based approaches, rather than linking these activities to the Intervention Pyramid and other activities across UNHCR that seek to improve well-being.

The overlaps between community-based approaches and the MHPSS framework are evident. Community-based approaches clearly constitute Level 1 and 2 activities, within the Intervention Pyramid. However, without linking these activities to a broader framework, connections to other activities that directly address protection issues and improve health and well-being are not clear. Of note, this critique has similarly been made of community-based approaches without reference to MHPSS. In a 2010 assessment of the role of community-based approaches within UNHCR, Calhoun stated that while UNHCR had embraced a community development approach (which is not the case of MHPSS approaches currently), the connection between the approach and the core protection mandate was "not clearly articulated," with results being that commitment to the approach in terms of resource allocation and results expected was unclear.[124] This lack of articulation of a vision and strategy had material and practical impacts, entailing that "the organisation does not have a strong basis for investment in community development activities and is stuck in a cycle of under-investment and under-performance in this area of work." Calhoun's conclusion is especially pertinent in the case of MHPSS programs: that UNHCR lacks evidence for the assertion that a MHPSS approach necessarily leads to more effective and efficient programs that improve well-being and outcomes for Persons of Concern, and that without this evidence, community services activities and interventions focused primarily on a community-based approach are the first to be cut. Calhoun concludes that despite many actors in UNHCR committing to community-based approaches,

> *"when funding becomes tight, these community services activities are often the first to be cut, as they are not seen as lifesaving. In fact, because they strengthen the social ties crucial to good health, these activities may be protecting the refugees' right to health at an efficient cost"*

The linkages between community-based approaches and MHPSS activities are clear. However, currently, these linkages are not being adequately defined and utilised, disconnecting these approaches from protection and core UNHCR activities and undervaluing the ways in which MHPSS can contribute towards protection, multi-sectoral integration, and well-being of PoC.

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124 Calhoun (2010).

Afghanistan / Returned IDPs / An Afghan IDP returning from the “Russian Compound” in Kabul to land in the Shomali Plain stands in the wreckage of what was once his home.
© UNHCR / N. Behring-Chisholm / 3 March 2002

IASC Guidelines

When the Guidelines were released in 2007, UNHCR officially endorsed and released the Guidelines to all UNHCR staff. However, there was limited training, capacity-building or advocacy on the Guidelines within UNHCR. UNHCR’s approach is in contrast to the engagement of other humanitarian actors. As discussed in Section II, other agencies have worked to adapt or integrate the Guidelines into their programs, using a variety of approaches including training, developing operational guidelines and adapting principles to their specific mandates. However, awareness of the Guidelines as a tool to support development of MHPSS programs and activities has not permeated throughout UNHCR. As it stands, UNHCR’s endorsement of the Guidelines is neither meaningful nor effective at the current time.

In 2008, the co-chairs of the IASC MHPSS Reference Group posed the question about the Guidelines: “[w]hat is the most effective way to use them to improve practice?”[125] There are a number of different approaches to dissemination and implementation of the Guidelines, yet currently it does not appear that UNHCR has strategically considered or implemented any approach adequately.

[125] Melville & Rakotomalala (2012).

TEXTBOX 12

Program Snapshot: Psychological First Aid

One example of a particular intervention that could be incorporated into current protection activities is PFA. The IASC Guidelines define PFA as:

basic, non-intrusive pragmatic psychological support with a focus on listening but not forcing talk; assessing needs and ensuring that basic needs are met; encouraging but not forcing company from significant others; and protecting from further harm.[126]

A field guide for implementation of PFA in emergencies, developed by the World Health Organisation, War Trauma Foundation, and World Vision, has been endorsed by 24 NGOs and UN agencies, including UNHCR.[127] According to the field guide, the guidelines "reflect the emerging science and international consensus on how to support people in the immediate aftermath of extremely stressful events." PFA involves helping people to access basic needs and services, helping people to cope with their problems, including helping them to access support and coping mechanisms within their families and communities, giving accurate information about the crisis, and connecting people with social support.

Outlining the key components of PFA, the guide emphasises that PFA is based on the following three principles in order to support people's long-term recovery:

- Feeling safe, connected to others, calm and hopeful;
- Having access to social, physical and emotional support; and
- Feeling able to help themselves, as individuals and communities.

As such, it is evident that PFA is one approach that could be incorporated into core protection activities in order to improve their psychosocial impact and ensure that protection activities address people's key concerns and needs.

However, it is important to note two key limitations. Firstly, PFA is not an evidence-based treatment. It is a response to initial needs, whereas if more serious additional needs were identified, specific mental health or psychosocial responses would be needed.[128] Secondly, PFA is most appropriate in settings where exposure to trauma – through exposure to conflict, displacement, or violence – is recent. This may include settings where violence continues to be experienced by individuals within camp-based settings, for example. However, in settings in which UNHCR works that are more stable, PFA is not always suitable response for community-wide interventions. However, many of the skills taught in PFA are useful in all humanitarian settings. Receiving a half day orientations in PFA may be useful to many UNHCR staff.

126 IASC (2007).

127 WHO, War Trauma Foundation & World Vision (2011).

128 Fox, Burkle, Bass et. al. (2012).

3.4 UNHCR and the MHPSS framework

In the course of this review, some resistance to the term psychosocial within UNHCR emerged. This included concerns expressed by UNHCR staff that psychosocial activities, specifically, are already being supported under current policy approaches, and therefore that introducing the term psychosocial and the MHPSS framework more broadly is neither necessary nor an effective approach to strengthening current activities.

However, the MHPSS framework is a valuable reframing based on important principles that can improve quality and integration of services. Firstly, by definition, the term psychosocial enables a focus on the individual embedded within the environment, and therefore focuses attention on both specific issues individuals may be facing, and also the broader environmental factors influencing these problems. UNICEF's framing of psychosocial activities as a way of reinforcing "well-being, dignity, and resiliency" draws attention to the fact that the psychosocial approach and activities is substantively different in its objectives, focus, and processes.[129]

Secondly, it is a language and approach that supports integration of services across sectors. These linkages operate in two ways. One, the MHPSS framework provides a comprehensive approach to promote linkages between sectors that contain specific psychosocial or mental health focus. UNHCR staff, implementing partners, and experts commented on the missed opportunities to take a broader approach to community strengthening, improving well-being, and preventing distress by engaging with and working with the MHPSS framework. Viewing UNHCR's activities within the broader MHPSS framework enables linkages, including referral mechanisms, between activities in Community Services, Health, and Protection. Two, these linkages operate as integration of psychosocial concerns into sectors that are not primarily focused on psychosocial or mental health issues. As an operational agency working across many relevant sectors, UNHCR can both play a role in promoting the use of MHPSS approaches within other sectors, and use the framework to integrate highly relevant activities within community services, health, and protection. That is, UNHCR can implement both a MHPSS *approach* and MHPSS *interventions.*

The MHPSS framework represents an integrated approach to 1) addressing stress, 2) preventing further mental distress, and 3) responding to protection risks and adverse psychosocial and mental health outcomes throughout the population, including the general population and those with more specific needs. The MHPSS framework is a comprehensive way of capturing the various issues influencing well-being, and possible responses. For UNHCR, this framework is particularly important and useful both on a conceptual level – as a basis and framing of *all* activities, and on a practical level – as a way to bring together and integrate activities across sectors

Rather than maintaining a focus on the debate concerning whether the concept of psychosocial should replace or be additional to current frameworks, there are practical actions UNHCR can take to further engage with the MHPSS framework, in order to achieve objectives such as quality improvement for programs and activities in the field, and co-ordination and communication with implementing partners and other agencies. UNHCR cannot, and should not, be responsible for all components of the IASC guidelines in any given setting. Instead, UNHCR should articulate and identify areas in which engagement with MHPSS activities links to key areas of work and existing sectors, while also allowing UNHCR to work with partners to more comprehensively cover MHPSS needs.

