



**Operational Guidance
Mental Health & Psychosocial Support
Programming for Refugee Operations**

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Cover Photo: Syrian children look out the window of their home at the Oncupinar refugee camp, near the Turkish border city of Kilis. UNHCR / A. Branthwaite/ September 2012.

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Operational Guidance Mental Health & Psychosocial Support Programming for Refugee Operations

A colourful family portrait of three of
the almost 200,000 internally displaced
people in Mali, including some 47,000 in
Bamako. UNHCR/ H. Caux /
November 14, 2012



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LIST OF ABBREVIATIONS AND ACRONYMS

AGD:	Age, Gender and Diversity
CBO:	Community Based Organisation
CBP:	Community-Based Protection
CBR:	Community Based Rehabilitation
CHW:	Community Health Worker
CMD:	Common Mental Disorders
HIS:	Health Information System
IASC	Inter-agency Standing Committee
IDP:	Internally Displaced Person
INGO:	International Nongovernmental Organisation
LGBTI:	Lesbian, gay, bisexual, transgender and intersex
MHPSS:	Mental Health and Psychosocial Support
mhGAP:	mental health Gap Action Programme
MNS disorders:	Mental, Neurological and Substance use Disorders
NGO:	Nongovernmental organisation
OPD:	Outpatient Department
PFA:	Psychological First Aid
PHC:	Primary Health Care
SGBV:	Sexual and Gender Based Violence
SMD:	Severe Mental Disorders
UNHCR:	United Nations High Commissioner for Refugees
WHO:	World Health Organization

ABOUT THIS GUIDANCE

This operational guidance on Mental Health and Psychosocial Support (MHPSS) provides a practical orientation and tools for UNHCR country operations. It covers specific points of good practice to consider when developing MHPSS programming and offers advice on priority issues and practical difficulties, while also providing some background information and definitions. Since MHPSS is a cross cutting concept this operational guidance is relevant for programming in various sectors, including health, community-based protection, education, shelter, nutrition, food security and livelihoods.

The focus of this operational guidance is on refugees and asylum seekers, but it may apply to other persons of concern within UNHCR operations such as stateless persons, internally displaced persons and returnees.

The guidance is meant for operations in both camp and non-camp settings, and in both rural and urban settings in low and middle-income countries with a UNHCR presence. The guidance should be adapted according to different contexts. A standardized format for programme implementation cannot be offered because this depends to a large extent on existing national capacities and local opportunities.

Muslim female refugees from Myanmar sit on the porch of their home at a camp in Bangladesh. The UNHCR-backed Asia Pacific Refugee Rights Network advocates for greater refugee rights.
UNHCR / G.M.B. Akash



1. INTRODUCTION

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT MATTER IN REFUGEE SETTINGS

Experiences of displacement due to armed conflict, persecution, or disasters put significant psychological and social stress on individuals, families and communities. The ways in which refugees experience and respond to loss, pain, disruption and violence vary significantly and may in various ways affect their mental health and psychosocial well-being or increase their vulnerability to develop mental health problems. Often, reactions to disruptive situations are normal and can be overcome with time. Many refugees will be able to cope with these difficult experiences, and even build resilience, if a supportive family and community environment is available.

In settings of mass displacement normal and traditional community structures, such as extended family systems and informal community networks, which often regulate community well-being, may have broken down. This may lead to social and psychological problems or exacerbate existing problems, but in the emergency response, opportunities for new mechanisms with novel leadership structures may also arise, which may or may not be representative of all members of the community (UNHCR, 2007a).

Some refugees may develop negative coping mechanisms that may be reinforced while they struggle to meet basic needs. Some will newly develop mental disorders while others with pre-existing mental disorders may experience exacerbation of their symptoms. The usual systems for providing mental health care may be negatively affected, leaving people with mental disorders without adequate treatment.

THE ROLE OF UNHCR IN ADDRESSING MENTAL HEALTH AND PSYCHOSOCIAL PROBLEMS

Mitigating immediate and long-term risks and consequences for mental health and psychosocial wellbeing of individuals, families and communities are an integral part of UNHCR's protection mandate. Therefore MHPSS should be a regular element of UNHCR's refugee response.

A recent review by [UNHCR's Policy Development and Evaluation Service](#) [PDES] concluded that, although across the organisation and its functional sectors significant activities in the field of MHPSS are already employed, the organization as a whole has not yet adequately engaged with MHPSS concepts, definitions and approaches.

MHPSS problems in humanitarian contexts can be addressed through activities such as supporting communities' resilience, promoting mechanisms for social support, and offering services to individuals with more complex mental health needs.

A central notion in this operational guidance is that considerations around MHPSS are relevant for a wide range of actors within UNHCR operations. We distinguish between an *MHPSS approach* and *MHPSS interventions*.

- Adopting an ***MHPSS approach*** means providing a humanitarian response in ways that are beneficial to the mental health and psychosocial wellbeing of refugees. This is relevant for all actors involved in the protection of and assistance to refugees.
- ***MHPSS interventions*** consist of activities with a primary goal to improve the mental health and psychosocial wellbeing of refugees. MHPSS interventions are usually implemented by in the sectors for health, community-based protection and education.

BUILDING ON EXISTING STRATEGIES AND POLICIES

This guidance builds on and complements existing key strategies and policies of UNHCR such as:

- [A Community Based Approach in UNHCR operations](#) (2008a);
- [Accountability Framework for age, gender, diversity mainstreaming](#) (UNHCR, 2007b);
- [Policy on refugee protection and solutions in urban areas](#). (UNHCR, 2009);
- [Education Strategy 2012-2016](#) (UNHCR, 2012b);
- [Working with persons with disabilities in forced displacement](#) (UNHCR, 2011d);
- [Guiding principles and Strategic Plans from UNHCR's Public Health Section](#) (UNHCR, 2013a);
- [Ensuring Access to Health Care – Operational Guidance on Refugee Protection and Solutions in Urban areas](#) (UNHCR, 2011b);
- [Public health equity in refugee and other displaced persons settings](#) (UNHCR, 2010);
- [Protection Policy Paper: Understanding Community-Based Protection](#) (UNHCR, 2013b);
- [Global Review of UNHCR's mental health and psychosocial support for persons of concern](#) (UNHCR).

Additionally this guidance is in line with interagency consensus around MHPSS and related subjects such as described in:

- [The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#) (IASC, 2007);
- [The Sphere Handbook](#) (The Sphere Project, 2011);
- [The Minimum standards for child protection in humanitarian action](#) (Child Protection Working Group, 2012);
- [Mental health and psychosocial support for conflict-related sexual violence: 10 myths](#) (WHO, 2012a);

- [IASC Guidelines on Gender-Based Violence in Humanitarian Settings](#). (IASC, 2005).
- [Community-based Rehabilitation: CBR Guidelines](#) (World Health Organization et al., 2010).
- Office of The United Nations High Commissioner for Human Rights (2006). [Frequently asked questions on a human rights-based approach to development cooperation](#) (United Nations, 2006).
- [Assessing mental health and psychosocial needs and resources: Toolkit for major humanitarian settings](#) (WHO & UNHCR, 2012).
- [mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings](#) (WHO, 2010).
- [Assessment and Management of Conditions Specifically Related to Stress – mhGAP Intervention Guide Module](#) (WHO & UNHCR, 2013).

2. OBJECTIVES

This document is intended to provide support for UNHCR country programmes to advocate for and facilitate access to quality mental health and psychosocial support (MHPSS) for refugees.

This operational guidance aims to do this through:

- Building a common understanding among UNHCR and partners about MHPSS interventions and their importance for the health and non-health sectors,
- Providing guidance on how to use an *MHPSS approach* throughout the operations,
- Providing practical guidance on how to design *MHPSS interventions* within a multileveled system of care that enhances existing capacities.

Within each refugee operational setting UNHCR should take on a guiding role, and based on the guiding principles described in this document, together with partners, needs to make choices how to organize services and mobilize community support in order to promote a functional and balanced MHPSS system for refugees.

3. GUIDING PRINCIPLES

This document is constructed around the following ten guiding principles. Each of these will be operationalized in chapter four.

1. **Use Rights-based, Community-based and Participatory Approaches**

UNHCR and partners need to ensure that refugees and other persons of concern, including children, youth, women, older persons, sexual and other minorities, as well as groups with specific needs, are involved in all stages of design and implementation of the MHPSS activities.

2. **Ensure equity of care and access**

All refugees and other persons of concern should have access to quality mental health and psychosocial support. This access must be provided to beneficiaries in ways that are similar to the services available to the host population and with at least similar quality and at similar or lower costs and without discrimination within the refugee community.

3. **Assess needs and resources**

MHPSS programmes should be based on systematic and inclusive assessment of needs.

4. **Use a systems approach**

MHPSS programmes should be conceptualized through a systems-based approach with multiple layers of complementary supports with functional referral systems between the different layers.

5. **Strive for integrated service provision**

MHPSS services and support should not be considered as a 'stand-alone' sector, isolated from other services, but should be integrated into existing general community support and public health programmes and systems.

6. Adapt services to the stages of the refugee displacement cycle

Use an MHPSS-approach from the onset of a refugee emergency and a phased approach to developing core MHPSS interventions throughout the displacement cycle.

7. Build capacity

Direct service provision should be accompanied by a strategy for capacity building through partnerships and include systems for follow-up training and supervision.

8. Use appropriate and systematic monitoring and evaluation

MHPSS interventions and methods should be monitored and evaluated systematically.

9. Ensure compliance with UNHCR policies and strategies and national and international standards and guidelines

The provision of MHPSS services should be delivered in ways that are consistent with UNHCR policies and strategies, adhere to minimum international standards and are in line with government policies.

10. Do no harm

It is important to be aware of the potentially negative impacts of humanitarian programmes and activities, including those with the aim to improve mental health and psychosocial support, and to prevent inadvertently harming refugees.

Portrait of a young Syrian refugee taken
in her mobile home in the Za'atari
refugee camp in Jordan. UNHCR /
O. Laban-Mattei



4. OPERATIONAL GUIDANCE

1. USE RIGHTS-BASED, COMMUNITY-BASED AND PARTICIPATORY APPROACHES

UNHCR and partners need to ensure that refugees and other persons of concern, including children, youth, women, older persons, sexual and other minorities, as well as groups with specific needs, are involved in all stages of design and implementation of the MHPSS activities.

