Parental and Carer Mental Health in Conflict and Emergency Settings:

The impact on the child. A narrative synthesis of existing evidence and opportunities

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Table of Contents

Executive Summary

This is an annex to the paper "Parental and carer mental health: impact on the child. A narrative synthesis of existing evidence and opportunities." It specifically looks at the influence conflict and emergency settings make to the wider challenges facing parents and carers, children and their mental health.

Mental health and psychosocial problems are extremely common in disasters and conflict affected populations for men, women and children, **1 in 5 people have a recognizable mental disorder after an acute onset major emergency brought on by conflict. Close to 1 in 25 people will have a mental disorder so severe that it undermines their ability to function and survive a chaotic emergency environment.**

The effects of mental health conditions in emergency and refugee settings differ within population groups with children being particularly vulnerable. **The prevalence of PTSD and major depression, for example, in settled refugee populations has been discovered to be anywhere from 5-15 % for PTSD and 10-40% for depression[1]. However, for children and adolescents, the rates of PTSD range from 50-90 % and major depression from 6-40%[2].**

Knowledge about what works has increased substantially in the last decade. The formal guidelines and recommendations underlying the documents are examined below. These are increasingly evidence based, though it needs to be acknowledged that more research is needed on diverse groups and at different stages in the life course (including children, parents and carers). Whilst key global policies and frameworks address mental health provision in emergency settings most do not provided specific guidance to the mental health care of parent, care givers, and children.

Despite the scale of the problem the vast majority of the affected population does not receive any mental health and psychosocial support (MHPSS), due to lack of adequate recognition and very low capacity of delivering effective interventions. There are however some good examples of interventions. Generally, these can be categorised into four types:

- Use of non-specialist care providers (e.g. community workers, trained lay persons)
- Integration within existing services and combining delivery of services with reform of the systems of care
- Use of technology (e.g. internet, mobile devices, consultation using telemedicine).
- Use of self-help interventions (delivered using printed material, radio and television, audio-books, videos and online material).

There is evidence of why it is important to invest in parental and carer mental health in order to improve early childhood development. However, the evidence of what works, where and how, is limited. And the funding for such programmes is also restricted. Currently WHO and UNICEF are developing the Minimum Intervention Standards Package (MISP) for launch at the Dutch Summit in October 2019. This will help determine what are the optimal projects and programmes requiring investment and how the international community can best deliver MHPSS. The Dutch and UK governments are co-hosting a donor group to help increase funding and direct it to the best possible interventions in a coordinated and effective way.

To increase political support and funding for mental health in emergency and conflict settings, particularly for parents and carers, it will be necessary to demonstrate the need for action, examples of why interventions can have such positive outcomes, and how best to deliver such interventions in the future.

To achieve this the following is recommended:

- **Championing of a coordinated approach under the MISP –** this will help ensure that a quality programme is delivered and supported in a collaborative way by the international community.
- **Investment Case** - a case for support needs to be developed to explain why investing in parents and carers mental health will positively benefit not only them but the children that they care for.
- **Donor coordination** – through the donor group co-chaired by the UK and the Netherlands, there is the potential to advocate for a focus on parental and carers' mental health - and to encourage greater coordination to improve the impact of such programmes. Similarly, through the Moving Minds Alliance or other such groups there can be coordination on MHPSS philanthropic support.
- **Involvement of the national and local authorities** at the earliest possible moment to help develop a programme that is sustainable – by the MHPSS working group on the ground coordinator and the donor group. Given the length of time refugees can expect to be living in temporary accommodation it would be helpful to take the example of Lebanon and work closely with national authorities to support parents and carers in addressing their mental health and that of their children.
- **Leverage funding through country selection**. While some countries are the focus of large increases in aid for mental health, others have suffered from lack of funds despite a willingness to reform and deliver improved services. It would be helpful to invest in advocating for the inclusion of parental and carer mental health programmes in some countries with significant resources (e.g. Syria and Iraq) in order to leverage these resources. At the same time, it would be helpful to invest in innovative programmes in one or more countries among those that have received least support. This would then enable the development of a body of evidence that makes the case for support across different settings. One means to do so will be through the WHO Special Initiative on Mental Health[3].