Section IV presents specific recommendations and brief overview of findings leading to these recommendations.

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129 UNICEF at http://goo.gl/TClXV

4. Findings and Recommendations for UNHCR's MHPSS Activities

Overall findings from this global review of UNHCR and MHPSS are presented here, with a list of key recommendations. Strategies for implementation of recommendations are included in the Conclusion.

FINDING 1: UNHCR has not adequately engaged with MHPSS concepts, definitions and approaches

Recommendations:

1. **UNHCR should strongly and clearly articulate its role in the field of MHPSS by developing and issuing a MHPSS strategy**
2. **UNHCR should promote and adapt the key principles in the field of MHPSS activities, including the Intervention Pyramid, within the organisation and within current policy approaches**
3. **UNHCR should seek to build internal capacity to develop, implement and support MHPSS activities**

Implementation strategy:

1. Issue MHPSS strategy
2. Utilise forthcoming Operational Guidelines for MHPSS as guidance for implementation of key MHPSS activities for field offices
3. Identify and adopt minimum standards of MHPSS interventions, based on Sphere standards, developing accountability measures to assess fulfillment of these standards.
4. Identify a recruitment initiative through which to build internal capacity on MHPSS, enabling provision of direct technical support and advice to field operations on MHPSS needs and response

One of the central challenges UNHCR faces in adequately responding to the MHPSS needs of the people they serve is that UNHCR as an organisation has not engaged with the key concepts, definitions and approaches in the field of MHPSS. UNHCR regularly offers MHPSS supports but does not do it using the prevailing language in MHPSS, which leads to inconsistencies and missed opportunities in response. UNHCR has thus far failed to develop a vision and strategy for involvement with MHPSS activities. UNHCR's capacity and support for adequate MHPSS activities cannot be based on the interest or commitment of an individual or only a handful of staff members, who may or may not be able to secure resources and support for high-quality MHPSS activities at any given time. Instead, UNHCR's position must be based in specific principles and policies such that UNHCR's involvement with MHPSS activities in all contexts is predictable and structured, and based on a clear strategy, as highlighted in **Recommendation 1.**

One of the central ways in which the lack of clarity within UNHCR surrounding concepts and principles of MHPSS approaches is demonstrated is UNHCR's current policies and strategies. As discussed, the majority of UNHCR policy guidelines either fail to mention or substantively engage

with MHPSS components relevant to key areas of work. UNHCR has avoided utilising the language of psychosocial well-being, psychosocial approaches or psychosocial interventions. Introducing psychosocial approaches into the language, policies, and approach of the organisation need not supplant current policy frameworks. Instead, they can could be introduced and defined alongside current policy frameworks. In using specific and separate language and framing of activities with similar objectives, UNHCR is isolating itself from the broader field and community of humanitarian actors involved with MHPSS activities, and limiting its capacity to support and enhance MHPSS activities in various contexts. If UNHCR wants to provide improved support to implementing partners working in the MHPSS field, and play a coordinating if not leadership role in the MHPSS field, it needs to develop and improve its use of key MHPSS concepts and incorporate the MHPSS framework within existing policy frameworks.

UNHCR's limited and lacking engagement with the IASC Guidelines entails that it has not benefitted from principles developed in the Guidelines. The Intervention Pyramid contained in the IASC Guidelines is increasingly well-understood across the field of MHPSS actors, forms the basis of mapping of MHPSS activities (4Ws), and, furthermore, is a way for UNHCR to think about and maximise linkages between MHPSS activities across sectors. The pyramid offers an opportunity for UNHCR to identify parts of MHPSS response that it prioritises, or has the most capacity to deliver, and to communicate that to other actors in the field of MHPSS activities in humanitarian response where UNHCR's activities lie, and how these activities can be linked to other components of response. As stated in **Recommendation 2,** UNHCR should adopt and incorporate these principles into its MHPSS activities.

UNHCR currently lacks enough internal capacity to support MHPSS activities and increase UNHCR's engagement with the field. As one UNHCR staff member stated, "[t]here is also a lack of knowledge and understanding and capacity in the staff to really monitor on this issue….People know them [the IASC Guidelines] but I don't think they know that much the content and what it means concretely and how concretely we can do psychosocial support to our people of concern."[130] Building internal capacity to oversee MHPSS activities is a key component of incorporating MHPSS throughout UNHCR. Building internal capacity and understanding of MHPSS can lead to further support for MHPSS, as one UNHCR staff member reported, "[t]here's no understanding and there's no availability of resources. I think once people have the understanding, the resources come. Like now, resources for SGBV are always found in a refugee situation. You will not find a donor who refuses or gives totally zero resources for SGBV. But the same has not happened for MHPSS."[131] This leads to **Recommendation 3.** There are various models for building this internal capacity and drawing on external capacity, including, for example, modelling an expert recruitment scheme on the current International Catholic Migration Commission-UNHCR Resettlement Deployment Scheme.

130 Interview, UNHCR staff member, July 20 2012

131 Interview, UNHCR staff member, October 11 2012

FINDING 2: There is a lack of strong assessment of HPSS needs, and monitoring and evaluation of MHPSS interventions in the humanitarian sector

Recommendations:

4. **UNHCR should identify feasible and effective assessment and evaluation methodologies and select commonly implemented MHPSS activities to evaluate, publishing case studies of results**

5. **UNHCR should play a central role in translating and disseminating research findings to practice and field-settings**

Implementation strategy:

1. Create collaborations and partnerships with academic institutions and research teams to answer central questions concerning design, implementation, and impact of UNHCR's MHPSS activities

2. Increase specific indicators linked to MHPSS indicators in *Focus*

This finding is based on UNHCR's current activities in needs assessments, monitoring of outcomes and impacts, and evaluation of MHPSS activities. Table 8 below identifies the primary tools available for UNHCR in MHPSS needs assessment, monitoring and evaluation, which are described further below.

Table 7: Current MHPSS tools, indicators and activities for assessment, monitoring and evaluation

Tool	Role	Description
Participatory assessments	Assessment	Regular participatory assessments can be used to identify MHPSS needs, as well as methods to support and strengthen family and community supports
Health Information System [HIS]	Assessment, monitoring	Collects routine health and nutrition data from refugees in primary health care settings in 21 countries
Focus	Monitoring	Results-based management system for all UNHCR activities, has multiple indicators relevant to MHPSS in various categories, including health, protection and community services
WHO and UNHCR toolkit: Assessing Mental Health and Psychosocial Needs and Resources (2012).	Assessment	Collection of simple and rapid assessment tools for field use

Assessment of MHPSS needs within UNHCR is currently done in multiple ways.

Mental and neurological diseases are recorded in the Health Information System [HIS].[132] Currently, the HIS captures those refugees who attend primary health care, covering camp-based and some urban refugees in 21 countries. The data captured in this system could inform service provision for

[132] The HIS is UNHCR's primary source of routine data collection on health and nutrition. It was launched in 2005 in order to co-ordinate and standardise data collection that can be used to inform programs and monitor progress on health and nutrition indicators. It is used in 21 countries where there are refugees, covering camp-based and some urban refugees. In urban settings, the HIS is used in stand-alone health

UNHCR staff approach the remote river village of Inbargyi by boat in Myanmar's Rakhine state.The field staff make regular trips to these remote communities to inspect the conditions in which the people are living in and try to assess their needs.Most of the Rohyinga villages along the river have been badly damaged in the recent conflict in Oct 2012. © UNHCR / P. Behan / Dec 7 2012

severe mental disorders, offering opportunities for monitoring prevalence of seven categories of severe mental disorders.[133]

Beyond this, participatory needs assessments may capture MHPSS needs and inform intervention design, a process that was described as effective by UNHCR staff in contexts such as Syria, Costa Rica, and Nepal. Moreover, some MHPSS activities have emerged from specific needs assessments, usually led by implementing partners or UNHCR consultants. More work is needed to ascertain the effectiveness of participatory assessments for capturing MHPSS needs, especially the degree to which prevalence of common mental disorders, such as depression and anxiety, can be detected using current approaches.