All interventions in UNHCR, including those for MHPSS, should prioritize the interests of the refugees, show respect for their decisions, and be guided by principles of confidentiality, safety, security, respect, dignity and non-discrimination. Gender equality and respecting the rights of all refugees of all ages and backgrounds are central to the work of UNHCR. This is reflected in the [Age, Gender, and Diversity Mainstreaming Approach](#) (UNHCR, 2012a) that integrates three strongly interlinked approaches:

- A *participatory approach* that seeks to link refugee participation to programme design, and feedback.
- A *community-based approach* that recognizes the resilience, capacities, skills and resources of the refugees, and focuses on identifying and building on community capacities for self-protection.
- A *rights-based approach* that requires actively working towards the realization of human rights of refugees, seeking to redress discriminatory practices and unjust distributions of power that impede development progress and ensuring that plans, policies and processes of development are anchored in a system of rights and corresponding obligations established by international law.

This operational guidance for MHPSS reflects UNHCRs Age Gender, Diversity approach and attempts to build further on it. Disregard for diversity may lead to a breach of impartiality by the exclusion and marginalisation of groups, which may lead to worsening of the condition of particular groups.

Practical steps

1.1. Consult the community and people with mental and psychosocial problems when designing services

Community consultation should be the norm rather than the exception when designing and implementing interventions for mental and psychosocial problems. This implies:

- Determine how the refugee communities define, identify, and deal with people who have mental and psychosocial problems (including how communities may overlook them).
- Determine how communities cope with disability and psychosocial stress and how the refugee context has perhaps ruptured those coping mechanisms.
- Use participatory methods for needs assessments, and ensure that the voice of people with mental and psychosocial problems and their families is included. Keep in mind that persons most in need may be the least likely to come forward to make their needs known. (See operational guidance point 3 for details on assessment).

1.2. Advocate for the economic and social rights of people with mental health and psychosocial problems

- Encourage people with mental and psychosocial problems to take part in community activities and encourage communities to facilitate their participation.
- Arrange, jointly with the community, sensitive and systematic identification of individuals and/or groups with specific MHPSS needs
- Seek consensus for ways to provide basic services to people with specific MHPSS needs, in consultation with the community and affected persons.

Resources

- UNHCR. (2008). [A community-based approach in UNHCR operations](#). Geneva: Office of the United Nations High Commissioner for Refugees.
- UNHCR. (2011). [Age, Gender and Diversity Policy](#). Geneva: United Nations High Commissioner for Refugees.
- [Protection Policy Paper: Understanding Community-Based Protection](#) (UNHCR, 2013b).
- Office of The United Nations High Commissioner for Human Rights (2006). [Frequently asked questions on a human rights-based approach to development cooperation](#).

2. ENSURE EQUITY OF CARE AND ACCESS

All refugees and should have access to quality mental health and psychosocial support. This access must be provided to beneficiaries in ways that are similar to the services available to the host population and with at least a similar quality and at similar or lower costs and without discrimination within the refugee community.

There may be various reasons why people with mental and psychosocial problems would not receive the assistance they need. This may be due to stigmatization and shame, social marginalization of certain groups and a lack of information about available services.

Practical steps

2.1. Monitor which groups access services and which do not

- Monitor who has access to and *de facto* control of services. In refugee settings, groups or individuals with specific needs may be intentionally or unintentionally ignored or excluded, leading to further problems.

- If marginalized groups are identified, such as women and girls, older persons, persons with disabilities, sexual and other minority groups, or unaccompanied and separated children, work with the community and partners to act on any discriminatory patterns and improve access to MHPSS services for these groups.

2.2. Ensure that people have information about available services and supports for mental health and psychosocial problems

- Take appropriate steps to inform the target population about the availability and location of these services and support.
- Use existing community-based methods of information distribution as much as possible, for example by training community (outreach) workers, health educators, teachers, members of parent-teacher associations or youth clubs, and other key figures within the refugee community and using staff from UNHCR partners in the refugee operation.
- Conduct specific outreach to marginalized groups, if necessary, to reach people who may otherwise remain unaware of MHPSS services, or may not have access due to physical or social barriers.

2.3. Take measures to combat stigma and discrimination of people with mental disorders and psychosocial problems

- People with mental disorders and psychosocial problems and their families may fear that seeking help for such problems makes them vulnerable to discrimination and rejection in the communities.
- In the design of services it is important to minimise any interventions that may cause stigma and discrimination. For example ensure confidentiality using designated consultation rooms and provide MHPSS promotion messages in non-stigmatizing language.
- Actively involve people with mental disorders in the design and execution of interventions. This may send a positive message to communities by demonstrating that people with mental disorders are able to play a useful role in society.

- Integrate services for MHPSS within existing services and support to decrease the barriers to seek help (See operational guidance point 4 for details).

2.4. Take measures to ensure that individuals with specific MHPSS needs are able to access basic services.

Ensure that people with specific MHPSS needs are able to access basic services. In some cases it may be necessary to conduct outreach to excluded groups, who may be unaware of MHPSS services, or may not have access due to physical or social barriers. Examples of potential measures are:

- Arrange for peer-support if children have difficulties to access education, for example because a child or parent is too afraid of the walk to an educational facility.
- Include messages of equal access to services in any sensitization messages in the community.
- Advocate for medication for chronic mental, neurological or substance use (MNS) conditions that are affordable to all, by making them either free of charge or available at subsidized rates.
- If necessary and appropriate, arrange for adapted systems for distribution of food and non-food items to people with specific needs to ensure that they are not being taken advantage of or discriminated.

3. ASSESS NEEDS AND RESOURCES

MHPSS programmes should be based on systematic and inclusive assessment of needs.

Assessments within UNHCR operations are generally aimed at providing a better understanding of the refugee context, the problems of refugees, their ability to deal with these problems, the resources that are already available and the kind of response required to strengthen these resources. MHPSS needs and resources should be included in the assessment processes.

Practical steps

3.1. Assess MHPSS needs

- Include the perspectives of various stakeholders including girls and boys, youth, women, men, older people and different cultural, religious and socio-economic groups.
- Collect only information that will result in direct action. Collecting too much data wastes resources and places unnecessary burdens on interviewees.
- Use a broad definition of mental health and psychosocial problems. Assessments with a narrow perspective, such as focusing only on one mental disorder such as posttraumatic stress disorder (PTSD), do not provide the data needed to design a salient and comprehensive MHPSS programme.
- Collect and analyse existing information to avoid duplicating assessments.
- Coordinate design, implementation and interpretation of assessments with relevant stakeholders including, where possible, governments, NGOs, community and religious organisations, local universities and affected populations.
- Use tools that are appropriate to the specific refugee setting. Usually qualitative methods are best suited to quickly get an understanding of the most urgent problems and the way various stakeholders perceive these problems. See box 1 for a quick general overview of this methodology.
- In the context of standard programming in refugee settings it is not recommended to do research on prevalence figures of mental disorders because this is methodologically complicated, requires specific resources and, most importantly, the research outcomes are not essential to design services.¹ As a rule of thumb the projections by WHO for mental disorders in adult populations affected by emergencies can be used. See box 2.

1 The use of self-report questionnaires to estimate prevalence figures of mental disorders in the midst of emergencies is controversial. In many humanitarian settings self-report instruments such as the Hopkins Symptom Checklist -25 (HSCL-25), the Self-Reporting Questionnaire (SRQ) for common mental disorders and the Harvard Trauma Questionnaire for PTSD do not distinguish adequately between *non-disordered distress* (for example stress that is related to the current living circumstances of refugees) and *mental disorder* (conditions outside normal reactions usually associated with significant impairment in functioning), and may thus provide grossly inflated 'estimated prevalence rates' for depression and anxiety disorders. The WHO/UNHCR *Toolkit for humanitarian settings: Assessing mental health and psychosocial needs and resources* therefore does not recommend these instruments for population-based needs assessments of mental disorders in humanitarian settings.

BOX 1: USING RAPID ASSESSMENT METHODS FOR MHPSS IN REFUGEE SETTINGS

Rapid assessment methods can be used to quickly gather information on MHPSS issues and resources in an identified area or community. These methods can be used to quickly gather contextual, social and institutional information to develop intervention programmes.

Key aspects of these methods are:

- Rapidity
- An intervention focus;
- Multi-sectoral engagement – including health, community and protection;
- Multi-level analysis – individual, community, structural;
- A community-based approach – engaging community members from the beginning; and
- A predominantly qualitative nature.

These methods use the following principles:

- Multiple data sources and continued triangulation of data (verification of information by cross-checking with other sources); for example, interviews conducted by one person with one interpreter are not sufficient and must be verified by other sources of information;
- An iterative approach to hypothesis formulation and testing, evolving throughout the data collection and analysis period; and
- Data saturation, where further data collection provides little or no new information.

Based on UNHCR & WHO (2008)

**BOX 2: WHO PROJECTIONS OF MENTAL DISORDERS IN ADULT POPULATIONS
AFFECTED BY EMERGENCIES (WHO & UNHCR, 2012)**

	Before the emergency 12-month prevalence ^a	After the emergency 12-month prevalence ^b
Severe disorder (e.g. psychosis, severe depression, severely disabling form of anxiety disorder)	2% to 3%	3% to 4% ^c
mild or moderate mental disorder (e.g. mild and moderate forms of depression and anxiety disorders, including mild and moderate posttraumatic stress disorder)	10%	15% to 20% ^d
normal distress / other psychological reactions (no disorder)	No estimate	Large percentage

- a. The assumed baseline rates are median rates across countries as observed in World Mental Health Surveys.
- b. The values are median rates across countries. Observed rates vary with assessment method (e.g. choice of assessment instrument) and setting (e.g. time since the emergency, sociocultural factors in coping and community social support, previous and current exposure to adversity).
- c. This is a best guess based on the assumption that traumatic events and loss may contribute to a relapse in previously stable mental disorders, and may cause severely disabling forms of mood and anxiety disorders.
- d. It is established that traumatic events and loss increase the risk of depression and anxiety disorders, including posttraumatic stress disorder

3.2. Assess resources for MHPSS

- Assess available resources for MHPSS, both formal and informal resources, to increase the likelihood that any humanitarian response builds on the supports, resources and capacities that are already there.
- Conducting an initial assessment and analysis of existing practices, training needs and competencies with all stakeholders involved in MHPSS, to make sure the training fits within the larger system.

See annex 3 for tools that can be used in MHPSS assessments.

