

This document forms part of the 4th edition of the UNHCR Emergency Handbook and was generated from the digital Emergency Handbook system.

---

## Mental health and psychosocial support

### Key points

- Do not consider MHPSS services and support a 'stand alone' sector, or let them become isolated from other services: they should be integrated in general community support and programmes and systems for public health, education and protection.
- Do not describe a whole population as 'traumatized'. The term 'trauma' should not be used outside clinical programmes.
- Integrate an MHPSS approach in all programmes and ensure that interventions foster the dignity and resilience of persons of concern.
- Revive and strengthen family and community support systems and promote positive coping mechanisms of affected individuals and their families: these are key psychosocial interventions in an emergency.
- Ensure that mental health care is functionally linked to, and preferably integrated in the general health system; avoid establishing parallel mental health services.
- Take steps to introduce psychotherapeutic interventions for people with prolonged distress and take measures to avoid excessive prescription of psychotropic medication.
- Facilitate intersectoral coordination through a Technical Working Group for MHPSS with actors in health, community-based protection, child protection, SGBV, education and nutrition.

### 1. Overview

Emergencies put significant psychological and social stress on individuals, families and communities. People not only experience atrocities prior to or during flight; their living conditions once they have reached safety also impose significant stress and hardship. Refugees and other people of concern experience and respond to loss, pain, disruption and violence in significantly different ways, influencing their mental health and psychosocial well-being and their vulnerability to mental health problems. Men and women, and boys and girls of different ages, may have different ways of experiencing and expressing distress. Their reactions to disruptive situations are often overcome with time. Most people cope with difficult experiences and may become more resilient if a supportive family and community environment is available. Some people are more vulnerable to distress, however, especially those who have lost, or been separated from, family members, or who are survivors of violence.

When mass displacement occurs, the normal and traditional community structures that often regulate community well-being, such as extended family systems and informal community networks, may break down. This can cause or exacerbate social and psychological problems; and, in response, new mechanisms and new forms of leadership can arise, which may or may not be representative of age and gender or a community's diversity. The way in which humanitarian and refugee services are provided can also increase or diminish stress in affected populations. Some persons of concern may develop negative coping mechanisms that put them at increased risk. While most people will not develop mental disorders, some will, and the symptoms of individuals who already had disorders may worsen. If persons of concern no longer have access to the usual systems for providing mental health care, or those systems have deteriorated, they may be left without adequate treatment or support.

#### **MHPSS**

The composite term 'mental health and psychosocial support' (MHPSS) refers to any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental disorders. Among humanitarian agencies the term is widely used and serves as a unifying concept that can be used by professionals in various sectors. MHPSS interventions can be implemented in programmes for health & nutrition, protection (community-based protection, child protection and SGBV) or education. The term 'MHPSS problems' may cover a wide range of issues including social problems, emotional distress, common mental disorders (such as depression and post-traumatic stress disorder), severe mental disorders (such as psychosis), alcohol and substance abuse, and intellectual or developmental disabilities.

## **2. Protection objectives**

- To ensure that emergency responses are safe, dignified, participatory, community owned, and socially and culturally acceptable.
- To maintain the protection and well-being of persons of concern by strengthening community and family support.
- To ensure that persons distressed by mental health and psychosocial problems have access to appropriate care.
- To ensure that persons suffering from moderate or severe mental disorders have access to essential mental health services and to social care.

## **3. Underlying principles and standards**

UNHCR, Operational guidance on mental health & psychosocial support programming for refugee operations

A comprehensive description of a multi-sectoral MHPSS response. Provides specific guidance on MHPSS interventions in community-based protection, health and education.

IASC, Guidelines on Mental Health and Psychosocial Support in Emergency Settings

.

Provides detailed guidance that helps humanitarian actors to plan, establish and coordinate minimum multi-sectoral responses to protect and improve mental health and psychosocial well-being in an emergency.