It is encouraging to see UNHCR's recent co-publication (with the WHO) of a toolkit of MHPSS assessment methods in humanitarian settings.[134] This resource should be a first step towards developing a series of simple and rapid measures that can be integrated into assessment, monitoring and evaluation, while also engaging in more in-depth and rigorous evaluations of program outcomes and impacts through collaborations with researchers.

In terms of monitoring of current MHPSS activities, *Focus* – under which country operations select specific objectives with measurable indicators – is UNHCR's primary method of capturing programs. Many objectives listed in *Focus* are highly relevant to MHPSS, including "Services for persons with specific needs" (which includes number of persons counselled as its associated performance

clinics for refugees funded for UNHCR. In other health-care settings, UNHCR is reliant on data obtained from the national Ministry of Health.

133 The HIS has case definitions for and collects data on: epilepsy/ seizures; alcohol and other substance use disorder; mental retardation/ intellectual disability; psychotic disorders; severe emotional disorder; medical unexplained somatic complaint; and other disorders.

134 UNHCR & WHO (2012).

indicator), as well as objectives focused on quality of reception conditions (including provision of psychosocial assistance), SGBV response (specifically focusing on counselling), targeted programs for adolescents, psychiatric services within the health system, and a range of self-reliance and livelihoods activities that could have psychosocial components. This indicates the scope of MHPSS activities in which UNHCR is already involved, as described in Section II. Yet, this also indicates the challenge inherent in the fact that objectives, outputs, and performance indicators for MHPSS activities are dispersed under a range of categories within *Focus,* and, moreover, are not primarily understood as MHPSS activities. As such, the focus and quality of MHPSS activities could be improved through an increase in specific indicators that link to MHPSS activities, or re-grouping of relevant indicators under a series of MHPSS-specific indicators. Currently, *Focus* is a limited tool for the purposes of capturing the scope and impact of MHPSS activities, which are multi-sectoral and implicated in many types of programs and approaches.

In terms of evaluation, approaches to understanding the *impact* of UNHCR's MHPSS activities on PoC are needed. Evaluation of the impact of MHPSS activities is a central challenge in the MHPSS field overall [as discussed previously in Textbox 8]. Impacts of MHPSS activities are often less obvious and apparent than impacts of other humanitarian interventions, yet careful and structured evaluation can bring to light important impacts of these activities, making visible many of the potentially invisible yet significant benefits of MHPSS interventions in humanitarian contexts. Challenges in the field of evaluation of MHPSS programs are broadly applicable to all agencies involved in MHPSS activities. However, lack of evidence generated in high-quality evaluations was cited numerous times by UNHCR staff as a primary reason for lack of support for MHPSS activities within UNHCR, and therefore is particularly important for moving UNHCR's work in this area forward. Evidence and evaluation is an essential element of promoting and developing UNHCR's MHPSS activities. However, as reported in the survey, monitoring and evaluation of MHPSS activities within UNHCR is perceived as weak. UNHCR's current approaches to evaluating MHPSS activities have primarily been through ad hoc collaborations with WHO and consultants, and have been located in the Health Unit. These findings indicate the necessity of implementing **Recommendation 4.**

Compounding the lack of available data from evaluations is the issue of *relevance* of available data for use for a humanitarian organisation such as UNHCR. A disconnect between "relevance" (practitioners' priorities that research be able to be readily translated into solutions) and "excellence" (academic researchers' priorities that research be conducted using high quality scientific methods to ensure validity of results) is evident.[135] This indicates a need to increase communication and cooperation between researchers and practitioners.[136] UNHCR is uniquely positioned within the humanitarian sector to enter into long-term partnerships with academic institutions to collaborate on *evidence-generation* and *evidence-dissemination* in the field. As such, **Recommendation 5** identifies UNHCR's role in promoting evaluation and dissemination of findings in order to improve programs in the field.

135 Tol, Patel, Tomlinson et. al. (2012).

136 Tol & van Ommeren (2012).

FINDING 3: The sectoral nature of UNHCR's work currently limits integration of MHPSS activities across the organisation

Recommendations:

6. **UNHCR staff in different sectors should complete a mandatory online course on how to protect and promote the dignity and psychosocial well-being of displaced persons during their daily work.**

7. **UNHCR should operationalize models for increased collaboration and communication on MHPSS activities, ensuring that Health, Protection and Community Services sectors utilise a MHPSS framework that enables referral systems and linkages between activities**

8. **UNHCR should clarify the role of Community Services as lead on Level 2 activities, linking current activities to best practices in the MHPSS field and ensuring Community Services has the resources and expertise to support these activities**

9. **UNHCR participatory assessments should be used to develop strategies to strengthen family and community self help and social supports.**

Implementation strategy:

1. Ensure that orientation on a MHPSS approach is incorporated into training within the water, sanitation and hygiene, shelter and site planning, and camp management sectors

2. Develop a range of training mechanisms for Community Services, Protection and Health staff, focusing on MHPSS concepts, principles and skills

3. Identify where MHPSS responsibility lies in field operations, including appointing Focal Points or creating specific MHPSS units where the context requires

The IASC Guidelines recognise the substantial impact that core components of humanitarian response can have on the mental health and psychosocial well-being of affected populations, stating that "[t]here is increasing inter-agency consensus that psychosocial concerns involve all sectors of humanitarian work, because of the manner in which aid is implemented…affects psychosocial well-being." Level 1 activities within the Intervention Pyramid entail ensuring that "social and psychological considerations" are taken into account in food security and nutrition, shelter and site planning, and water and sanitation.

It is evident that there are challenges to facilitating integration of MHPSS approach across sectors. One respondent reported on experience with another large multi-sectoral humanitarian organisation, stating:

> *"I think it makes sense [to house it in protection]. But at the same time, the danger in seeing that issue is protection specific. You have psychosocial issues within health, within education, within water and sanitation. So, that is a danger. When you house it [within a specific sector], you have to make a case for that issue all the time. But at the same time, you do have to have a house for some of these issues. If you just leave at cross-sectoral at some time it doesn't get done. Basically, that's the compromise you make."*[137]

When there is no specific unit or sector that is the lead or maintains primary responsibility for MHPSS, there is a risk that MHPSS issues are not adequately brought to the fore in *any* sector. It

[137] Interview, staff member international agency, August 14 2012.

is evident that ensuring the quality and integration of a MHPSS approach in sectors not primarily focused on MHPSS is a challenge across the humanitarian sector, and no less for UNHCR. The multi-sectoral nature of MHPSS activities, and the diffuse nature of what has been defined throughout this review as a MHPSS *approach* is a challenge not only for UNHCR, but for all humanitarian actors. UNHCR should promote adoption of a MHPSS *approach* throughout the organisation. Staff in core sectors throughout UNHCR whose work has impacts on the mental health and psychosocial well-being of refugees can be trained and oriented as to best practices in promoting and supporting well-being, as per **Recommendation 6.**