Resources

- IASC-RG MHPSS. (2012a). [IASC Reference Group Mental Health and Psychosocial Support Assessment Guide: IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings.](#)
- IASC-RG MHPSS. (2012c). [Who is Where, When, doing What \(4Ws\) in Mental Health and Psychosocial Support: Manual with Activity Codes \(field test-version\).](#) Geneva: IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings.
- UNHCR. (2006). [Participatory Assessment in Operations.](#) Geneva: United Nations High Commissioner for Refugees.
- UNHCR, & WHO. (2008). [Rapid Assessment of Alcohol and Other Substance Use in Conflict-affected and Displaced Populations: A Field Guide.](#) Geneva: United Nations High Commissioner for Refugees.
- WHO & UNHCR. (2012). [Assessing mental health and psychosocial needs and resources: Toolkit for major humanitarian settings.](#) Geneva: World Health Organization.

4. USE A SYSTEMS APPROACH

MHPSS programmes should be conceptualized as systems with multiple layers of complementary supports with functional referrals between the different layers. A generic MHPSS approach should be combined with specific MHPSS interventions.

Different people will have different types of needs (ranging from preventive and promotion services to specialized treatments), and it is crucial that the diversity of needs are taken into consideration. It is equally important to promote a balanced and justified use of resources. Therefore MHPSS activities should be developed within a system of multiple layers of complementary supports with referral systems.

MHPSS is recognized as a crosscutting issue within the humanitarian response and not the sole responsibility of a handful of specialists. Many interventions by actors in the humanitarian response have an effect on the mental health and psychosocial wellbeing of refugees and other persons of concern. Within this operational guidance we distinguish between a 'MHPSS approach' and 'MHPSS interventions' (see box 3).²

BOX 3: MHPSS APPROACH AND MHPSS INTERVENTIONS

Adopting an **MHPSS approach** means providing a humanitarian response in ways that are beneficial to the mental health and psychosocial wellbeing of the refugees. This is relevant for all actors involved in the assistance to refugees.

MHPSS interventions consist of one or several activities with a primary goal to improve the mental health and psychosocial wellbeing of refugees. MHPSS interventions are usually implemented by in the sectors for health, protection and education.

2 A similar distinction between a 'psychosocial approach' and 'psychosocial interventions' is made by NGOs such as TdH (Terre des hommes, 2010).

Practical steps

4.1. Create a balance between a generic MHPSS approach and specific MHPSS interventions

Creating a balanced MHPSS system may be challenging when interest groups try to push for a narrowly defined MHPSS agenda (for example focusing only on specific groups such as SGBV survivors, former child soldiers, survivors of torture, or initiating specialized services without strengthening the other levels of a multi-layered MHPSS service delivery system). The needs of specific groups must be addressed by MHPSS programmes, but ‘overtargeting’ of such groups should be avoided as it can create risks for discrimination and tensions in the community.

An MHPSS approach alone will not be able to address more complex problems, although it may contribute to prevention of such problems, and create fertile ground for MHPSS interventions where these are needed.

MHPSS interventions have as specific goal to improve mental health and psychosocial wellbeing of refugees, but this should preferably not lead to stand-alone activities. Activities that are integrated into wider systems like general health services, education, or social services or are embedded within existing community support mechanisms, tend to be accessible to more people, are often more sustainable, and tend to carry less stigma (IASC, 2007). See Guiding principle 5.

When developing MHPSS interventions:

- Ensure that psychosocial supports are integrated within other pre-existing community services and networks.
- Prioritize normalization of educational facilities, even in emergency stages of operations, since this will provide significant opportunities for support to children and their caregivers.
- Ensure that mental health care is functionally linked to and integrated into the general health system, rather than establishing parallel mental health services.

4.2. Build a system of multi-layered services

A good way to conceptualize a balanced MHPSS system is the IASC pyramid of multi-layered services. See figure 1. In this section the principles of a multi-layered system of MHPSS services will be described. Details about specific activities, and how to position them within the sectors of UNHCR operations will be described under ‘guiding principle 5’.

Layer 1: Provision of basic services and security

Ensure that *provision of basic needs and essential services* (food, shelter, water, sanitation, basic health care, control of communicable diseases) and security is done in a way that does not undermine psychosocial wellbeing or negatively affect mental health. This implies that the actors responsible for providing these essential services should use a ‘MHPSS approach’. This may require advocacy from MHPSS professionals to ensure that these services and assistance are inclusive for people with specific vulnerabilities including people with mental disorders, survivors of sexual and gender based violence, but avoid exclusively targetting a single group as this can lead to discrimination, stigma, and potential further distress.

Layer 2: Strengthen community and family supports

Refugees, as anyone else, maintain their mental health and psychosocial wellbeing through using key community and family support. In many refugee settings there are significant disruptions of family and community networks and it is therefore important to enable refugee communities to (re) establish these support systems. Emergencies often damage the social structures among refugees and may negatively affect the ability of people to support each other effectively. Activities to foster social cohesion amongst refugee populations are therefore very important. Within UNHCR coordinated operations activities related to this layer are usually implemented through Community-based Protection and their partner organizations and may include activities such as supporting the re-establishment and/or development of refugee community based structures which are representative of the population from an age, gender and diversity perspective and supporting community opportunities to improve the wellbeing of persons of concern (UNHCR, 2007a).

Layer 3: Focused psychosocial supports

A number of people will require more focused individual, family or group interventions by trained and supervised general health workers or community workers. Participants in these activities are usually people who have difficulty coping with their existing support network.

Layer 4. Clinical services

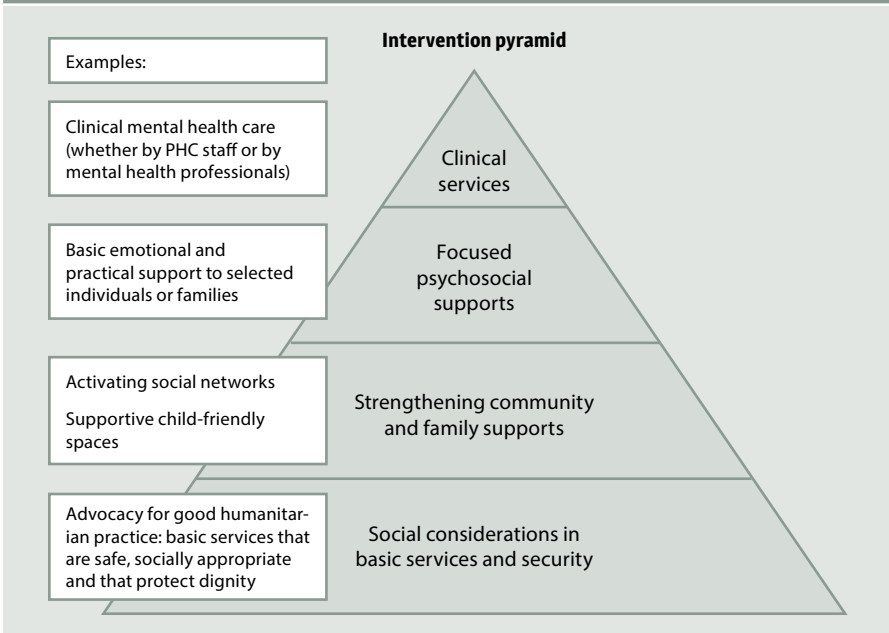
A relatively small percentage of the population will have severe symptoms, and/ or an intolerable level of suffering, and have great difficulties in basic daily functioning. This group includes people with pre-existing mental health disorders and emergency-induced problems. Examples are people suffering from psychosis, drug abuse, severe depression, disabling anxiety symptoms, and people who are at risk to harm themselves or others.

Examples of interventions at this level:

- Delivery of basic primary mental health care by trained doctors, nurses, clinical officers.
- Supervision and monitoring of primary care staff by a visiting/supervising psychiatrist.

(see 5.2. for more details)

FIGURE 1. THE IASC PYRAMID (ADAPTED WITH PERMISSION)



4.3. Develop Standard Operating Procedures (SOPs) for referral

It is of key importance to establish functional links between various types of services and support. This can be enhanced by:

- Establish clear standard operating procedures for the referral of cases.
- Appoint MHPSS focal points for each relevant sector in the refugee operation (minimum: health, community-based protection and education).
- Appoint community based (psycho)social workers or case-managers, who can serve as links between interventions on community level and interventions in the primary health care centre and more specialized settings. They can also assist people with mental health and psychosocial problems and their family in accessing appropriate services and supports.
- Regular meetings of practitioners on local level to discuss difficult cases, referrals, and coordinated interventions.

4.4. Establish coordination mechanisms for MHPSS

MHPSS interventions should be coordinated at country level, as well as on the level of actual provision of services for individuals, families and communities. Given the multi-sectoral nature of MHPSS it is essential to engage stakeholders from various sectors in the development of MHPSS interventions. Sectors that should be included are health, community based protection, education and camp coordination & camp management/ or other established field coordination mechanism for the out of camp situations.

Coordination at country level

- Create mechanisms to harmonize MHPSS activities in the operations.
- Participate in interagency MHPSS working groups if these are established.
- Ensure MHPSS is discussed, where relevant, in on-going sectoral coordination meetings.

Coordination at local level

- Create an MHPSS working group that meets regularly to discuss services and discuss complex cases. Such group should include staff from relevant sectors (health, community-based protection, education) including service providers.
- Create a mechanism for feedback from the refugees themselves for example by initiating an advice committee from people with mental health and psychosocial problems and community representatives.
- Ensure mental health is discussed in the on-going monthly health coordination meetings, for example by making it a standard point on the agenda.
- Ensure MHPSS is discussed in ongoing sectoral coordination meetings.
- Ensure that there is an updated database (eg 3-monthly) on who is where when doing what (4Ws) for MHPSS (IASC-RG MHPSS, 2012c).

Resources

- IASC. (2007). [IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#). Geneva: Inter-Agency Standing Committee.
- IASC-RG MHPSS. (2012b). [Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Camp Coordination and Camp Management Actors Know?](#) Geneva: IASC Reference Group for Mental Health and Psychosocial Support.
- The Sphere Project. (2011). [Humanitarian Charter and Minimum Standards in Disaster Response](#). Geneva: the Sphere Project.

5. STRIVE FOR INTEGRATED SERVICE PROVISION

Mental health and psychosocial support should not be considered as a 'stand alone' sector, isolated from other service and support, but should be integrated into existing general community support and public health programmes and systems.

Practical steps

5.1. Promote the adoption of an MHPSS approach within UNHCR and with partners

Employing participatory approaches and providing services in a respectful way can foster psychosocial wellbeing of refugees. Staff involved in the refugee response may not always be aware of the effects of their interventions for mental health and psychosocial wellbeing. Therefore it is important that all stakeholders in the UNHCR supported programmes develop an awareness for MHPSS as a cross cutting issue.