Sphere Handbook

: Protection Principle 3: "*Assist people to recover from the physical and psychological effects of threatened or actual violence, coercion or deliberate deprivation.*"

One of the four protection principles underpinning the Sphere Handbook. It underlines the importance of appropriate referrals, fostering community action and establishing reporting mechanisms for rights violations.

Sphere Handbook,

*Essential healthcare standard 2.5: Mental health*, 2018.

Affirms that affected persons should have access to health services that prevent or reduce mental health problems and associated impaired functioning.

UNHCR, *Global Strategy for Public Health 2014-2018, Public Health Strategic Objective 4: facilitate access to integrated prevention and control of non-communicable diseases, including mental health services.*

Sets out programmes of mental health and psychosocial support, focusing on primary health care standards and establishing multi-sectoral referral mechanisms.

Child Protection Working Group, *Minimum Standards on Child Protection in Humanitarian Action, Standard 10: Mental Health and Psychosocial Distress.*

Sets out strategies and interventions that will strengthen girls' and boys' coping mechanisms and resilience and promote access to appropriate support for severely affected children.

*Interagency Network for Education in Emergencies (INEE), Minimum Standards for Education: Access and Learning Environment Standard 2: Protection and Well-being*

.

Sets out interventions that ensure learning environments are secure and safe, and promote the protection and the psychosocial well-being of learners, teachers and other education personnel.

UNHCR, Age, Gender and Diversity (AGD) Policy, 2018.

Builds on UNHCR's 2011 AGD Policy, lessons learned and consolidates existing commitments to accountability to affected people, and updates and expands the High Commissioner's commitments to refugee women and girls (2001) to include IDP, stateless and other persons of concern. The Policy brings together the essential components for change regarding all aspects of age, gender and diversity into six areas of engagement and ten core actions with stronger and clear accountability to all persons of concern, defined responsibilities across senior management and entities in the organization, and consistent monitoring leading to evidence-based regular reporting.

#### **4. Protection Risks**

In humanitarian settings, mental health and psychosocial well-being are closely associated with protection.

- The loss and stress experienced during humanitarian emergencies cause grief, fear, anxiety, guilt, shame and hopelessness that overtax individuals' capacity to cope. Stress can cause health problems and increase communal and interpersonal violence, including intimate partner violence.
- Humanitarian emergencies increase the risk of developing mental disorders, including depression, posttraumatic stress disorder, and alcohol and substance abuse, all of which weaken the ability of individuals to fend for themselves and care for others who depend on them.
- Significant stress over long periods harms the development of children, especially young children, increases the risk that they will have physical or mental health problems, and may contribute to educational difficulties later in life. Adolescents with mental problems are highly vulnerable if they experience violence, abuse or exploitation.
- During emergencies, people with severe mental disorders (psychosis, bipolar disorder, severe forms of depression or posttraumatic stress), or intellectual disabilities, are at heightened risk if they experience neglect, abandonment, homelessness, sexual or domestic abuse, social stigma, or are excluded from humanitarian assistance, education, livelihood opportunities, health care, a nationality, or other services.
- Those who care for people with severe mental disorders can experience extreme distress, isolation and strain on financial and other resources.
- In urban settings and displacement sites, individuals with MHPSS concerns are at higher risk because the communities in which they live are often less cohesive and community protection mechanisms are likely to be weaker.

#### **5. Other risks**

- UNHCR faces reputational risks. If it fails to protect people with MHPSS problems, this will harm its credibility and moral authority and may generate negative media coverage. Increasingly, the media pay attention to psychological trauma and mental health issues in humanitarian settings.

#### **6. Key decision points**

It is important to build understanding of MHPSS in UNHCR and among partners in all sectors, to reduce the burden of mental illness, improve the ability of refugees to function and cope, and strengthen resilience. To this end, it is important to adopt an MHPSS approach and integrate MHPSS interventions in field operations as a priority.