The question of sectoral responsibility and the challenge of identifying the ideal organisational structure to support MHPSS activities is a core obstacle to UNHCR improving and increasing its MHPSS activities. MHPSS has components that most logically fit within Community Services, within Health, and within Protection. Co-ordination of services and activities across all these sectors requires significant communication and promotion of linkages between services and activities. This is especially important in creating referral mechanisms, and providing complementary services to individuals in need – for example, psychosocial support programs for individuals with severe mental illness receiving care from the health sector. One survey respondent working in Chad reported, "mental health is usually governed by the health implementing partner, while psychosocial is handled by community services implementing partner, which can create confusion and problems." According to some UNHCR staff, co-ordination across MHPSS activities is sometimes effective through ad hoc communication and co-ordination structures created in order to facilitate improved services at the level of field operations. However, overall, the connections between MHPSS activities in different sectors appear to be limited, indicating the need to implement **Recommendation 7.**

One specific structural issue is the division of MHPSS activities between Community Services and Health. The Health sector approaches MHPSS activities largely through provision of medical services (often Level 3 and 4 activities within the Intervention Pyramid), while Community Services addresses psychosocial issues through a range of community-focused activities (often Level 2 and 3 activities). These approaches can and should be complementary. However, many UNHCR staff members discussed the frequent fragmentation of response between the sectors, resulting in a tendency to look at mental health and psychosocial response as separate and independent actions. One UNHCR staff person stated, there is "an unnatural divide in operations between Community services and the Public Health care partners. People are not automatically working together, which makes referral systems more complicated, and results in duplication of issues."[138] Community Services is the ideal location for Level 2 MHPSS activities, some of which are already occurring – for example, child-friendly spaces. However, Community Services is not positioned to be able to adequately support these activities. Clarification of Community Services' role within UNHCR's approach to MHPSS is needed, as indicated in **Recommendation 8.** Some activities that are currently implemented as part of UNHCR's participatory assessments and AGDM work can be used to develop, implement and strengthen approaches to family and community support, as per **Recommendation 9.**

UNHCR has not addressed the question of where primary responsibility for MHPSS activities should fall. Respondents suggested a number of approaches to this question, including context-specific responses – that is, placing primary responsibility within Community Services, or Health, or Protection, depending on the needs and structure of a particular field operation. Alternately, some respondents reported the need for a specific unit, with a MHPSS focal point with the same level of responsibility as a Community Services or Public Health office, and with the mandate to liaise across sectors in a particular field operation. Some respondents discussed the challenges of locating MHPSS activities primarily within a single sector. However, while there is considerable debate as to the organisational structure that would best facilitate MHPSS activities, respondents recognise that "somebody has to take ownership of it, it has to be given some home."[139]

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138 Interview, UNHCR staff member, August 2 2012.

139 Interview, UNHCR staff member, July 19 2012.

FINDING 4: Synergies between protection and MHPSS within UNHCR are not being maximised

Recommendations:

10. **UNHCR should frame MHPSS activities as core components of its protection mandate**

11. **UNHCR should integrate MHPSS principles and approaches into core protection activities**

Implementation strategy:

1. Adopt MHPSS orientations, including Psychological First Aid, for protection staff interacting with PoC during registration, refugee status determination, response to SGBV, best interest determination and resettlement interviews.

2. Incorporate discussion of social components of protection within policy statements and programmatic guidance

Protection and MHPSS are obviously connected. An improved protection environment can result in reduced mental health and psychosocial problems – for example, a reduction in sexual and gender-based violence in a camp can result in reduced mental health and psychosocial problems. Conversely, the connection between improved mental health and psychosocial well-being and improved protection environment is also evident – for example, that improved mental health and psychosocial well-being can reduce alcohol use, aggression, and violence, improving safety and protection for individuals, households, and communities. These examples demonstrate the interconnections between protection and MHPSS approaches, which was described by child protection expert Mike Wessells:

> *"you have to have a protective environment to have good mental health. Where people live in constant fear, of recruitment, or where they are at risk of being attacked or tortured, their mental health deteriorates--that's a fairly clear link between protection and mental health. Where you have mental health issues going unaddressed, that cycles back and can increase protection risks. These are reciprocal, cyclical, interlocking circular processes that go on."*[140]

The IASC's 2011 document, *"Mental Health and Psychosocial Support in Emergency Settings: What should Protection Programme Managers Know?"*[141], describes the interconnections between protection and MHPSS approaches, stating "[i]ncluding psychosocial consideration in the protection response will protect the dignity of survivors and enhance the overall protection response." This document reflects widespread recognition in the humanitarian sector that protection activities and protection actors play a key role in the field of MHPSS activities, and that protection responses can be improved through use of a MHPSS approach and interventions.

However, while UNHCR staff widely recognise the linkages between MHPSS and protection, there is also a widespread perception that while MHPSS activities are potentially helpful above and beyond life-saving measures, such as activities in health, nutrition, and shelter, they are neither essential nor core elements of UNHCR's work. UNHCR staff widely described MHPSS activities as being "first on the chopping block" when limitations in financial resources require there to be budget cuts. However, while in some cases these cuts may be necessary from a cost-benefit analysis, it is also the case that this prioritisation of other forms of protection and assistance emerges not only from evidence-driven cost-effectiveness analysis, but from a perception within UNHCR that MHPSS activities are a luxury. As one UNHCR staff member reported, MHPSS activities are "annexed as the

140 Interview, July 9 2012.

141 IASC (2011).

little kind of luxury programs that go alongside when we have the time and we have the money."[142] **Recommendation 10** reflects the need to frame MHPSS activities within the realm of the protection mandate within UNHCR.

It is evident that a strong protection response has the potential to improve mental health and psychosocial well-being amongst individuals, households, and communities. MHPSS activities are unlikely to be effective in a context where key protection concerns are not addressed. As such, UNHCR's core protection activities are a way in which UNHCR currently works to prevent mental health and psychosocial problems, and improves mental health and psychosocial well-being. The survey conducted for this evaluation showed a high level of reporting of a range of protection activities with linkages to MHPSS activities and outcomes [see Table 8 for selected protection activities]. However, the interconnections between protection and MHPSS approaches are not present within UNHCR policy and language, and interviews conducted for this review revealed a number of obstacles to UNHCR fully maximising the potential for current protection activities to improve response to mental health problems and increasing psychosocial well-being amongst PoC.

Table 8: % of respondents reporting selected protection activities.

Protection activity	% reporting activity
Apply an Age, Gender and Diversity perspective to all protection and assistance interventions	91%
Training on the psychosocial impacts of human rights violations for staff and officials (can be embedded in other training programs)	41%
Local protection groups to improve the communal protection capacity (for example, Protection Working Groups or similar committees).	55%
Community-based protection responses (for example, supporting local dispute resolution mechanisms, local support mechanisms for persons most at risk)	56%
Activities to increase affected people's awareness of their rights and their ability to assert these rights	65%
Complementary provision of psychosocial support and legal protection support for survivors of human rights violations	51%
Services for persons with specific needs	79%

One issue that acts to hinder increased integration of MHPSS within protection activities is the definition and conceptualisation of protection within UNHCR. In interviews, UNHCR staff expressed concerns that protection was still conceptualised within UNHCR as primarily, or solely, a legal activity. A broader definition of protection is present in some UNHCR policies, for example, AGDM.[143] However, the concept of social protection – of protection encompassing efforts to improve the overall well-being of Persons of Concern, inclusive of material, social, economic, political, and legal dimensions – is not perceived as fully accepted and integrated throughout UNHCR. The definition of protection adopted and operationalised within UNHCR has important impacts on prioritisation of and support for MHPSS activities. For example, a practitioner interviewed for this review reported not being able to convince UNHCR staff to support a psychosocial program she was implementing as UNHCR staff stated, "that it not our mandate, our mandate is protection."[144]

There are concrete ways in which protection activities and MHPSS activities overlap. In some contexts, the majority of individuals receiving specific psychosocial or mental health services have been identified as having protection concerns, yet integration of protection and MHPSS activities is often limited. Use of MHPSS activities can be a way in which to identify protection issues, for example, through the use of psychosocial outreach volunteers, as presented in Textbox 9: Program

142 Interview, UNHCR staff member, August 3 2012

143 UNHCR (2010).

144 Interview, other organization staff member, July 26 2012.

Sierra Leone / IDPS / Former child soldiers in rehabilitation / CAW (Children Affected by War) / Freetown
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snapshot: Outreach volunteers. As such, recognition of the interconnections between protection and MHPSS, and integration of these activities, can concretely improve services. However, at the moment, the widespread understanding of protection activities and MHPSS as disconnected leads to a "complete split between the work of the protection unit managing violence cases and the work of the psychosocial unit managing psychosocial issues."[145] The separation of protection and MHPSS approaches and activities is not just an issue of definition or language, but has concrete impacts on quality of services.