Examples of activities

- Inclusion of MHPSS items in general needs assessments including participatory assessments (See part 10.1. for more details);
- Improving awareness of and information on MHPSS in refugee populations by UNHCR staff working in reception centres and registration desks, through for example
 - Organizing a seminar for registration staff on MHPSS in refugees, which could include aspects such as effective communication skills, dealing with strong emotions, identifying MHPSS problems in refugees etc.
- Attention to effects on psychosocial wellbeing in UNHCR supported activities in various sectors/clusters such as camp coordination and camp management, shelter, water & sanitation and nutrition. The manner in which a camp is designed and set up, how basic services are organized, offered and communicated, and the extent to which the sense of agency of the residents is promoted or disregarded all contribute towards the well-being of camp residents, and can mitigate or enhance the distress. Promoting participation of the refugee community in construction/rehabilitation of their shelters, maintenance of water stands, latrines, maintaining playgrounds, helps refugees to regain a sense of control and agency (IASC-RG MHPSS, 2012b).
- Inter-sectoral capacity building and training on integrating MHPSS. Examples are:
 - Organizing 0.5-day or 1-day orientation seminars on Psychological First Aid (PFA) for emergency deployments (WHO et al., 2013 (in press))
 - Organizing 0.5-day or 1-day seminars on effective communication and active listening skills for general health workers.
 - Include training on communication skills and dealing with strong emotions in training for staff and volunteers involved in educational programming.
- Integrating MHPSS into Sexual and Gender Based Violence (SGBV) training for workers involved in programmes for Community Based Rehabilitation (CBR), SGBV.
- Orient and/or refresh senior managers in all sectors about the importance of using an MHPSS approach in all sectors, for example by organizing a short briefing session for the senior management.

- Ensure that groups or individuals with specific MHPSS needs are able to access basic services such as distribution of food and non-food items. If necessary and appropriate, arrange for separate queuing systems or a 'buddy/helper' system and monitor the distribution of goods to groups or individuals with specific needs to ensure safe, dignified and equitable access.

Resources

- IASC-RG MHPSS. (2012b). [Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Camp Coordination and Camp Management Actors Know?](#) Geneva: IASC Reference Group for Mental Health and Psychosocial Support.
- UNHCR. (2011d). [Working with persons with disabilities in forced displacement. Need to Know Guidance nr 1.](#) Geneva: Division of International Protection, United Nations High Commissioner for Refugees.
- WHO, World Vision International, & War Trauma Foundation. (2013 (in press)). Orientation seminars on Psychological First Aid (PFA) (working title). Geneva: World Health Organization, World Vision International & War Trauma Foundation.

5.2. Design and implement core MHPSS interventions in community-based protection programmes

Most communities are already employing protection measures to support vulnerable members within their communities. It may be possible to maintain or revitalize strategies that refugee populations used before they became refugees. However, some coping strategies (for example measures to restrict freedom of movement for women, or measures that exclude religious, ethnic, or other minorities) may create harm and may be particularly disadvantageous for some vulnerable groups. Refugees frequently establish community-based groups or committees. Such groups may become a mechanism for strengthening protection responses and advocacy and can be actively used to promote psychosocial wellbeing and minimize the negative effects of mental disorders.

MHPSS activities in the community protection programmes are usually situated in layer 2 (strengthen community and family supports) and layer 3 (focused psychosocial supports) of the IASC pyramid (see figure 1. page 32).

Examples of activities

- Establish Child Friendly Spaces, and youth friendly spaces or activities (Guidelines for Child Friendly Spaces in Emergencies, 2011).
- Implement recreational activities and engagement of young adolescents through sport activities, access to computer and literacy classes.
- Facilitate of community support activities through self-help groups in the community and/ or integrate psychosocial support projects into multi-functional community centers in urban settings.
- Facilitate and train staff and volunteers from community based groups (such as women's groups, youth organisations, cultural groups and religious groups (churches, mosques, etc.) to provide support to people with mental and psychosocial problems in an adequate way.
- Support activities aimed at reducing tensions among refugees themselves and between refugees and surrounding communities.
- Integrate basic MHPSS concepts in the training and supervision of community outreach workers and volunteers and train them to for example:
 - Provide a mixture of emotional and livelihood support for e.g. survivors of sexual and gender-based violence (SGBV) and people requiring rehabilitation from conflict-related injuries or torture.
 - Provide individual or group psychological or psychosocial interventions for people with mild depression or mild anxiety.
- Promote integration of people with severe mental disorders, intellectual disabilities and epilepsy in programmes for Community Based Rehabilitation.
- Appoint case managers/social workers to assist refugees with multiple or complex mental and psychosocial problems to access services.
- Start activities to decrease harmful use of substance and alcohol: engage in discussions with camp managers (field staff) and community representatives and health workers about options to minimize harmful use of alcohol and drugs in the camp (for example barring alcohol sale, regulating opening hours for sale, or prohibiting alcohol shops/ bars to be located near collective shelters in urban contexts).

Resources

- ARC (Action for the rights of children). (2009). [Foundation module 7: Psychosocial support: ARC resource pack](#). Geneva: ARC. (ARC (Action for the rights of children), 2009).
- [Guidelines for Child Friendly Spaces in Emergencies](#). (2011): Global Education Cluster, Global Protection Cluster, Inter-Agency Network for Education in Emergencies (INEE) & IASC Reference Group for Mental Health and Psychosocial Support.
- UNHCR. (2008a). [A community-based approach in UNHCR operations](#). Geneva: Office of the United Nations High Commissioner for Refugees.
- World Health Organization, War Trauma Foundation, & World Vision International. (2011). [Psychological first aid: Guide for field workers](#). Geneva: WHO.
- IASC (2007) [Minimise harm related to alcohol and other substance use. Action Sheet 6.5 in Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#). Geneva: Inter-Agency Standing Committee.

See also:

- <http://psychosocial.actalliance.org> (ACT Alliance – Guide on Community based Psychosocial Support).
- <http://mhpps.net> (Mental health and Psychosocial Support Network).

5.3. Design and implement MHPSS interventions within educational programmes

Education is an important tool within UNHCR's broad protection mandate. Education for children and youth early within emergency situations has a normalizing effect and may thus lessen the psychosocial effects of extreme stressors and displacement and protect at-risk groups (UNHCR, 2001). Education may not only produce a healing effect on children, but also on parents and communities as a whole, by introducing some routine and normalcy into refugees' lives and giving them hope for a better future. In addition, parents who have been psychologically affected by past events and current stressor may be provided better opportunities to learn cope with the new situation when they know their children are cared for some hours during the day. The extent to which the educational system contributes to the psychological and emotional well-being of children can be influenced by the quality of the educational programming provided (UNHCR, 2011c). MHPSS activities in education programmes are usually situated in layer 2 (strengthen community and family supports) and layer 3 (focused psychosocial supports) of the IASC pyramid (see figure 1 on page 32).

Examples of activities

- Train educators in fostering a supportive, gender-sensitive learning environment and using child friendly learning methods for children with learning and behavioural difficulties.
- Provide psychoeducation for caregivers of children with MHPSS problems.
- Develop a system of psychosocial support for all educators including peer support systems.
- Facilitate the establishment of parent/school associations and provide training to them, accompany them if needed.
- Train teachers to identify children with MHPSS problems and refer them to dedicated persons in the health sector such as a psychiatric nurse or case manager.
- Organize social events, including sports events, around schools and existing informal education programmes to maximize schools' potential to have a positive impact on parents and the community.
- Create a system of follow-up on drop-outs, e.g. out-of-school clubs.

- Ensure safe learning environments so that children feel that schools are safe and conducive to learning. This involves both infrastructural safety such as well-built classrooms and separate latrines for boys/girls, as well as the culture within the school, with policies against corporal punishment, exploitation by teachers, discrimination of minority children or children with special needs.

Resources

- [Guidelines for Child Friendly Spaces in Emergencies](#). (2011): Global Education Cluster, Global Protection Cluster, Inter-Agency Network for Education in Emergencies (INEE) & IASC Reference Group for Mental Health and Psychosocial Support.
- INEE (Inter-Agency Network for Education in Emergencies) (2008). INEE Minimum standards toolkit: psychosocial protection and well-being. Retrieved from http://ineesite.org/uploads/documents/store/doc_1_Combined_INEE_Psychosocial_Toolkit_Sheets.pdf (INEE (Inter-Agency Network for Education in Emergencies), 2008).
- INEE. (2010). [Minimum Standards for Education: Preparedness, Response, Recovery](#). Geneva: Interagency Network for Education in Emergencies.

See also:

- <http://mhps.net> (Mental health and Psychosocial Support Network).

5.4. Design and implement MHPSS interventions within health programmes

People with mental disorders and /or psychosocial problems frequently present to general health services, but their problems are frequently not properly identified and managed. General health care staff must have some basic knowledge to identify and manage people with MHPSS problems (which includes people with psychological distress, mental disorders, substance use problems, unexplained medical complaints and epilepsy).

MHPSS interventions that must be implemented within health programmes

- ***Train and supervise primary health care providers***
 - Train health staff (e.g. clinical officers, medical doctors, nurses) using the mhGAP Intervention Guide (WHO, 2010), preferably using the forthcoming version for humanitarian settings (WHO & UNHCR, in preparation).
 - Regular support visits by a psychiatrist for supervision and mentoring, at least twice per month).
- ***Ensure that people with severe mental disorders have access to care***

Severe mental disorders (such as psychosis and severe depression) are highly have a huge impact on the affected person, the family and the communities. They make people highly vulnerable. Access to minimum care for people with severe mental disorders must therefore be made available in all UNHCR operations. It is generally preferable for people with severe mental disorders to remain within their own setting. This implies that:

- Hospitalizations need to be avoided and if they are required they should be limited to short term admissions for emergencies (e.g., if the person exhibits behaviour that is dangerous or harmful for the person or for others).
- People with severe mental health problems should have access to a network of community-based social supports as well as clinical care through available health services (e.g., general hospitals, primary care clinics, etc.). Organizing basic clinical mental health care usually involves either organizing rapid training and supervision of general health staff or adding a mental health professional to the health facility.
- Mechanisms must be developed to identify people with severe mental disorders, particularly the most vulnerable among them, and link them to available services. This can be best done in consultation with key community

informants, including religious leaders/healers and community workers, who often serve as a first contact.