- Adopting an MHPSS approach. This implies providing humanitarian assistance in ways that support the mental health and psychosocial well-being of persons of concern. MHPSS is relevant for all humanitarian actors and all forms of humanitarian action.

- Integrating MHPSS interventions. This implies focusing on activities in which the primary goal is to improve the mental health and psychosocial well-being of persons of concern. Such activities are usually implemented via projects in health, community-based protection, SGBV, child protection, and education.

MHPSS activities that are integrated in wider systems (such as general health services, education, or social services) or embedded in community support mechanisms are likely to be accessible to more people, are often more sustainable, and tend to carry less stigma.

## 7. Key steps

### 1. Include MHPSS elements in assessments

- Initial rapid assessments for health and protection should include some MHPSS elements, to increase understanding of the MHPSS problems refugees face, their ability to deal with them, the resources that are available, and the kind of responses required.
- Make assessments participatory; involve persons of concern at every stage, with a particular focus on including more isolated or marginalized individuals.
- Assess MHPSS needs and MHPSS resources. Focus on problems but also on coping mechanisms and formal and informal sources of support.
- Apply a broad definition of MHPSS. Assessments that narrowly focus only on one mental disorder, such as post traumatic stress (PTSD), do not provide the data needed to design a comprehensive MHPSS programme.
- In general, do not try to estimate the prevalence of mental disorders because such an assessment is methodologically complicated, requires specific resources and, most important, is not essential to start implementing services.
- As a rule of thumb, use WHO projections of mental disorders in adult populations affected by emergencies (Box 1)

<b>Box 1.WHO projections of mental disorders in adult populations affected by emergencies</b> (WHO and UNHCR,2012)		
	<b>Before emergency 12-month prevalence</b>	<b>During emergency 12-month prevalence</b>
<b>Severe mental disorder</b> (Psychosis, severe depression, severely disabling forms of anxiety disorder.)	2% to 3%	3% to 4%

<b>Mild or moderate mental disorder</b> (Mild or moderate forms of depression, anxiety disorders, post traumatic stress disorder.)	10%	15% to 20%
<b>Normal distress / other psychological reactions</b> (No disorder.)	No estimate	Large percentage

## 2. Conceptualize MHPSS as a multi-layered system

- Think of MHPSS programmes as a systems-based approach, which has several layers of complementary support, with referral systems between the layers. It is important to develop layers of MHPSS services, ranging from interventions that benefit all persons of concern to targeted interventions for specific groups. The model is illustrated below (intervention pyramid).
- Layer 1: Apply an AGD approach to basic services and security. Ensure that security is achieved and basic needs and essential services (food, shelter, water, sanitation, basic health care, control of communicable diseases) are met in a manner that protects the dignity of all people, including those who are particularly marginalized or isolated and who may face barriers to accessing services. To avoid discrimination, stigma and further distress, consider the implications of any targeted interventions, in consultation with affected populations. Apply the same principles to advocacy. Always inform persons of concern how, where and when they can access humanitarian services, to reduce distress. The objectives of protection mainstreaming are very similar to those of layer 1 in the MHPSS intervention pyramid.
- Layer 2: Strengthen community and family support. Promote activities that foster social cohesion. Support the restoration or development of community-based structures that represent the population in terms of age, gender, disability and other aspects of diversity. Promote community mechanisms that protect and support individuals using participatory approaches. Ensure that play and recreation spaces and activities are available, especially for children and youth.
- Layer 3: Provide focused psychosocial support. Promote individual, family or group interventions to provide emotional and practical support to those who find it difficult to cope alone or with their own support network. Non-specialised workers in health, education, community-based protection or child protection usually deliver such support, after training and with ongoing supervision.
- Layer 4: Clinical services. Make clinical mental health services available to those with severe symptoms or whose intolerable suffering renders them unable to carry out basic daily functions. The problems of such persons are usually induced by the emergency, or pre-existed it. They include (but are not limited to): psychosis, drug abuse, severe depression, or disabling anxiety symptoms; some may be at risk of harming themselves or others. Interventions are usually led by mental health professionals, but can also be led by specialists in social work.