There are protection activities that could be improved through use of a MHPSS approach. For example, UNHCR staff reported that registration activities, resettlement interviews, and best interest determination interviews – all of which are activities that have the potential to have a negative psychosocial impact, if not conducted with sensitivity – do not explicitly use MHPSS approaches. It is notable that two such approaches – MHPSS orientations or trainings for legal protection workers, and psychosocial training for staff involved in refugee status interviews – were the least commonly reported protection activities, and amongst the least commonly reported activities across all sectors and areas. There is scope for use specific MHPSS activities, for example, Psychological First Aid [PFA] [see Textbox 12], within some protection activities, as stated in **Recommendation 11.**

145 Interview, staff member international agency, August 21 2012.

FINDING 5: There is a lack of guidance on how to support MHPSS programs in non-emergency and/ or urban settings

Recommendations:

12. **UNHCR should lead development of MHPSS guidelines for non-emergency and urban settings**

13. **UNHCR should assess the role of MHPSS activities in the context of protracted refugee situations impacted by resettlement and/ or repatriation, identifying key interventions that should be supported as a part of ongoing activities or phasing out of humanitarian support**

Implementation strategy:

1. Utilise role in the IASC MHPSS Reference Group to prioritise developing adapted Guidelines that specifically address MHPSS interventions in non-emergency settings and urban environments

2. Profile case studies of MHPSS activities in protracted refugee situations in flux

The guidelines, tools, and expertise in the MHPSS field primarily focus on the emergency-phase of displacement. The IASC Guidelines state, "[t]he focus of the guidelines is on implementing minimum responses, which are essential, high-priority responses that should be implemented as soon as possible in an emergency." Moreover, some of the interventions detailed in this report – for example, PFA – are considered most appropriate for emergency settings. Furthermore, many experts and practitioners have noted that the Guidelines lack a focus on MHPSS in urban settings. Activities that are components of "comprehensive response" – activities to implement when "the population has access to at least the minimum response" – may be able to be adapted to constitute a response to evolving MHPSS needs in non-emergency or urban settings. However, overall, there is limited guidance or expertise that specifically focuses on how to support and improve MHPSS programming in these contexts, leading to **Recommendation 12.**

Many PoC are situated in non-emergency contexts, for example, protracted refugee situations.[146] UNHCR's discussion of the challenges of protracted refugee situations has included references to the MHPSS issues that emerge and persist in situations of prolonged displacement. For example, UNHCR describes protracted refugee situations as often resulting "basic rights and essential economic, social and psychological needs remain[ing] unfulfilled after years in exile,"[147] and that these situations are characterised by "high levels of personal trauma, social tension, sexual violence and negative survival strategies."[148] Thus, it appears that UNHCR recognises that the very nature of protracted refugee situations can impact on mental health and psychosocial well-being.

Even though UNHCR, along with other humanitarian actors, does not plan on the situation becoming protracted, there are actions that can be taken in the midst of an emergency phase that can improve delivery, quality, and sustainability of services in the event that the displacement situation does become protracted. Given the focus of the MHPSS field on emergencies, there is currently limited guidance and expertise on how these measures could be applied in the area of MHPSS activities. Moreover, in situations of protracted displacement that are in a context of flux due to mass resettlement or impending repatriation, the need for MHPSS activities may increase

146 A protracted refugee situation is defined as a situation where refugees have lived in a displacement context for more than five years, and when they still have no immediate prospect of finding a durable solution to their plight by means of voluntary repatriation, local integration, or resettlement (Crisp 2003).

147 UNHCR (2004).

148 UNHCR (2008b).

due to widespread anxiety and fears as to the impact of the changes on individuals, households, and communities. For example, in the context of resettlement of Bhutanese refugees in Nepal, resettlement-related stressors are perceived to have increased mental health issues, including suicide, and impacted coping mechanisms amongst refugees in the camps.[149] However, funding for MHPSS activities may actually decrease in these situations, in a context of a shift towards self-reliance, a focus on resettlement, or phasing out of humanitarian programs, and as such **Recommendation 13** is an important step towards supporting MHPSS needs in these settings.

In the context of urban environments, UNHCR has recognised the need to shift traditional approaches to delivering services, engaging "creative approaches" to ensure that health needs are met, including enabling access to national health systems and establishing and facilitating referral pathways for refugees.[150] UNHCR has also developed operational guidelines to address specific health systems and services issues that emerge in urban environments, for example, health insurance[151] and referral systems.[152]

UNHCR has identified the role of some key MHPSS activities in addressing the needs of refugee displaced in urban environments. UNHCR has supported an innovative and effective psychosocial outreach program in Cairo, and its multi-layered MHPSS program in Syria was also designed and delivered in an urban setting. UNHCR's 2009 *Policy on refugee protection and solutions in urban areas* uses the language of community mobilisation and development, stating that participatory assessments will be utilised, and efforts undertaken to "strive to mobilise and capacitate the refugee population, so as to preserve and promote their dignity, self-esteem, productive and creative potential."[153] Some key mechanisms of psychosocial support and outreach are described in the policy, including engagement of trained refugee outreach volunteers to maintain contact with the refugee community and establishment of local community centres as a space for provision of information, counselling and socialising. Therefore, it is possible to use the policy as a basis to support development of MHPSS activities for refugees in an urban context.

There is a lack of guidance and expertise in the MHPSS field that addresses the particular challenges of MHPSS in urban settings. However, UNHCR is in the unique position of 1) having begun to develop operational guidelines in the area of public health that address challenges largely unique and specific to urban environments, 2) having urban refugee policy guidelines that broadly support the use of MHPSS approaches and activities, and 3) having supported or directly implemented some successful models of MHPSS activities in urban environments. UNHCR could profile these experiences, building on findings from these contexts and expanding these activities to urban settings in other regions. UNHCR is in a position to provide input and advice to the IASC MHPSS Reference Group, in order to issue guidelines or tools on the use of the IASC Guidelines in urban settings.

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149 Chase (2012); Schinina, Sharma, Gorbacheva and Mishra (2011).

150 Guterres & Spiegel (2012); Spiegel, Colombo & Palk (2010).

151 UNHCR (2012a).

152 UNHCR (2009a).

153 UNHCR (2009b).

FINDING 6: Clinical mental health services can be increased and strengthened

Recommendation:

14. **UNHCR should actively engage implementing partners who have expertise to manage severe mental health problems in adults and children**

Implementation strategy:

1. Map and identify national capacity or implementing partners with capacity to provision of clinical mental health services in field settings

2. UNHCR should work to develop protocols and operational tools to support improved clinical mental health services.

Displaced persons with severe mental disorders are neglected both within research literature and policy approaches.[154] Severe mental illness, such as psychosis, can be exacerbated by exposure to conflict and displacement, and in situations of prolonged displacement, individuals often face significant barriers to adequate ongoing care for severe mental illness.[155] Findings from this review indicate that challenges remain in provision of clinical mental health services, primarily delivered through the Health sector, for refugees. Some progress has been made in the field of clinical mental health services within UNHCR – for example, inclusion of psychotropic medicines in the list of essential medicines,[156] and monitoring of severe mental disorders is conducted through the Health Information System, as described above.