- Ensuring regular follow-up for people with severe mental disorders and their families. This can be done by involving community workers and refugee outreach volunteers.
- Case managers and social workers (or staff from Community-based Protection) should promote that refugees receive adequate social and family support aside from addressing their medical needs.

- ***Ensure that care for people with epilepsy is made available***

Epilepsy and seizure disorders are common and need to be treated within the general health care system by trained and supervised general health workers.

- ***Provide essential drugs***

Each health programme should make generic medication available for selected mental, neurological and substance use disorders, using the UNHCR essential medicine list.

- ***Make sufficient human resources for MHPSS available***

For camp based operations, see box 4. In non-camp based operations such as in urban settings, different arrangements can be made based on available resources. Here, too, the principle is to provide mental health services at logical and accessible points of access, preferably integrated within general health care systems. If resources allow consider assigning and training 'case managers'.

BOX 4: HUMAN RESOURCES FOR MHPSS IN THE HEALTH SECTOR IN CAMP-BASED OPERATIONS

- A mental health professional (typically a psychiatric nurse, but in some contexts this may be a psychiatrist) employed within the health care system for assessment and management of people with severe or complex mental disorders and to provide guidance and support to primary health care staff.
 - Availability (usually on parttime or consultative basis) of other mental health specialists (psychiatrists, clinical psychologists, psychiatric nurses) to support the primary health care staff and build their capacity through training, consultation, mentoring and supervision.
 - Trained community based workers (refugee outreach volunteers or community health workers) to do home based follow up and support and link people with MHPSS problems (including epilepsy) to health and community services and to encourage /support self-help and mutual support for people with MHPSS problems.
-
- Establish links between facility-based health professionals and other staff such as social workers, community services' staff or refugee outreach volunteers for home visits to persons with mental disorders.
 - Ensure the integration of early childhood stimulation in nutrition programmes for children with severe and moderate malnutrition (UNICEF & WHO, 2012).

Examples of MHPSS interventions that may be implemented within health programmes

- Consider making evidence-based psychological treatments available for people with disabling forms of depression³ or disabling forms of posttraumatic stress disorder.⁴
- Facilitate the integration of integrated early child development (ECD) initiatives in the health sector.

3 Evidence-based psychological treatments for disabling forms of depression include Behavioural Activation, Cognitive Behavioural Therapy, Interpersonal Therapy. See WHO (2010). Feasibility of these treatments in refugee settings is dependent on available resources and cultural and social relevance.

4 Evidence-based psychological treatments for posttraumatic stress disorder include EMDR (Eye Movement Desensitization and Reprocessing) and trauma-focused cognitive behavioural therapy (WHO & UNHCR, 2013) Feasibility of these treatments in refugee settings is dependent on available resources and cultural and social relevance. These treatments should only be used where qualified training and supervision is in place.

- Consider integrating *screening* and *brief interventions* for alcohol and drug use in primary health care settings;
 - The ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) is an eight item *screening* questionnaire that can be administered by a health worker to patients in a primary health care setting. It takes about 5-10 minutes to administer (Humeniuk et al., 2010a);
 - Trained health workers can subsequently offer a *brief intervention* to people with a high score on the ASSIST. The brief intervention follows ten well described steps and lasts 3 to 15 minutes (Humeniuk et al., 2010b).

Generally, brief interventions are not intended as stand-alone treatments for people who are dependent or at high-risk for alcohol and drug use, and need to be complemented by more specialized treatment, either within general health care or by a specialized alcohol and drug treatment centre.

- Do not routinely implement MHPSS screening of patients in the health care system or the general population without a clear evaluation of benefits and harms. There is not enough evidence to advise using routine screening for MHPSS problems in refugee settings. (*See Box 5*)

BOX 5: MHPSS SCREENING

Screening for mental health and psychosocial conditions should only be considered if:

- The mental health and psychosocial conditions constitute a significant problem affecting the health and wellbeing of individuals and the community.
- A suitable screening test is available which is acceptable to the refugee population and can be made available at a reasonable cost.
- Early identification and intervention leads to better outcomes than later treatment.
- There are acceptable treatments or interventions available for refugees who screen positive.
- There are sufficient resources to provide the intervention to all who screen positive

Adapted from: Humeniuk et al. (2010b)

Resources

- WHO. (2012). [Mental health and psychosocial support for conflict-related sexual violence: principles and interventions](#). Geneva: World Health Organization.
- UNICEF & WHO. (2012). [Integrating Early Childhood Development \(ECD\) into Nutrition Programmes in Emergencies. Why, what and how](#). New York: UNICEF.
- WHO. (2010). [Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings](#). Geneva: World Health Organization.
- WHO & UNHCR. (2013). [Assessment and Management of Conditions Specifically Related to Stress](#). mhGAP Intervention Guide Module.
- WHO & UNHCR. (in preparation). MhGAP Humanitarian Intervention Guide: Clinical management of mental, neurological and substance use conditions: initial response in humanitarian settings Geneva: World Health Organization and United Nations High Commissioner for Refugees (publication scheduled for 2014).
- World Health Organization, International Committee of the Red Cross, International Federation of Red Cross and Red Crescent Societies, Médecins Sans Frontières, United Nations Children's Fund, United Nations Population Fund, & United Nations High Commissioner for Refugees. (2011). [The interagency emergency health kit 2011: medicines and medical devices for 10 000 people for approximately three months](#). Geneva: World Health Organization.
- World Health Organization, War Trauma Foundation, & World Vision International. (2011). [Psychological first aid: Guide for field workers](#). Geneva: WHO.
- World Health Organization. (in preparation). *Mental Health Gap Action Programme (mhGAP) Training Course for Community Health Workers Slides and Facilitation Guide* (WHO, in preparation).

See also:

- <http://mhpps.net> (Mental health and Psychosocial Support Network).

5.5. Adaptations in urban refugee settings within community protection and health programmes

The setting in which the refugees are located influences the way MHPSS interventions can be organized. Increasingly refugees are spread out over larger urban and other out of camp settings. The organisation of MHPSS interventions in such settings faces particular challenges such as difficulties in obtaining access to the community, developing adequate communication channels, difficulties in identifying the most vulnerable refugees and other persons of concern, and mapping support and services. Examples of successful adaptations in urban and out of camp settings include:

- Installing a system of community based psychosocial refugee outreach volunteers who conduct home visits, facilitate support groups and accompany persons of concern to appointments.
- Appointing (mobile) psychosocial case managers who act as intermediary between refugees and services and can manage persons or family with multiple problems.
- Establishing community centres in which psychosocial support is integrated within other activities for community building, such as recreational activities and vocational training.
- Facilitating access to existing mental health services in the host country.
- Supporting the development of services (such as outpatient mental health care at general hospitals) that are integrated in the national health system and are accessible for refugees and other persons of concern.
- Hotlines – both for emergency response e.g., providing support and advice to people with urgent MHPSS problems such as suicidality and SGBV, and to provide general information on available services/ opening times of clinics etc.

Resources

- WHO (2013). [Building Back Better: Sustainable Mental Health Care After Disaster](#). Geneva: World Health Organization.

6. ADAPT SERVICES TO THE STAGES OF THE REFUGEE SITUATION

It is important to use an MHPSS approach from the onset of a refugee emergency and for all ongoing refugee programmes, and use a phased approach to develop core MHPSS interventions.

Much of the existing guidance for MHPSS is designed for refugee camp settings, while refugees and other persons of concern increasingly are located in urban settings/out of camp that require significant adaptations to programme design.

Practical steps

6.1. Contingency planning

When an emergency situation is considered likely within the next twelve months, the operation should prepare for potential scenario's. MHPSS aspects need to be taken into account. Contingency planning should be an integral part of any UNHCR operation. MHPSS should be mainstreamed in any response being planned by the operation.

Examples of interventions in this stage

- Conduct risk analysis, develop response plans, with communities and governments, including early warning systems, and strengthen local capacity to implement such plans.
- Consider what the approach will be to particularly vulnerable persons (unaccompanied minors, the elderly, single female headed households, people with severe mental disorder or severe learning disabilities and other disabilities).
- Consider whether special arrangements need to be made to ensure that all groups in the community have equal access to relief commodities and services and how refugee community structures can be mobilized to meet these needs.
- Take measures for ensuring supply of medication (for example providing patients

with chronic mental disorders or epilepsy with larger than usual quantities of medication.

- Train and supervise existing community and health workers on how to provide appropriate emergency MHPSS support.
- Organize training in Psychological First Aid (0.5-1 day) for staff and community volunteers.

6.2. Immediate response in acute emergencies

This situation is characterized by sudden massive displacements of refugees and an overwhelmed response system. Here most of the interventions including the MHPSS interventions are aimed at survival and meeting immediate and acute basic needs.

Examples of interventions in this stage

- Providing essential medicines for treatment of mental disorders and epilepsy consistent with the InterAgency Emergency Health Kit (World Health Organization, International Committee of the Red Cross, et al., 2011); and UNHCR essential medicine list.
- Ensuring that family tracing services and child friendly spaces are not only protective but also supportive.
- Incorporate psychological first aid into a standard package of post-rape care offered by (locally determined) first point of contact (WHO, 2012b).
- Provide SGBV survivors with survivor-centred information (where to obtain response services and what to expect).
- Facilitate conditions for mourning, including the appropriate, dignified and respectful burial of dead persons.
- Establish clear referral mechanism between health and protection/community services.
- Ensuring access to care people with severe mental disorders and epilepsy.

- PFA training for humanitarian workers, if not done during preparedness phase.
- Human rights protection of people with severe mental disorders, particularly those in institutions.
- Set up temporary learning spaces.

6.3. Post emergency/ stabilization phase

As the situation stabilizes, outreach psychosocial activities can be expanded (including engagement of community leaders and traditional healers), community workers trained in core psychosocial and mental health skills, referral networks established, and health workers trained and supervised in basic mental health knowledge and skills. In general there will be a transition from emergency response to longer-term support (care and maintenance). It is very important to include communities into the planning and running of the programmes.

Examples of interventions in this stage

- Train and supervise of general health workers in diagnosis and treatment of mental disorders and epilepsy.
- Establish trainings for MHPSS caseworkers or community based (psycho)social workers;
- Promote diversification of core MHPSS interventions in order to cater for various needs;
- Making available evidence-based psychological treatments, such as interpersonal psychotherapy, if appropriate.
- Start community based programmes for preventing and responding to SGBV, and to reduce alcohol and drug use.
- Start community based rehabilitation programmes that include persons with conflict-related injuries and persons with intellectual disabilities, severe mental disorders or epilepsy.
- Start more formal education programmes and explore possibilities of integration into national education system.