## 3. Promote the adoption of an MHPSS approach in UNHCR and with partners

- Employing a participatory approach and providing services respectfully can improve the psychosocial well-being of persons of concern; but staff involved in a refugee response may not always be aware of these effects. It is important to ensure that all stakeholders in UNHCR-supported programmes are aware that MHPSS is a cross-cutting issue.
- Improving staff awareness of and information on MHPSS, including the awareness of staff in reception centres and registration desks, can be achieved by seminars or training. Relevant themes include: effective communication, dealing with strong emotions, and identifying MHPSS problems in persons of concern.
- Build inter-sectoral capacity to integrate MHPSS. For example:
- Provide half or one day orientation seminars on psychological first aid (PFA) using the facilitator guide.
- Integrate MHPSS in the regular training programmes for staff working on sexual and gender-based violence (SGBV), Child Protection and Community-Based Protection
- Inform senior managers about the importance of using MHPSS approaches in all sectors. Consider holding a short briefing session for senior management.
- Ensure that groups or individuals with specific MHPSS needs can access basic services (including food and non-food distributions). If necessary and appropriate, arrange separate queuing systems or a 'buddy/helper' system; monitor the distribution of goods to groups or individuals with specific needs to ensure that distribution is safe, dignified and equitable.

#### **4. Include MHPSS interventions in community based protection programmes**

Most communities already employ protection measures to support vulnerable members. You may find you can sustain or revive strategies that refugee and IDP populations used before they became displaced. At the same time, certain coping strategies (for example measures that restrict women's freedom, or exclude religious or ethnic minorities) may harm or disadvantage vulnerable groups.

- Discuss MHPSS issues with the community, using culturally and contextually relevant terminology and concepts and accessible communication formats and channels. Minimise stigmatization of and discrimination against people with mental health conditions.
- Ensure that MHPSS support is available to men, women, girls and boys of all ages, ethnicities, backgrounds and religions, and is tailored to meet their different needs, including accessible for persons with disabilities.
- Integrate MHPSS in existing interventions such as sporting activities and computer and literacy classes that can support development of coping mechanisms in addressing and alleviating stress and trauma and support avoidance of stigma that stand-alone interventions may cause. Ensure that these are age and gender appropriate and accessible for all groups. Involve people of concern (including young people) in their design and delivery.

- Facilitate community activities, using self-help groups in the community; introduce psychosocial support projects in urban multi-purpose community centres.
- Recruit and train staff and volunteers from community groups (women's groups, youth organisations, organizations of persons with disabilities, cultural and religious associations) to support individuals with mental and psychosocial concerns.
- Promote and support activities that reduce tensions between people of concern, and between people of concern and surrounding communities.
- Take steps to integrate people with severe mental disorders (in disability programmes the term psychosocial disabilities is used for this group), intellectual and developmental disabilities and epilepsy in programmes for community-based rehabilitation; provide support to enable them to participate in mainstream programmes.

For more information, see the Entry on community-based protection.

## **5. Design and implement MHPSS interventions in child protection programmes**

- Provide parents and caregivers with information on children's and their own emotions and behaviour in emergencies, and explain how they can help their children and themselves to recover, and access services.
- Support community-based early childhood care and development programmes, to ensure that very young children receive appropriate protection, care, stimulation and support. Where relevant, link these activities to nutrition and breast-feeding programmes.
- Establish structured recreational activities, led by community volunteers, and coordinate these with education activities.
- Ensure that children at risk, and separated and unaccompanied children, are identified and referred to relevant services, including best interest procedures and multi-sectoral services. Ensure that such children receive appropriate psychosocial support, including individual, family and group based interventions appropriate to their needs, and where necessary refer family members to appropriate psychosocial or mental health services.
- Ensure that psychosocial support activities link to and support safe emergency education of good quality and to child protection services, such as best interests procedures, community based child protection activities and where appropriate, family tracing and reunification services.
- Work with other sectors to ensure that they consider the protection and well-being of children. Assist them to make their services child-friendly and accessible

For more information, see the Entry on child protection.