However, findings from the survey indicate that activities in mental health services were less commonly reported than activities within other sectors [see Table 6]. Reasons for this were indicated in interviews with UNHCR staff conducted for this review. UNHCR staff regularly discussed the challenges of providing clinical mental health services in contexts where clinical mental health services are limited or of low-quality for national populations. It may be ideal to draw on capacities available within national health systems, where possible – for example, for UNHCR to fund psychiatrists or mental health nurses to make visits and provide services to refugees, as is the case in some UNHCR programs, for example, Yemen, Nepal and Ethiopia. However, in contexts where local capacities are not strong or available, or where refugees are located in areas remote from population-centers, it is important, as per **Recommendation 14,** for UNHCR to identify and support implementing partners who can provide high-quality clinical mental health services.

154 Silove, Ekblad & Mollica (2000).

155 Jones, L., Asare, J. et. al. (2009).

156 UNHCR (2011d).

5. Conclusion

The violence and deprivation wrought by conflict and displacement impacts every aspect of the lives of those affected. Families are torn apart, social structures undermined, and loss and hopelessness can be pervasive. Years of living with uncertainty and deprivation can impact current and long-term well-being. However, as many UNHCR staff have experienced in their work, affected populations also exhibit immense strength and capacity to address their own problems and concerns. It is imperative that UNHCR develop approaches, frameworks, and structures that enable it to effectively build on these resources, strengthen resilience, and address MHPSS gaps and needs that inevitable emerge in the wake of emergencies and persist in situations of on-going displacement.

The field of MHPSS is evolving, based on the IASC Guidelines and emerging tools and approaches. The historical background, conceptual developments, and evidence-base presented in this review demonstrate the degree to which the field of MHPSS activities has changed and consolidated over the past decade, demonstrating increasing consensus around principles and practices. As such, it is both surprising and disconcerting that UNHCR has not only not taken a lead in implementing these principles and approaches, but actually appears to have separated itself from these developments, continuing to use organisation-specific language with the understanding that MHPSS activities are outside of its mandate, and issuing policies and guidelines that do not engage with core MHPSS principles.

This review outlined the distinction between a MHPSS approach and MHPSS interventions. It is evident that for UNHCR to fulfil its mandate of protection, and best develop and support activities and services that improve PoC's well-being, UNHCR must engage both with an MHPSS approach – integrating this approach through all sectors in the organisation, and MHPSS interventions – activities in Community Services, Health and Protection that specifically aim to improve mental health and psychosocial well-being. This will require strong advocacy on MHPSS principles within UNHCR, leadership and prioritisation of activities seeking to address MHPSS needs, and significant work establishing the structures and systems required to oversee and develop a stronger role in addressing MHPSS needs.

The key findings of this review are outlined below, alongside recommendations and implementation strategies for the recommendations. Some of these findings are specific to UNHCR, and require conceptual development, policy guidance, and shifts within institutional structures and approaches to overcome. For example, the sectoral structure of UNHCR poses a significant challenge to integrating MHPSS approaches and interventions within UNHCR, and requires strengthening Community Services' engagement with MHPSS and re-thinking of where MHPSS activities should have a "home." Other findings are applicable to many agencies and actors in the field, and UNHCR can both learn from actions other actors have taken to address these challenges, and take a lead in addressing these issues, for example, monitoring and evaluation, and guidance on MHPSS in non-emergency and/ or urban settings.

Finding	Key recommendations	Implementation strategy
Finding 1: UNHCR has not adequately engaged with MHPSS concepts, definitions and approaches		
	1. UNHCR should strongly and clearly articulate its role in the field of MHPSS by developing and issuing a MHPSS strategy 2. UNHCR should promote and adapt the key principles in the field of MHPSS activities, including the Intervention Pyramid, within the organisation and within current policy approaches 3. UNHCR should seek to build internal capacity to develop, implement and support MHPSS activities	1. Issue MHPSS strategy 2. Utilise forthcoming Operational Guidelines for MHPSS as guidance for implementation of key MHPSS activities for field offices 3. Identify and adopt minimum standards of MHPSS interventions, based on Sphere standards, developing accountability measures to assess fulfillment of these standards. 4. Identify a recruitment initiative through which to build internal capacity on MHPSS, enabling provision of direct technical support and advice to field operations on MHPSS needs and response
Finding 2: There is a lack of strong assessment of MHPSS needs, and monitoring and evaluation of MHPSS interventions in the humanitarian sector		
	4. UNHCR should identify feasible and effective assessment and evaluation methodologies and select commonly implemented MHPSS activities to evaluate, publishing case studies of results 5. UNHCR should play a central role in translating and disseminating research findings to practice and field-settings	1. Create collaborations and partnerships with academic institutions and research teams to answer central questions concerning design, implementation, and impact of UNHCR's MHPSS activities 2. Increase specific indicators linked to MHPSS indicators in Focus
Finding 3: The sectoral nature of UNHCR's work currently limits integration of MHPSS activities across the organisation		
	6. UNHCR staff in different sectors should complete a mandatory online course on how to protect and promote the dignity and psychosocial well-being of displaced persons during their daily work. 7. UNHCR should implement models for increased collaboration and communication on MHPSS activities, ensuring that Health, Protection and Community Services sectors utilise a MHPSS framework that enables referral systems and linkages between activities 8. UNHCR should clarify the role of Community Services as lead on Level 1 and 2 activities, linking current activities to best practices in the MHPSS field and ensuring Community Services has the resources and expertise to support these activities 9. UNHCR participatory assessments should be used to develop strategies to strengthen family and community self help and social supports.	1. Ensure that orientation on a MHPSS approach is incorporated into training within the water, sanitation and hygiene, shelter and site planning, and camp management sectors 2. Develop a range of training mechanisms for Community Services, Protection and Health staff, focusing on MHPSS concepts, principles and skills 3. Identify where MHPSS responsibility lies in field operations, including appointing Focal Points or creating specific MHPSS units where the context requires
Finding 4: Synergies between protection and MHPSS within UNHCR are not being maximised		
	10. UNHCR should frame MHPSS activities as core components of its protection mandate 11. UNHCR should integrate MHPSS principles and approaches into core protection activities	1. Adopt MHPSS orientations, including Psychological First Aid, for protection staff interacting with PoC during registration, refugee status determination, response to SGBV, best interest determination and resettlement interviews. 2. Incorporate discussion of social components of protection within policy statements and programmatic guidance

Finding	Key recommendations	Implementation strategy
Finding 5: There is a lack of guidance on how to support MHPSS programs in non-emergency and/ or urban settings		
	12. UNHCR should lead development of MHPSS guidelines for non-emergency and urban settings 13. UNHCR should assess the role of MHPSS activities in the context of protracted refugee situations impacted by resettlement and/ or repatriation, identifying key interventions that should be supported as a part of ongoing activities or phasing out of humanitarian support	1. Utilise role in the IASC MHPSS Reference Group to prioritise developing adapted Guidelines that specifically address MHPSS interventions in non-emergency settings and urban environments 2. Profile case studies of MHPSS activities in protracted refugee situations in flux
Finding 6: Clinical mental health services can be increased and strengthened		
	14. UNHCR should actively engage implementing partners who have expertise to manage severe mental health problems in adults and children	1. Map and identify national capacity or implementing partners with capacity to provision of clinical mental health services in field settings 2. UNHCR should work to develop protocols and operational tools to support improved clinical mental health services.