6.4. Protracted refugee situations

Long-term refugee situations may lead to loss of hope and frustration and dependence. Interventions should focus on full participation of the refugees and on empowerment, while looking for linkages to surrounding systems of care in the host population. Interventions are rather similar to phase 2, but with even more attention to self-reliance for families, community development, self-help, and addressing socio-economic factors, which affect the wellbeing of refugees. Coordination with development agencies is important to work towards durable solutions.

6.5. Transition to durable solutions

A humanitarian situation may end when refugees are repatriated or integrated into the local community or resettled to a third country. MHPSS interventions should be aimed at aiding the transition to durable solutions.

Examples of interventions in this stage

- Ensure capacity building of local governments and NGOs during the integration process;
- Enabling people to independently seek MHPSS care when they transition from one country to another;
- Establish confidential referral systems for referral of returnees into existing mental health services in their country of origin and ensure establishment of safety nets and support for them and their families;
- Ensure all medical confidentiality is kept where confidential medical documentation is involved.
- Prioritisation of people with MHPSS vulnerabilities for resettlement to third countries, bearing in mind that resettlement (particularly of individuals on their own) is not always the best response, but that analysis should be done on a case-by-case basis.

7. BUILD CAPACITY

Direct service provision should be accompanied by a strategy for capacity building and knowledge management through partnerships and includes systems for follow up training and supervision.

Practical steps

7.1. Ensure appropriate training of staff

Training is an important part of any effective MHPSS programme. Training activities must be well targeted to meet the objective of the programme, and this is dependent on the definition of roles and responsibilities among various levels of health care and identifying the necessary qualifications.

- Training should only focus upon knowledge and skills that the trainees are likely to use in practice. Competency-oriented trainings (focused on transfer of practical skills) are preferred to knowledge-oriented trainings.
- Training methodology should be based on the principles of adult learning, providing an active role for the participants in what they learn and how they learn.
- Training should have clear expectations, and thus not only contain information about what the trainee *can* do, but also what they *cannot* do independently. It must be clear what activities should be done only under supervision and when referral needs to take place. For example, a short MHPSS course for teachers will not make them professional psychosocial counsellors.
- Initial training should be followed by supervision, mentoring and refresher training.
- MHPSS training must be functionally linked to other training activities in the same and where possible be fully part of these general programmes (for example, integrating MHPSS in general curricula for health workers, teachers or social workers, including staff working with SGBV survivors).

Resources

- Action for the Rights of Children. (2009). *ARC resource pack: Facilitator's toolkit* (<http://www.arconline.org>).
- WHO. (nd). *Facilitators guide for mhGAP-IG Base course training*. Geneva: World Health Organization.
- WHO. (n.d.). *mhGAP Training of Trainers and Supervisors (ToTS). Guide* Geneva. Unpublished draft.

7.2. Install supervision systems

- Do not merely 'train and hope': Follow-up on training skills and supervision or mentoring are essential parts of maintaining and improving skills. Supervision and mentoring should be done on a regular basis and included attention for clinical skills, administrative/logistic aspects and personal aspects of workers involved in doing MHPSS work (such as self-care/ stress management).
- Link MHPSS supervision and mentoring to other supervision activities and where possible fully integrate it within existing supervision structures or schedules.
- Involve a mental health specialist not only in treating complex cases, also in developing treatment plans with the primary health care staff and community protection officers to ensure that the person with severe mental disorder can remain treated at PHC level without having to be referred to in-patient psychiatric institutions.
- Involve the psychiatric nurse in an operation to supervise community outreach workers in providing support and follow up to people with mental disorders and epilepsy.

Resources

- WHO. (2013 (draft)). *Mental Health Gap Action Programme: Support and Supervision Guide*. World Health Organization. Geneva.
- WHO. (n.d.). *mhGAP Training of Trainers and Supervisors (ToTS) Guide*. Geneva. Unpublished draft.

7.3. Seek an appropriate balance between providing services and building capacity

Humanitarian workers are often focussed on providing assisting people to people in need. However it is also important to build the capacity of local and existing staff, in order to invest in sustainable MHPSS interventions. Some UNHCR partners may have their own additional funding to employ extra staff on top of usual human resources. While this is often very welcome, it is important that the additional of supplementary staff does not create unrealistic expectations among the beneficiaries that cannot be met when the partner ceases its operations.

- In evaluating plans and proposals of UNHCR and partners consider that extra staff should not only provide services but also build capacity through training and supervision of non-specialized staff.
- Ensure that added MHPSS services strengthen existing refugee services, and do not undermine them.
- Take measures to prevent that refugee MHPSS operations would weaken instead of support the capacity of existing national MHPSS systems and services.
- In general, prioritize training of existing staff above employing additional staff, for reasons of cost effectiveness, sustainability, accessibility and acceptability. However risks are: overburdening existing staff with tasks that are time consuming or require skills that cannot be realistically demanded from generalists.
- Consider pros and cons of accepting external support, both for the immediate and long term

- In general prioritize the employment of national MHPSS professionals for the provision of direct services instead of contracting international staff to provide these services.

8. USE APPROPRIATE AND SYSTEMATIC MONITORING AND EVALUATION

MHPSS interventions and methods should be systematically monitored and evaluated.

Practical steps

8.1. Use relevant monitoring systems

Monitoring for MHPSS activities should be integrated into existing routine monitoring systems for the various sectors, particularly health and community protection.

- Use and analyse existing data, such as those included in 'proGres' (Profile Global Registration System) and in the Focus Monitoring Results-based management system for all UNHCR activities.
- In all refugee settings the seven categories for Mental, Neurological and Substance use (MNS) disorders in UNHCRs regular Health Information System (HIS) should be used. In non-camp settings this may be as an adjunct to prevailing MoH reporting systems. See box 6.
- Ensure that HIS data for MNS disorders are available and annually reviewed and the implications are discussed for various sectors: health, community protection and education.
- Monitor the participation of people with severe mental disorders, learning disabilities and epilepsy in programmes for Community Based Rehabilitation.

BOX 6 : MNS DISORDERS IN EMERGENCY HIS SYSTEM

A. Neuropsychiatric disorders

- Epilepsy/seizures
- Alcohol or other substance use disorder
- Intellectual disability
- Psychotic disorder (including mania)
- Severe emotional disorder / depression

B. Other complaints of clinical concern

- Other psychological complaint
- Medically unexplained somatic complaint

See annex 2 for descriptions of these categories.

8.2. Evaluate MHPSS interventions

It is important to see if the changes that the intervention programme aimed to induce have occurred. A good monitoring system can provide valuable information on this. But usually, additional actions to collect further information are required. MHPSS evaluations should seek to measure the change in the lives of individuals, families and communities that have come about during the course of a project as a result of programming. Assessing whether '*beneficiaries*' or '*service users*' have indeed benefitted from programming is the core purpose of an *outcome evaluation*. However in MHPSS programmes we often also want to assess the *impact* of a programme: whether the interventions have contributed to sustainable improvements in a care system and in lasting changes people's lives.

- Explicitly require that plans and proposals for MHPSS interventions contain a mechanism for evaluation, preferably beyond counting output data, but also assessing outcome or impact.
- Consider partnering with universities or NGOs to conduct applied research focused on evaluating effectiveness of MHPSS interventions.
- In the assessment of research proposals from third parties such as universities,

research institutes or NGOs ensure that appropriate ethical review takes place, demand that research data can be used to improve programming and that results will be made available, within a reasonable time, to all stakeholders, including the staff of UNHCR and partners and the refugee community.

Resources:

- UNICEF. (2011). [*Inter-Agency Guide to the Evaluation of Psychosocial Programming in Emergencies*](#). New York: UNICEF.
- UNHCR. (2008a). [*A community-based approach in UNHCR operations*](#). Geneva: Office of the United Nations High Commissioner for Refugees.

9. ENSURE COMPLIANCE WITH UNHCR POLICIES AND STRATEGIES AND NATIONAL AND INTERNATIONAL STANDARDS AND GUIDELINES

The provision of MHPSS services should be delivered in ways that are consistent with UNHCR policies and strategies, should adhere to minimum international standards and be in line with the existing policies of the government in the country of asylum.

Practical steps

- Check for MHPSS aspects in national guidelines and policies, for example such as a basic package of health services, mental health policies and plans, and use these for refugee health programming.
- Provide support and capacity building to local staff of the national government ministries, using approved training materials and trainers for each sector expected to address the issue of MHPSS.

- Connect trainings with existing MHPSS trainings of the national governments, using approved training materials and trainers.
- Check whether proposed MHPSS programming is in line with
 - UNCHR policies (2008a, 2008b, 2012b);
 - International guidelines for MHPSS in emergency settings (Child Protection Working Group, 2012; IASC, 2007; The Sphere Project, 2011; WHO, 2012);
 - International standards for mental health care in low and middle income countries, such as the mhGAP programme (WHO, 2010);
 - Other international standard such as the CBR Guidelines (WHO et al., 2010).

10. DO NO HARM

It is important to be aware of potentially negative impacts of humanitarian programmes and activities, including those with the aim to improve mental health and psychosocial support, and to prevent to inadvertently harm refugees.

Refugee displacement creates a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies erode protective supports, increase the risks of diverse problems and tend to amplify pre-existing problems of social injustice and inequality. Attempts to provide assistance to refugees may induce or aggravate problems. See box 7.

BOX 7: EXAMPLES OF HUMANITARIAN AID-INDUCED PROBLEMS

- Governmental restrictions preventing refugees to take on jobs and a model of humanitarian aid in which refugees are seen as 'recipients of aid' may lead to erosion of the position of men in the refugee community. For example in an African country many female refugees complained about their husbands, saying that they were not their husbands anymore and that 'now we are married to UNHCR'. This led to frustration in male refugees, and an increased risk on SGBV and alcohol and drug problems.
- Organizing activities for children and youth without proper consultation with or involvement of families and community may undermine family support systems and create tensions in families.
- Creation of protection risks by insensitive provision of universal access to lower primary education regardless of age, gender and/or cultural norms.
- Awareness raising about depression may have as result that more people will visit the health centre with depressive complaints. If the health care staff are not properly trained, and/or if no psychosocial interventions are available a large number of people with mild depressive complaints may end up being prescribed unnecessary medication, and even become dependent on benzodiazepines.
- Implementing services that are not effective or potentially harmful (e.g. single session psychological debriefing).
- Inconsistent, irregular or random distributions of relief items making it difficult for families to plan rations & meals etc.
- Lack of lighting at isolated WASH facilities creating unnecessary fear & anxiety for women & children wanting to use the facilities at night-time.
- Separating families in collective shelters or camps (such as by gender) rather than keeping families together.