To accelerate action will take dedicated advocacy and campaigning prioritisation and capacity, a concerted, high level effort to engage key stakeholders, and technical material and knowhow to strengthen systems and surge capacity. There are historically important moments this year to achieve this including the ministerial meeting hosted by the Dutch government in October, with the launch of the MISP, and the Red Cross movement's development of the first, movement wide policy on mental health and planned resolution that will be launched in December. An influencing strategy will be submitted for discussion separately for development with the Bernard van Leer Foundation and partners.

1. Mental health in emergency and conflict settings and documented evidence of its impact on men, women and children.

- Mental health and psychosocial problems are extremely common in disasters and conflict affected populations.
- Rates of a wide range of mental health problems increase as the result of emergencies, with the prevalence of mental disorders (depression, anxiety, post-traumatic stress disorder, bipolar disorder and schizophrenia) at 22% (or 1 in 5) at any point in time during conflict[4] (Figure 1).
- The prevalence of PTSD and major depression for settled refugee populations has been discovered to be anywhere from 5-15 % for PTSD and 10-40% for depression[5]. For children and adolescents, the rates of PTSD range from 50-90 % and major depression from 6-40%[6]. Rates vary with different populations.
- The vast majority of the affected population does not receive any mental health and psychosocial support, due to lack of adequate recognition and very low capacity of delivering effective interventions.

Between 2011 and 2016 the global refugee population increased 65 percent[7]. Most of these refugees are in 'protracted refugee situations', which is defined by UNHCR as a situation in which 25,000 or more refugees from the same nationality have been in exile for five or more years in a given asylum country[8]. The latest estimates (from 2017) suggest 40 million people are internally displaced as a result of disaster or conflict and 25.4 million people are living outside their country of origin as refugees – children comprise around half of this refugee population, with 52% below 18 years old[9]. In 2015 alone more than 16 million babies were born in conflict zones — 1 in 8 of all births worldwide[10]. Children are extremely vulnerable in conflict and crisis contexts; children under five have the highest morbidity and mortality rates of any age group — twenty times higher than standard levels[11].

International agreements, such as the UN Global Compact for Migration[12], the UN Global Compact on Refugees[13], the Universal Declaration of Human Rights and the UN Convention on the Rights of the Child[14], symbolize a commitment made by the global community to use unity of intent, solidarity and shared humanity to protect rights of the children, families and individuals disproportionately affected due to migration, refugee or humanitarian and conflict situations.

There is a growing recognition of how essential MHPSS is to displaced people and to people living in areas of ongoing conflict, or humanitarian contexts. Rates of a wide range of mental health problems increase as the result of humanitarian crises brought on by conflict (Figure 1); this translates into a greater need for services, which may be weakened due to circumstances.

	Point prevalence (95% uncertainty interval)
Severe disorder (severe anxiety, severe post-traumatic stress disorder, severe depression, schizophrenia, and bipolar disorder)	5·1% (4·0–6·5)
Moderate disorder (moderate anxiety, moderate post-traumatic stress disorder, and moderate depression)	4·0% (2·9–5·5)
Mild disorder (mild anxiety, mild post-traumatic stress disorder, and mild depression)	13·0% (10·3–16·2)
Total	22·1% (18·8–25·7)

Table 1: **Point prevalence estimates for mental disorders in conflict-affected populations, adjusted for comorbidity**

Figure 1: Impact of Conflict on Prevalence of Mental Disorders. Source: Charlson et al (2019). New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. https://doi.org/10.1016/S0140-6736(19)30934-1

Disasters can also lead to longer-term physical and psychological impacts due to the outcomes on the individual, including delayed mental development, being orphaned, post-traumatic stress disorder, family separation and sexual and psychological abuse[15]. People living as refugees report a high degree of depression and frustration as they struggle to exert any control over the circumstances in which they find themselves, and children can experience toxic stress due to experiencing ongoing trauma (physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship) that disrupts brain development and increases the risk of cognitive impairment later in life[16]. Figure 2 illustrates potential interventions to address these challenges.