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Annex 2: List of interviews conducted

UNHCR Interviews:

Unit/ sector	Number of key informants
Health (including nutrition)	3
Community Services (including education, SGBV, child protection)	8
Shelter	1
Emergencies	1
UNHCR MHPSS Consultants	3
Specific country operations [Syria, Nepal, Ethiopia and Costa Rica]	7

Interviews from other organisations:

Organisation	Number of key informants
Inter-Agency Standing Committee [IASC]	1
IASC MHPSS Reference Group	1
International Committee for the Red Cross [ICRC]	1
International Organization for Migration [IOM]	2
International Medical Corps [IMC]	4
International Rescue Committee	1
Medicins Sans Frontieres, Switzerland	1
Save the Children UK	1
Terre des Hommes	1
World Health Organization [WHO]	1
UNICEF	2
Other CBO	1

Academic experts consulted:

1. Florence Baingana, Makerere University
2. Paul Bolton, Johns Hopkins School of Public Health
3. Ananda Galappatti, Good Practice Group, Sri Lanka
4. Ken Miller, Lesley University
5. Mike Wessells, Columbia University/ Randolph-Macon College
6. Joop de Jong, VU University Medical Center in Amsterdam/ Amsterdam Institute of Social Science Research, University of Amsterdam
7. Wietse Tol, Johns Hopkins School of Public Health

Annex 3: Example in-depth interview guide

1. What are the key **theoretical/conceptual underpinnings** of your organisation's approach to psychosocial/ mental health work? How are psychosocial and mental health programs defined and conceptualised? Is there a distinction between the two, and if so, how does that impact interventions?

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2. What are your organisation's **key areas of work** in psychosocial support/ mental health? Can you describe a successful program? Can you describe a program that did not meet its objectives?/ had major challenges? What are the major obstacles to achieving program objectives in this field?

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3. From the perspective of your organisation, what is the **state of the field of practice?** What types of interventions predominate? Why?

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4. **Partnerships and collaboration:** What models of co-operation, collaboration and partnership exist in this field? Between whom? How do these partnerships function? How could these types of partnerships be improved?

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5. **Impact of key policy initiatives:** What has been the impact of the IASC guidelines on your work? In your experience, how widely accepted and implemented are the principles and guidelines? Does your organisation use the principles to guide your work? The "intervention pyramid"?

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6. **Use of evidence:** What evidence exists for effectiveness of your approach? How to you generate evidence? How do you draw on evidence? How do you understand success of a psychosocial program? Can you discuss the role of evaluation measures, monitoring and evaluation, needs assessments? How do you measure impact?

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7. **Psychosocial and mental health programs and specific contexts:** Psychosocial needs and programs vary by context, for example, protracted refugee situations, emergency settings, urban settings, middle-income settings. How does your organisation approach these different contexts and how does context impact on the design and implementation of MHPSS? How do your activities differ at different phases of emergency – acute emergency, post-emergency?

Annex 4: On-line survey

I. Demographic Information

1. What is your job title?
2. Region: [Africa/ Asia/ Americas/ Europe/ MENA/ HQ]
3. What is your country of operation?
4. How many years have you worked for UNHCR?

Mental health and psychosocial support (MHPSS):

A psychosocial approach means taking an approach that addresses the well-being of a person in their environment.

Psychosocial support programs include activities to improve family and community supports, such as child friendly spaces, parenting programs and women's groups and support to particularly vulnerable groups, such as survivors of SGBV, as well as provision of basic services in socially and culturally appropriate ways.

Mental health programs include specialised supports, such as clinical counselling interventions and provision of mental health care to individuals with severe mental disorders.

II. Experience with MHPSS Programs

1. Do you currently or have you ever worked on MHPSS programs for UNHCR? Yes/ No
    ① If yes, for how many months or years have you worked on psychosocial and/ or mental health programs for UNHCR?
2. In your entire career, how many months or years total have you worked on psychosocial and/or mental health?
3. Prior to beginning your work with UNHCR, had you completed any formal training in the field of psychosocial and/ or mental health? Yes/ No
    ③ If yes, how many years?
4. Since beginning your work with UNHCR, have you attended any training focused on MHPSS? Yes/ No
    ④ If yes, please describe
5. Please list any tools, documents or guidelines you use as a reference for your work.

III. Perspectives on MHPSS Programs

❶ MHPSS programs contribute towards protection of Persons of Concern

- Strongly agree
- Agree
- Disagree
- Strongly disagree

❷ Partnerships with implementing partners are an effective means of implementing MHPSS programs

- Strongly agree
- Agree
- Disagree
- Strongly disagree

❸ The impacts of MHPSS programs are easy to identify

- Strongly agree
- Agree
- Disagree
- Strongly disagree

Please explain:

❹ There are clear monitoring and evaluation systems in place to assess the impact of MHPSS activities in my operational area

- Strongly agree
- Agree
- Disagree
- Strongly disagree

❺ MHPSS activities are integrated into other programs in my operational area

- Strongly agree
- Agree
- Disagree
- Strongly disagree

❻ The need for MHPSS programs is identified through (Check all that apply)

① Participatory Assessments
② Reports from Implementing or Operational Partners
③ Requests from Community Based Organisations and/or Refugee Groups
④ Reports or recommendations from HQ
⑤ Other, please explain:

IV. Programs and activities across sectors:

1. In the area of **water and sanitation and hygiene promotion** (WASH), does your operation have any of the following activities? (please check all that apply)
   - ① Inclusion of social and cultural issues in WASH activities
   - ② Community participation in planning and implementation
   - ③ Using the community members to monitor and give feedback on WASH activities
   - ④ My operation does not have activities in the area of WASH
   - ⑤ Other – please describe:
2. In the area of **nutrition**, does your operation have any of the following activities? (please check all that apply)
   - ① Programs to encourage mother-child bonding and interactions
   - ② Programs directly aimed at improving mothers' psychosocial well-being to improve feeding practices (i.e. baby friendly tents)
   - ③ Integration of early childhood development activities with health and nutrition interventions
   - ④ Activities to maximise participation in the planning, distribution and follow-up of food aid
   - ⑤ Inclusion of social and cultural considerations in distributing food assistance
   - ⑥ My operation does not have activities in the area of nutrition
   - ⑦ Other – please describe:
3. In the area of **shelter**, does your operation have any of the following activities? (please check all that apply)
   - ① Use of a participatory approach to site or settlement planning
   - ② Site and settlement designs that include social and cultural considerations
   - ③ Inclusion of communal spaces and safe spaces in site design
   - ④ Approaches that maximise privacy, ease of movement and social support
   - ⑤ Support for people who are unable to build their own shelters
   - ⑥ My operation does not have activities in the area of shelter
   - ⑦ Other – please describe:
4. In the area of **education**, does your operation have any of the following activities? (please check all that apply)
   - ① Promotion of both formal and non-formal education
   - ② Measures to create Safe Learning Environments
   - ③ Training for teachers on awareness of psychosocial issues, including recognising psychosocial distress
   - ④ Inclusion of life skills development in education
   - ⑤ Play and sports-focused activities
   - ⑥ In-school support for students experiencing psychosocial and mental health difficulties
   - ⑦ Options for referral pathways for children experiencing psychosocial or mental health issues
   - ⑧ Inclusive education for children with diverse needs e.g. children with disabilities, ethnic minorities, children living with HIV/ AIDS
   - ⑨ Support groups for teachers
   - ⑩ Mechanisms for community consultation/participation in education

xi. Focused activities for young people

xii. My operation does not have activities in the area of education

xiii. Other – please describe:

5. In the area of **protection**, does your operation have any of the following activities? (please check all that apply)

   ① Apply an Age, Gender and Diversity perspective to all protection and assistance interventions

   ② Activities to protect survivors of human rights violations from stigmatisation and discrimination

   ③ Training on the psychosocial impacts of human rights violations for staff and officials (can be embedded in other training programs)

   ④ Mechanisms for reporting abuses and exploitation

   ⑤ Multi-sectoral participatory assessments from an Age, Gender and Diversity perspective

   ⑥ Local protection groups to improve the communal protection capacity (for example, Protection Working Groups or similar committees).