Practical steps

The risk of harm through MHPSS interventions can be reduced by:

1. Building on strengths: Do not assume that all distressed refugees are psychologically ill and in need of specialized services.
2. Designing interventions on the basis of information from various sources, taking the perspectives of refugees seriously, and not just 'rolling out' pre-formulated protocols. It is important to ensure that MHPSS interventions are relevant within the given setting.
3. Establishing effective MHPSS referral systems so actors can harmonize their activities.
4. Committing to regular monitoring, evaluation and external review: monitoring and evaluation should include collecting information from various stakeholders, including from refugees themselves.
5. Adopting a long-term perspective when planning, taking factors such as coordination with and integration into national programmes into concern.
6. Continuing to advocate with the aim of addressing the root causes of most psychosocial stress, which is the lack of durable solutions and self-reliance for refugees.

Resources:

- WHO. (2012x). Do's and don'ts in community-based psychosocial support for sexual violence survivors in conflict-affected settings. Geneva: World Health Organisation.





ANNEXES

Syrian children look out the window of their home at the Uncupinar refugee camp, near the Turkish border city of Kilis. UNHCR / A. Branthwaite/ September 2012.

ANNEX 1: UNHCR CHECKLIST FOR MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN REFUGEE SETTINGS

		Stage of implementation			
		Not done	Planned	Partially	Fully
MHPSS approach					
1	Age, Gender and Diversity perspective explicitly used in all protection and assistance interventions?				
2	Basic services (food, security, shelter, water and sanitation), provided in a safe and culturally adequate manner that optimizes equal, dignified access for all refugees?				
3	Measures implemented to ensure that needs of persons with specific needs are met (for instance nutritional support for breastfeeding and pregnant women, early child-care development and positive parenting in parent-child groups)?				
4	Activities in nutrition programmes directly aimed at improving psychosocial well-being of mother and child? (e.g.: activities to encourage mother-child bonding and interactions or activities to promote childhood development)				
5	Activities in shelter programmes to promote psychosocial wellbeing (e.g. including social and cultural considerations in site and shelter design and inclusion of communal spaces and safe spaces)?				
6	MHPSS orientations/trainings organized for legal protection workers?				
7	MHPSS orientations/trainings organized for staff involved in refugee status interviews?				

		Stage of implementation			
		Not done	Planned	Partially	Fully
MHPSS interventions in Community-based Protection					
1	Community self-help activities/ refugee committees in place, with participation of people representing the different sectors of the community?				
2	Do children have adequate access to supportive friendly spaces?				
3	Are livelihood activities available for adults, in particular for those who are marginalized?				
4	Facilitation of community based psychosocial activities, such as women's groups, self-help groups?				
5	Activities and skills building and community projects for youth?				
6	MHPSS capacity building (training, mentoring) for community-based support groups and CBOs?				
7	Programmes for strengthening parenting and family supports?				
8	Community-based approaches to prevent and respond to SGBV?				
9	System for confidential referrals for SGBV survivors including psychosocial support?				
10	Link of SGBV services with health services (for basic mental health care)?				
	Other.....				

		Stage of implementation			
		Not done	Planned	Partially	Fully
MHPSS interventions in Education					
1	Promotion of both formal and non-formal quality education for all age groups (including small children and adults)?				
2	Measures to create Safe Learning Environments (including training on positive discipline and gender-responsive pedagogy, introduction and implementation of codes of conduct, separate latrines)?				
3	Inclusion of life skills development in education?				
4	Inclusive education for children with diverse needs e.g. children with disabilities, children living with epilepsy, children living with HIV/ AIDS, ethnic minorities?				
5	Training for teachers on awareness of psychosocial issues, including recognising psychosocial distress?				
6	In-school support for students experiencing mental or psychosocial difficulties?				
7	Psychosocial support system for teachers in place?				
8	Parent-Teacher Associations and School Committees set up and training and support provided?				
9	Referral system for children experiencing severe or complex psychosocial or mental health issues?				
10	Extracurricular activities organized?				
	Other....				

		Stage of implementation			
		Not done	Planned	Partially	Fully
MHPSS interventions in Health					
1	Health staff trained in MHPSS with mhGAP (humanitarian version)?				
2	CHWs / volunteers trained in identification and follow-up of people with severe mental disorders?				
3	Psychiatric nurse present to support primary care staff and treat people with severe mental disorders?				
4	Regular support visits by psychiatrist for supervision and mentoring? (at least twice per month)?				
5	PFA offered by medical staff, including as part of post-rape care?				
6	Functional basic mental health services available at primary health care facilities (identification management, follow-up and referral)?				
7	CHW do follow-up and home-based support of people with MHPSS problems?				
8	Are evidence-based psychological treatments available?				
9	Are the essential drugs from UNHCR Essential Medicine List available in the health facilities?				
10	Are drug and alcohol use problems being addressed in the programmes? For example by: Screening & Brief Interventions				
11	MHPSS data in HIS system annually reviewed and used for planning?				
	Other:.....				

		Stage of implementation			
		Not done	Planned	Partially	Fully
Information & Coordination					
1	Regular inter-sectorial coordination meetings on MHPSS with UNHRC and partners?				
2	Updated mapping of MHPSS actors & activities (e.g. through 4Ws tool)?				
3	Does the community have information about MHPSS services?				
4	Posters and other information translated into appropriate languages?				
	Other.....				

ANNEX 2: HEALTH INFORMATION SYSTEM (HIS) FOR HUMANITARIAN SETTINGS

Mental Health Categories and Case Definitions

The seven categories below represent the mental, neurological and substance use disorders in the UNHCR Health Information System that must be used in all operations. The seven categories are “probable” and have been developed for use in a primary health care setting. Consultation by a specialist would be needed to make a confirmed diagnosis. The conditions are often chronic. The distinction between new and follow-up cases needs to be clear within HIS forms.

A. Neuropsychiatric Disorders

1. Epilepsy/seizures

A person with epilepsy has at least two episodes of seizures not provoked by any apparent cause such as fever, infection, injury or alcohol withdrawal. These episodes are characterized by loss of consciousness with shaking of the limbs and sometimes associated with physical injuries, bowel/bladder incontinence and tongue biting.

2. Alcohol or other substance use disorder

A person with this disorder seeks to consume alcohol or other addictive substances and has difficulties controlling consumption. Personal relationships, work performance and physical health often deteriorate. The person continues consuming alcohol or other addictive substances despite these problems.

3. Intellectual disability

The person has very low intelligence causing problems in daily living. As a child, this person is slow in learning to speak. As an adult, the person can work if tasks are simple. Rarely will this person be able to live independently or look after oneself and/or children without support from others. When severe, the person may have difficulties speaking and understanding others and may require constant assistance. **Exclusion criterion:** The category should not be applied to children younger than age 2 years.

4. Psychotic disorder (including mania)

The person may hear or see things that are not there or strongly believe things that are not true. They may talk to themselves, their speech may be confused, or incoherent and their appearance unusual. They may neglect themselves. Alternatively they may go through periods of being extremely happy, irritable, energetic, talkative, and reckless. The person's behaviour is considered "crazy"/highly bizarre by other people from the same culture. This category includes acute psychosis, chronic psychosis, mania and delirium.

5. Severe emotional disorder / depression

This person's daily normal functioning is markedly impaired for more than two weeks due to (a) overwhelming sadness/apathy and/or (b) exaggerated, uncontrollable anxiety/fear. Personal relationships, appetite, sleep and concentration are often affected. The person may complain of severe fatigue and be socially withdrawn, often staying in bed for much of the day. Suicidal thinking is common.

This category includes people with disabling forms of depression, anxiety disorders and posttraumatic stress disorder (characterized by re-experiencing, avoidance and hyperarousal). Presentations of milder forms of these disorders are classified as 'other psychological complaint'. **Inclusion criterion:** This category should only be applied if there is marked impairment in daily functioning.

B. Other Complaints of Clinical Concern

6. Other psychological complaint

This category covers complaints related to emotions (e.g., depressed mood, anxiety), thoughts (e.g., ruminating, poor concentration) or behaviour (e.g., inactivity, aggression, avoidance). The person tends to be able to function in most day-to-day, normal activities. The complaint may be a symptom of a less severe emotional disorder (for example mild forms of depression, of anxiety disorder or of posttraumatic stress disorder) or may represent normal distress (i.e., no disorder). **Inclusion criterion:** This category should only be applied if (a) if the person is requesting help for the complaint **AND** (b) if the person is not positive for any of the above five categories.

7. Medically unexplained somatic complaint

The category covers any somatic/physical complaint that does not have an apparent organic cause **Inclusion criterion:** This category should only be applied (a) after conducting necessary physical examinations (b) if the person is not positive for any of the above six categories **AND** (c) if the person is requesting help for the somatic/physical complaint.