## **6. Design and implement MHPSS interventions in programmes for SGBV prevention and response**

- Incorporate psychological first aid into the training package for first responders to SGBV survivors (including for medical staff trained in clinical management of rape survivors).

- Include linkages to available community-based psychosocial supports and social services for survivors based
- Consider including brief psychological interventions [PV1] in the training for SGBV case managers.
- Facilitate referral to trained providers of evidence-based psychotherapies (which can be trained and supervised non specialists) for survivors who are not functioning well because of their symptoms of mental health conditions such as depression and stress-related disorders
- Provide clinical care with follow-up for survivors who have developed moderate to severe mental health conditions (by mental health-care providers with appropriate training in the provision of mental health care of survivors of sexual violence).

## **7. Design and implement MHPSS interventions in education programmes**

If education programmes are provided quickly to children and youth in an emergency situation, it has a normalizing effect and can reduce the psychosocial impact of extreme stressors and displacement and thereby protect children at risk. Education may also have a healing effect on parents and communities, by restoring a routine and normalcy and creating hope of a better future.

- Encourage the creation of parent or school associations and provide training for them; accompany them if needed.
- Train teachers to identify children who have MHPSS problems and refer them to an appropriate professional (social workers, psychiatric nurses or case managers, for example).
- Organize social and cultural events, including sports events, in schools and informal education programmes, to raise the morale of children, parents and the community.
- Make sure that children feel their schools and learning environments are accessible, safe and conducive to learning. Consider structures (well-built classrooms, separate latrines for boys and girls) and the school's culture. Policies should prohibit corporal punishment, exploitation by teachers, and discrimination against minority children or children with disabilities.

For more information, see the Entry on education in emergencies.

## **8. Design and implement MHPSS interventions in health programmes**

- Train health staff (clinical officers, medical doctors, nurses) using the mhGAP Intervention Guide (WHO, 2010). If possible, use the version for humanitarian settings (WHO and UNHCR, forthcoming).
- Arrange regular visits (at least twice a month) by a psychiatrist or another mental health professional, to provide supervision and mentoring.
- Ensure that people with severe mental disorders have access to care.

- Avoid hospitalization; if it becomes necessary, limit it to short term emergency admission (for example, because an individual with a severe mental disorder becomes a danger to themselves or others).
- Ensure that individuals with severe mental disorders, and their families, receive regular follow-ups. Visits can be made by community workers or refugee outreach volunteers.
- Health programmes should make generic medication available for selected mental, neurological and substance use disorders, using the UNHCR essential medicine list.
- Ensure that mental health data are integrated in UNHCR's HIS system.
- Take steps to make brief psychological therapies available to people impaired by prolonged distress.

For more information, see the Entry on health responses.

## **9. Establish coordination mechanisms for MHPSS**

### **At country level**

- Participate in interagency MHPSS Technical Working Groups (TWG), if these are established and consider co-chairing. If a major refugee emergency does not have an MHPSS TWG, UNHCR should consider creating one.
- Ensure that a representative of the MHPSS TWG participates in coordination meetings for protection (including child protection) and health.

### **At local level**

- Create an MHPSS working group that meets regularly to discuss services and complex cases. It should include staff from health, protection, community-based protection, and education.
- Ensure MHPSS is discussed in coordination meetings on health and protection (including in sub groups for SGBV or Child Protection), for example by making it a regular agenda item.

## **8. Key management considerations**

Many humanitarian operations now consider MHPSS to be a normal area of intervention. However, approaches continue to vary widely, and conflicting approaches can lead to bad practices. Senior UNHCR managers should emphasize the important role of MHPSS in UNHCR's protection mandate and require colleagues and partners to observe the IASC's *Guidelines on MHPSS* and UNHCR's internal *Operational Guidance*.