Description	Before disaster: baseline 12 month prevalence	After disaster: projected 12 month prevalence	Recommended aid response	Sector
Severe disorder (for example, psychosis, severe depression, severely disabling form of anxiety disorder)	2-3%*	3-4%Ü	Make mental health care available in general health services and in community mental health services Develop social services to support in rehabilitation	Health and social services sector
Mild or moderate mental disorder (for example, mild and moderate forms of depression and anxiety disorders, including of post-traumatic stress disorder)	10%*	20% (reduces over time to 15% through natural recovery without intervention)á	Make mental health care available in general health services and in community mental health services Make social interventions and basic psychological support interventions available in the community	Health and a variety of other sectors
Moderate or severe psychological distress that does not meet criteria for disorder that may resolve over time or mild distress that does not resolve over time	No estimate	30-50% (reduces over time to an unknown extent through natural recovery without intervention)ß	Make social interventions and basic psychological support interventions available in the community	A variety of sectors
Mild psychological distress that resolves over time	No estimate	20-40% (increases over time as people with severe problems recover, sometimes partially)	No response	

*Assumed baseline rates are the median rates across countries as observed in the World Mental Health Survey 2000.9

Figure 2: Psychosocial and mental health assistance to populations affected by the 2005 tsunami: WHO projections and recommendations. Source: Van Ommeren M, Saxena S, Saraceno B. Aid after disasters. (2005). BMJ.330:1160. doi: 10.1136/bmj.330.7501.1160.

Moreover, today refugees spend an average of 26 years in temporary accommodation, long enough for children to be born, grow up and start their own family all while living as a refugee[17]. This means involvement of the national and local authorities at the earliest possible moment is essential to help develop a mental health programme that is sustainable – by MHPSS personnel on the ground and by international donors. This has led to the promotion of the 'Building Back Better' approach by WHO and other agencies in which they work with national governments to develop improved, comprehensive mental health programmes on the basis of innovations developed during the emergency and post-emergency phases[18].

According to the 2018 paper, *Early Childhood Development and Early Learning for Children in Crisis in Conflict*[19]*,* children are specifically affected in the following ways:

- Stress on the child is exacerbated through repeated exposure to violence, loss or separation from caregivers, and the damage and deterioration of support systems including government health and welfare services, schools and communities.
- The detrimental effects of conflict and crisis are exceptionally acute in the first years of a child's life, when the brain undergoes its most rapid period of development and is extremely sensitive to environmental influence.
- During this foundational stage of human development, severe and prolonged stress or deprivation can affect brain architecture and epigenetic structures that regulate gene expression and influence the physiological response to stress and disease.
- Prolonged adversity can lead to 'toxic stress' and have lifelong implications for physical and psychosocial health (see reference above).
- Experiences of severe, prolonged stress and psychosocial deprivation affect not only the individual child — the effects can extend to subsequent generations and to the broader community through biological, behavioural and socioeconomic processes, leading to the intergenerational transmission of adversity, disadvantage and violence, and the reinforcement of inequities. This threatens the future peace, social cohesion and stability of societies.

Caregivers living through conflict and crisis face tremendous obstacles to healthy parenting and responsive care. Traumatic experiences, a sense of hopelessness, insecurity and depression can prevent caregivers from attending to and positively engaging with their children[20]. Therefore, child and adolescent well-being is significantly affected by caregiver mental health in the refugee context.

However, there remains a lack of systematic data on the impact on caregivers of different interventions, and frequently interventions for children do not take account of the needs of caregivers, while interventions for adults (including caregivers) do not take account of the needs of children. Some of the challenges to correctly assessing both the problem and the solution include:

- Child protection interventions in humanitarian contexts frequently do not adequately address the influence of caregivers' mental health. Child protection programming could integrate caregiver mental health and parenting interventions in humanitarian context more effectively[21].
- Children who live in the world's poorest countries are more likely to suffer from violence, however a systematic review[22] looking at violence prevention interventions in HICs and LMICs found poor evidence in LMICs that these interventions prevented child maltreatment in harsh adverse contexts.
- Interpersonal violence (IPV) against women and children has increasingly been recognized as a public health priority in humanitarian emergencies[23] and yet there is paucity of interventions and lack of systematic or longitudinal studies on IPV, domestic violence and violence against children.

2. Addressing mental health in emergency settings: key challenges, guidelines, frameworks and priorities.

By way of background for examining interventions, it is helpful to note that those aiming to provide MHPSS for populations living in emergency and conflict settings have a number of challenges they need to address, in particular:

- Providing comprehensive and sustainable MHPSS from the outset of a conflict or natural disaster through to the development or reconstruction phase and sustaining continuous provision in protracted conflict settings.
- Ensuring MHPSS provision is coordinated among all those involved so there is a comprehensive, evidence-based and culturally appropriate response governed by agreed, international standards.
- Ensuring that MHPSS is integrated well within the existing and developing health and social care systems for the populations leading to overall capacity building and systems strengthening.
- Ensuring that the available resources are allocated in an equitable manner across and within countries and populations.