ANNEX 3: RECOMMENDED TOOLS FOR ASSESSMENT OF MHPSS NEEDS AND RESOURCES IN REFUGEE SETTINGS

Name of tool and source	Why use this tool?	Brief description	Resources needed
<p>WASSS (WHO-Assessment Schedule for Serious Symptoms in Humanitarian Settings): (WHO & UNHCR, 2012)</p>	<p>For advocacy, by demonstrating the scope of serious symptoms of mental health or psychosocial problems</p>	<p>A simple tool with six items. Part of a community household survey (representative sample)</p>	<p>Time needed: Two to three minutes for each interview. Human resources needed: interviewers, one analyst/report-writer</p>
<p>HESPER (Humanitarian Emergency Perceived Needs Scale): (WHO & Kings College London, 2011)</p>	<p>Advocacy and planning</p>	<p>A brief scale to collect data on physical, social and psychological needs as perceived by the community. Can be used in community household surveys and as a standalone tool (use representative sample of respondents) Takes about 15-30 minutes to complete per person.</p>	<p>Time needed: 15 to 30 minutes for each interview Human resources needed: A HESPER community household survey needs one team leader, 4-8 interviewers and one interviewer supervisor</p>
<p>Participatory assessment: perceptions by general community members (WHO & UNHCR, 2012)</p>	<p>For planning appropriate mental health and psychosocial support</p>	<p>Interviews with key informants or groups of general community members to learn about local perspectives on problems and coping (free listing with further questions)</p>	<p>(For 10-15 interviews) Time needed: One to two days Human resources needed: Four people</p>

Name of tool and source	Why use this tool?	Brief description	Resources needed
Participatory assessment; perceptions by community members with in-depth knowledge of the community (WHO & UNHCR, 2012)	For planning appropriate mental health and psychosocial support	Interviews with key informants or groups to learn about local their problems and coping	For 10-15 interviews Time needed: Three days for collecting data (assuming the interviewer carries out four interviews a day) and three days for analysis and reporting” Human resources needed: One person
Participatory assessment; perceptions by severely affected people (UNHCR & WHO, 2008)	For planning appropriate mental health and psychosocial support	Interviews with severely affected people (free listing with further questions) to learn about local perspectives on problems and coping	For 15 interviews: Time needed: Three to five days Human resources needed: Two people
Rapid Assessment of Alcohol and Other Substance Use in Conflict-affected and Displaced Populations: A Field Guide (UNHCR & WHO, 2008)	For planning services for alcohol and drugs users	In depth assessment of alcohol and drug use	Variable. At least one trained interviewer (and interpreter if needed)
Checklist for integrating mental health in primary health care (PHC) in humanitarian settings (WHO & UNHCR, 2012)	For planning a mental health activities in the primary health care system	Site visits and interviews with primary health care programme managers	One hour for each facility Human resources needed: One interviewer
Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support (MHPSS) (IASC-RG MHPSS, 2012c)	For coordination, through mapping what mental health and psychosocial supports are available	Detailed assessment of various MHPSS activities in different locations through interviews with agency programme managers	Depending on the scale of the crisis, approximately two weeks needed. Initially. Human resources needed: Two people

DEFINITION OF KEY TERMS

1. **Community based approach:**

A community-based approach is an inclusive partnership strategy, a process, and a way of working with persons of concern that recognizes their individual and collective capacities and resources and builds on these to ensure their protection. This implies working in partnerships with persons of concern during all stages of UNHCR's programme cycle and supports the community's own goals.

2. **Community mobilisation:**

Key component of a community based approach: strengthening their capacity to identify and address problems.

3. **Community based protection:**

Forms of protection that use a community-based approach to programming specifically to address protection issues faced by a community. The link between communities and protection is mutually reinforcing: by working through community mechanisms protection is enhanced, and by enhancing protection, communities are strengthened. Community based protection may be distinguished from formal protection mechanisms, but are not meant to replace them. (See also: Protection)

4. **Community services:**

Community services is the hybrid term for one of the 'sectors' of the international aid response to refugee crises co-ordinated by UNHCR. It used to be known as social services and focused on providing care for refugees who were unable to meet their needs with the basic provision in the camp (see community based protection)

5. **Coping:**

The process of adapting to a new life situation, managing difficult life circumstances, making an effort to solve problems, and/or trying to minimise, reduce or put up with stress or conflict.

6. Disability:

Umbrella term for impairments, activity limitations and participation restrictions. It encompasses both medical and social models of disability. As an example, disability could include impairment of seeing and walking, using the toilet, getting dressed but also impairments in social or occupational functioning such as accessing school, work or social services and difficulties in maintaining social relations.

7. Mental disorders:

Medical disorders characterized by a combination of abnormal thoughts, emotions, behaviour and relationships with others. Mental disorders can be divided into

- a. *Severe mental disorders:* Persons usually have typical symptoms, are severely disabled and are usually considered mentally ill or abnormal by the environment. Examples include psychosis, bipolar disorder and severe depression and people who are harmful to themselves or to others.
- b. *Common mental disorders:* characterized by moderate symptoms, causing significant social disability. They may or may not be considered mentally ill by the environment. People with common mental disorders often present to the general health care system. Examples are: mild to moderate depression, anxiety disorders, and stress related disorders.

Within the field of global public health mental disorders are often grouped with neurological and substance use disorders as MNS-disorders. See also: psychosocial problems.

8. Mental Health (MH):

Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

9. Mental Health and Psychosocial Support (MHPSS):

Composite term 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

(IASC, 2007). This may include support interventions in the health sector, education, community services, protection and in other sectors.

10. Mental Health Services:

Services offered with the goal of improving individuals & families' mental health and functioning with a particular focus on mental disorders. Services may include psychotherapy, medication, counselling, behavioural treatment, etc. In many national health systems the term 'mental health services' includes services for people with neurological disorders such as epilepsy and dementia.

11. MHPSS approach:

An MHPSS approach is a way to engage with and analyse a situation, and provide a response, taking into account both psychological and social elements. (See also: core MHPSS intervention).

12. MHPSS intervention:

A core MHPSS intervention consists of one or several interrelated activities with the explicit goal to improve the mental health and psychosocial wellbeing of refugees and other persons of concern. While many interventions in a humanitarian setting may affect mental health and psychosocial well-being, a core MHPSS intervention has the specific aim to contribute improved mental health and psychosocial well-being (see also MHPSS approach).

13. MNS disorders:

Mental, neurological and substance use disorders. See: mental disorders, neurological disorders and substance use disorders.

14. Neurological disorders:

Neurological disorders are disorders of the *nervous system*, which includes the brain, spinal cord and nerves. Examples are epilepsy, seizure disorders, dementia and Parkinson's disease. Within the field of global public health neurological disorders such as epilepsy and dementia are often grouped with mental and substance use disorders as MNS disorders. (See also: MNS disorders).

15. Participation:

The full and equal involvement of men, women, girls and boys of all ages and backgrounds in all decision-making processes and activities in the public and private spheres that affect their lives and the life of their community.

16. Person of concern:

Persons of concern to the UNHCR include refugees but also asylum seekers (someone who has made a claim that he or she is a refugee), internally displaced persons (people who have been forced to move from their homes because of collective violence, persecution or natural disaster, and remain displaced inside their own country), returnees (people who were refugees but have recently returned to the country of origin), and stateless persons (someone who is not considered as a national by any state under its domestic law). (See also: refugee).

17. Protection:

Ensuring that persons of concern are protected against the occurrence and effects of persistent internal or external threats of violence, coercion and systematic deprivation of basic rights. (See also: Community based protection).

18. Psychosocial:

The word psychosocial refers to the two-way relation between psychological factors (the way an individual feels, thinks and acts) and social factors (related to the environment or context in which the person lives: the family the community, the state, religion, culture) (PSW, 2003). Psychosocial is an adjective that needs to be followed by a noun, e.g. a psychosocial problem, a psychosocial intervention, a psychosocial approach.

19. Psychosocial problem:

A psychosocial problem is a negative life event or an environmental difficulty that causes significant interpersonal stress or an inadequacy of social support or personal resources. Psychosocial problems are generally characterized by both *social* (interpersonal) problems in the family or social network, and accompanying *psychological* phenomena such as worry and demoralization. Individuals with unstable or small social networks are particularly at risk for developing psychosocial problems.

Psychosocial problems increase the chance of developing mental disorders, particularly in people who already have a pre-existing vulnerability.

20. Psychosocial Support (PSS):

Psychosocial support includes all processes and actions that promote the holistic wellbeing of people in their social world. It includes support provided by family, friends and the wider community. It can be used to describe what people (individuals, families and communities) do themselves to protect their psychosocial wellbeing, and to describe the interventions by outsiders to serve the psychological, social, emotional and practical needs of individuals, families, and communities, with the goal of protecting, promoting and improving psychosocial well-being.

21. Psychosocial intervention:

Activities with the explicit goal to change aspects of an environment or situation which impacts the social and psychological well-being of affected populations. This is usually achieved by working with the local community, sectors, and organisations to advocate for improved access to community supports and basic services and restore everyday recreational, social and vocational activities in order to promote psychosocial well-being. Psychosocial interventions usually aim to improve one or more of the following domains:

- a. Skills and knowledge e.g. knowing how to communicate and listen, knowing how to make decisions, using culturally appropriate coping mechanisms, vocational skills, conflict management, knowing who to go to for information.
- b. Emotional well-being e.g. feeling safe, trust in others, self-worth, hopeful for the future with realistic goals, not worrying about being hungry or sick.
- c. Social well-being, e.g. attachment to caregivers, relationships with peers, sense of belonging to a community, resuming cultural activities and traditions, willing and respectful participation in appropriate household responsibilities and livelihood support.

(UNICEF, 2011)

An important difference with *mental health interventions* is that psychosocial interventions do not specifically focus on people with mental disorders.

22. Psychological First Aid:

Psychological first aid (PFA) is a humane, supportive response to a fellow human being who is suffering and who may need support. PFA involves the following themes:

- providing practical care and support, which does not intrude;
- assessing needs and concerns;
- helping people to address basic needs (for example, food and water, information);
- listening to people, but not pressuring them to talk;
- comforting people and helping them to feel calm;
- helping people connect to information, services and social supports;
- protecting people from further harm.

The approach can be trained to non-specialized workers through UNHCR endorsed training materials (World Health Organization, War Trauma Foundation, et al., 2011).

23. Resilience:

The ability of individuals and communities to anticipate, withstand and recover from adversity, including natural or manmade disasters and social crises. It refers to both the capacity of individuals to *navigate their way* to the psychological, social, cultural, and physical resources that sustain their well-being, and to the capacity of individuals and groups to *negotiate* for these resources to be provided and experienced in culturally meaningful ways.

24. Refugee:

A refugee is someone who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country. People fleeing conflicts or generalized violence are also generally considered as refugees. (see also: 'Person of concern').

25. Sexual and gender-based violence (SGBV):

Sexual and gender-based violence (SGBV) is violence that is directed against a person on the basis of gender or sex. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. While women, men, boys and girls can be victims of SGBV, women and girls are the main victims. SGBV shall be understood to encompass, but not be limited, to the following:

- a. Physical, sexual and psychological violence occurring in the family, including battering, sexual exploitation, sexual abuse of children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
- b. Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
- c. Physical, sexual and psychological violence perpetrated or condoned by the State and institutions, wherever it occurs.

26. Substance use disorders:

Behavioural disorders due to the use psychoactive substance such as alcohol or drugs. The term encompasses acute intoxication, harmful use, dependence syndrome, and withdrawal states. Within the field of global public health these disorders are often grouped with mental and neurological disorders as MNS disorders.

27. Well-being:

Well-being refers to the condition of holistic health and the process of achieving this condition. Well-being has physical, cognitive, emotional, social and spiritual dimensions. The concept includes 'what is good for a person' such a participating in meaningful social roles, feeling happy and hopeful, living according to good values as locally defined, having positive social relations and a supportive environment, coping with challenges through the use of healthy coping mechanisms, having security, protection and access to quality services and employing.

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