It is particularly important to promote integrated approaches and foster inter-sectoral collaboration (in health, community-based protection, education, child protection, SGBV, etc.). Adequate staffing and resources should be made available to ensure that MHPSS needs can be adequately addressed. Senior managers should also ensure an MHPSS approach is adopted throughout an operation and is not considered the responsibility of a handful of specialists.

## 9. Resources and partnerships

### Partners

- Partners should be aware of the Operational Guidance and be willing to apply its principles in their work.
- Partner organisations often have a background in either health or protection: for MHPSS programming an ability to work cross-sectorally is essential.
- Stand-alone programmes that focus on one aspect of MHPSS should be discouraged in favour of a more holistic approach.
- Partnerships with national services are generally preferable to new programmes that provide services exclusively to persons of concern.
- MHPSS components should be integrated into the child protection and community-based protection programmes of partner organizations.

### MHPSS professionals

- A mental health professional (such as a psychiatric nurse, a psychiatric clinical officer or a psychiatrist) should be employed to assess and manage individuals with severe or complex mental disorders, and to provide guidance and support to primary health care staff.
- Supervision by psychiatrists, clinical psychologists, or psychiatric nurses should be available to support primary health care staff and build their capacity through training, consultation, mentoring and supervision.
- Social workers and community-based workers (such as trained refugee outreach volunteers or community health workers) are needed to do home-based follow up, assist individuals with MHPSS problems (including epilepsy) to access health and community services, and to encourage or support self-help and mutual support initiatives.

## 10. Links

Mental health and psychosocial support resources (UNHCR Public Health Section).

Mental health and Psychosocial Support Network.

Guide on Community based Psychosocial Support (ACT Alliance).

Toolkit for the Integration of Mental Health into General Healthcare in Humanitarian Settings.

## 11. Media

Mental Health and Psychosocial Support in Urban Settings:

Child Protection in Humanitarian Action

Pieter Ventevogel talks about mental health and displacement (2017)

## Need help?

### **CONTACT** Contact:

- DPSM, Public Health Section (mental health). At: HQPHN@unhcr.org.
- DIP, Community-Based Protection. At: hqts00@unhcr.org.
- DIP, Child Protection. At: hqchipro@unhcr.org.
- DIP, SGBV unit. At: hqsgbv@unhcr.org.

## Annexes

- UNHCR, Operational guidance on mental health & psychosocial support programming for refugee operations
- Child Protection Issue Brief
- Community-Based Protection & Mental Health & Psychosocial Support
- Understanding Community Based Protection, Policy Paper
- Manual on UNHCR Community Based Approach
- WHO and UNHCR, Assessing mental health and psychosocial needs and resources
- Clinical management of mental, neurological and substance use conditions in humanitarian emergencies
- IASC, Guidelines on Mental Health and Psychosocial Support in Emergency Settings
- Mental Health and Psychosocial Support in Humanitarian Emergencies. What Should Camp Coordination and Camp Management Actors Know
- Mental Health and Psychosocial Support in Humanitarian Emergencies. What Should Protection Managers Know
- Mental Health and Psychosocial Support in Humanitarian Emergencies. What should Humanitarian Health actors know
- Helping Survivors of Sexual Violence in Conflict
- Faith Sensitive Approach in Humanitarian Response
- Mental Health for People on the Move in Europe
- Operational Guidelines - Community Based Mental Support in Humanitarian Settings
- Including Children with Disabilities in Humanitarian Action
- Individual Psychological Help for Adults
- Group Interpersonal Therapy (IPT) for Depression
- Psychological First Aid
- WHO, WVI, WTF, Psychological First Aid Guide for Field Workers, 2011

- Mental Health and Psychosocial Support - 10 Myths

<b>Version and document date</b>
----------------------------------

Version: 2.3

Document date: 25.09.2019