Knowledge about what works has increased substantially in the last decade. The formal guidelines and recommendations underlying the documents are examined below. These are increasingly evidence based, though it needs to be acknowledged that more research is needed on diverse groups and at different stages in the life course (including children, parents and carers).

Key guidelines and frameworks

Mental health action in emergencies is guided in particular by the work of the Inter-Agency Standing Committee (IASC) Reference Group on Mental Health and Psychosocial Support in Emergency and Conflict Settings[24]. The following are key guidelines and frameworks for humanitarian action:

1. The IASC Guidelines on MHPSS in Emergency Settings (2007)[25] provides guidance on which strategies should be recommended for implementation in humanitarian settings and how coordination should be achieved in delivering them. Apart from communicating core principles for MHPSS, the Guidelines identified minimal response in the domains of community mobilization and support, health services, education and dissemination of information. The Guidelines also dealt with the social considerations in sectoral responses to food security and nutrition, shelter and site planning and water and sanitation. The Guidelines were widely welcomed and have formed the basis for humanitarian response on MHPSS since then.
2. Other documents produced by IASC Reference Group on MHPSS include: Advocacy Support Package (2011)[26], Recommendations for Conducting Ethical Research (2014)[27], Who is where, when and doing What (2014)[28], a Monitoring and Evaluation Framework (2017)[29], and an Inter-Agency Referral Guidance Note (2017)[30].
3. Other key technical materials: Psychological First Aid: A guide to field workers (2011)[31]; mhGAP Humanitarian Intervention Guide for clinical management of mental, neurological and substance use conditions (2015)[32]; and some manuals for low intensity psychological interventions e.g. 'Problem Management Plus: psychological help for adults in communities exposed to adversity' (2016)[33].

One of most influential resources in humanitarian settings is the Sphere Handbook[34], which has covered MHPSS since 2004. However, it also fails to fully include children. For example, according to UNESCO's

report, “the Sphere standards do include important guidance on infant and young child feeding, the prevention and treatment of disease, the specific requirements of young children and their caregivers pertaining to water supply, sanitation and hygiene, and other relevant interventions. Yet the standards neglect to include guidance on interventions to promote responsive caregiving and early learning, components of the Nurturing Care Framework closely associated with the education sector. This critical omission may contribute to the lack of focus on education and other key aspects of early learning and cognitive development in subsequent Refugee and Humanitarian Response Plans.”[35]

The omission of these issues is also noted by the Nurturing Care Framework[36]. The Framework was established to provide a roadmap on ECD, and highlights the required actions and milestones for progress to improve ECD. It includes linkages to maternal mental health, advocating for efforts to improve health, well-being and human capital to begin from pregnancy to age 3. It calls to integrate the Framework into humanitarian policies, and to build up the capacity of caregivers for nurturing care.

Humanitarian Response Plans and Refugee Response Plans

Examining current practice and prioritisation is possible by looking at Humanitarian Response Plans (HRPs) which are prepared to respond to a protracted or sudden onset emergency, and Refugee Response Plans (RRPs), which are for large-scale or complex refugee situations. These plans guide the work of the international community (particularly UN agencies) and also guide the funds requested to support them.

A very useful analysis of 26 active HRPs and RRPs assessed the inclusion (or not) of references to early childhood development was done in April 2018.[37] Nearly half —12 plans —make no mention of any learning or education for under 5s. On responsive caregiving, 11 plans out of 26 made no mention of any component of interventions related to responsive caregiving.

There is no similar analysis known to be available that looks at mental health – assessing mental health inclusion and what the focus of the interventions are (and if these include parents and carers). However, based on the experience of the authors of this paper and discussions with colleagues, mental health services are included in education, health and protection clusters, yet activities are underfunded and not necessarily well coordinated.

Current Priorities for Mental Health Humanitarian Response Reform

There have been a series of attempts made by some organizations and groups to identify priorities within humanitarian and conflict settings (e.g. the Hague symposium 2015, the DFID and the Berlin meeting 2018). Recently, a group of experts was convened by the Dutch government in September 2018 to advise them on how to scale up MHPSS in emergency and conflict settings. The Dutch government is now following up on these recommendations as part of its work in preparation for the Ministerial Summit in October 2019.