   ⑦ Responses to protection threats based on consultations with Persons of Concern

   ⑧ Community-based protection responses (for example, supporting local dispute resolution mechanisms, local support mechanisms for persons most at risk)

   ⑨ Activities to increase affected people's awareness of their rights and their ability to assert these rights

   ⑩ Complementary provision of psychosocial support and legal protection support for survivors of human rights violations

   ⑪ Psychosocial and mental health orientations/trainings for legal protection workers

   ⑫ Psychosocial training for staff involved in refugee status interviews

   ⑬ Services for persons with specific needs

   ⑭ My operation does not have activities in the area of protection

   ⑮ Other – please describe

6. In the area of **SGBV**, does your operation have any of the following activities? (please check all that apply)

   ① System for confidential referrals, including psychosocial support

   ② Psychological first aid for post-incident care

   ③ Link with health services for basic mental health care

   ④ Approaches to activate psychological and social support for survivors and their families

   ⑤ Community-based approaches for the reduction of stigma

   ⑥ Community-based approaches to prevent and respond to SGBV

   ⑦ Information for survivors on how to stay safe and access appropriate services

   ⑧ My operation does not have activities in the area of SGBV

   ⑨ Other – please describe

7. In your operation, do you offer any of the following activities in the area of **strengthening communities and families?** (please check all that apply)

   ① Capacity building for community-based social support groups including community centers

   ② Programs strengthening parenting and family supports

③ Programs to support families to care for family members with specific needs such as persons with disabilities or older persons

④ Child friendly spaces

⑤ Improving community responses to vulnerable groups

⑥ Structured social activities

⑦ Structured recreational or cultural activities

⑧ Early childhood development activities

⑨ Provision of conditions for indigenous traditional, spiritual or religious practices, including communal healing practices

⑩ My operation does not have activities in the area of strengthening communities and families

⑪ Other – please describe:

8 In your operation, do you offer any of the following activities in the area of **psychological interventions**? (please check all that apply)

① Basic counseling for individuals, including psychological first aid

② Basic counseling for groups and families

③ Support groups with people with similar problems

④ Interventions for alcohol/ substance abuse problems

⑤ Psychotherapy

⑥ Individual or group psychological debriefing

⑦ Art therapy groups (includes, theater, dance, music)

⑧ My operation does not have activities in the area of psychological interventions

⑨ Other – please describe:

9 In your operation, do you offer any of the following activities in the area of **mental health services in the existing primary health care system**? (please check all that apply)

① Non-pharmacological (not using drugs) management of mental disorders

② Pharmacological management of mental disorders

③ Identification of people with mental disorders and subsequent referrals to services by community workers

④ My operation does not have activities in the area of mental health services in the existing primary health care system

⑤ Other – please describe:

10 In your operation, do you offer any of the following activities in the area of **specialised mental health care?** (please check all that apply)

① Non-pharmacological management of mental disorder by specialised mental health care providers

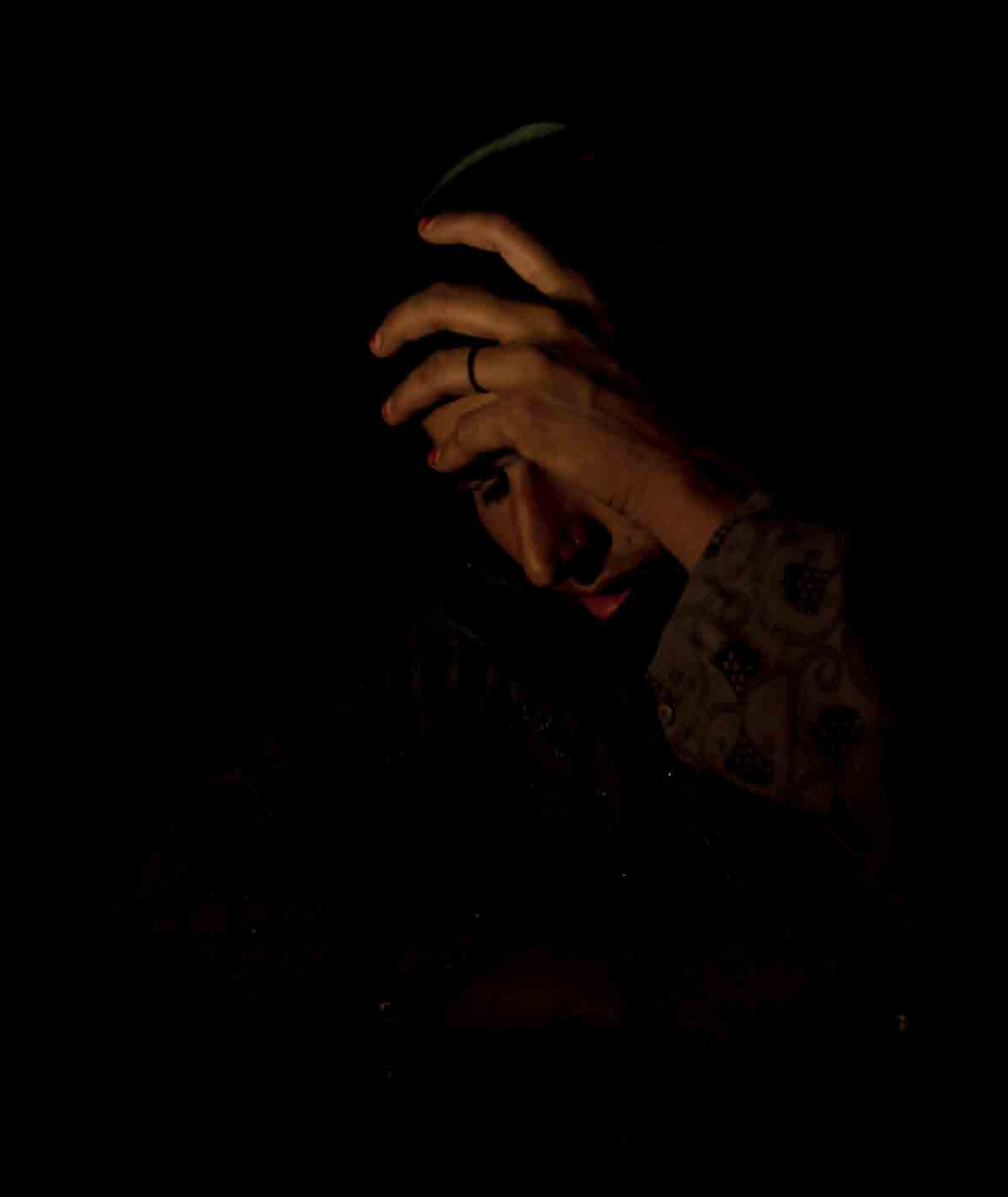
② Pharmacological management of mental disorder by specialised health care

③ Referral to specialised mental health services

④ Inpatient mental health care

⑤ My operation does not have activities in the area of specialised mental health care

⑥ Other – please describe



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Policy Development & Evaluation Service
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