The recommendations are as follows:

1. **Surge capacity (experts and others).** A key bottleneck in delivering care is lack of human resources. Experts are needed to plan services and to train, supervise and support. This requires surge capacity to quickly and efficiently scale-up services and meet increased demand to stabilise or alleviate suffering of those most affected. As outlined in the IASC guidelines, it would be essential to have a single, overarching coordination group on MHPSS, to be set up when an emergency response is first mobilized, with actors both inside and outside the health sector. The Dutch government is examining the formation of such a surge mechanism and capacity; the qualifications of those recruited as part of the surge capacity could include experts in parent and carers’ mental health.

2. **Basic training for delivery of MHPSS to maximum numbers**. The bulk of actual delivery of MHPSS can be done by health, protection, education, and other non MHPSS humanitarian care workers who have received training in delivery of basic care packages, with experts to provide ongoing support and supervision to them. Much of the trainings can take place before a disaster occurs, at least in those regions where conflicts and natural disasters are frequent e.g. in regions such as the Middle East and countries such as the Philippines. This is an ongoing area of support by donors but training that focuses on the needs of parents and carers could be better standardised and monitored.
3. **Development and roll out of a new guidance package for delivery of MHPSS on the ground** e.g. Minimum Service Package (MSP) for MHPSS. This should be developed, learning from the Minimum Initial Service Package (MISP) for reproductive health that has been highly successful in guiding implementation on the ground in a way that improves both quality and coordination. The MSP for MHPSS would provide guidance on the content, testing, and costing of MHPSS interventions and would include guidance on the necessary supplies, human resources , and manuals to deliver MHPSS care across sectors. It would be based on the use and measurement of a standard set of indicators. The Dutch government is funding the development of the MISP by UNICEF and WHO. The MSP could include specific recommendations on how best to address the mental health of parents and carers in order to positively support early childhood development.

In summary, while none of these recommendations specifically discuss the role of parents and caregivers and their impact on childhood development, there is scope to engage with these different initiatives to press for greater focus on these issues.

3. Innovations to address parental and carer mental health to improve early childhood development in emergency and conflict settings

While traditional ways of delivering interventions are still the mainstay in MHPSS, a number of innovative strategies are being tried and tested in a variety of regions and populations. Mental Health Innovation Network[38] describes 25 projects that have innovative strategies being used among humanitarian and conflict situations. The following common themes can be identified which have the most promise:

- Use of non-specialist care providers (e.g. community workers, trained lay persons) – which is common in all conflict and humanitarian settings
- Integration within existing services and combining delivery of services with reform of the systems of care
- Use of technology (e.g. internet, mobile devices, consultation using telemedicine).
- Use of self-help interventions (delivered using printed material, radio and television, audio-books, videos and online material).

Taking the specific focus of parental and carer mental health to improve early childhood development, we have examined a wide range of interventions from different countries and settings. The table below summarises a wide range of interventions and Annex 1 provides details on the interventions listed here.

Intervention date	***Country or Region***	***Organisation***	***Intervention***	***Assessment***
Use of non-specialist care providers (e.g. community workers, trained lay persons)				
2019	Uganda, Liberia and Nepal		Non-specialist workers trained on mhGAP	*Workers had some basic competence in supporting targeted populations*
2016	*Syria*		*Refugees trained as health workers, peer supporters*	*Refugee workers are an invaluable resource for healthcare delivery*
2015-16	*Cameroon Chad Ethiopia Democratic Republic of Congo Kenya Uganda Tanzania*	*The War Trauma Foundation*	*Training of staff with tool designed to guide clinical decision making in humanitarian settings*	*promoted the integration of mental health into primary health care; strengthened MHPSS capacities of the providers. However knowledge and skills of community workers are still insufficient in some countries and*

				continuing capacity building is required[39]
2011-present	*Burundi, Sri Lanka, Nepal, Sudan, Indonesia*	*HealthNet TPO (Health Works)*	*A multi-tiered psychosocial care package combining mental health promotion, prevention and treatment.*	*Improvement in case detection and made care available to over 96,000 children in the five countries*
Integration within existing services and combining delivery of services with reform of the systems of care				
2011-present	*Conflict settings*	*Mental health and psychosocial support in humanitarian settings (MH-SET)*	*Research programme*	*Three sets of findings have been associated with this work: (1) strengthened partnerships between humanitarian agencies and universities, (2) upgrading basic research skills of humanitarian practitioners to strengthen information gathering as part of programme implementation, and (3) increased funding for the research questions prioritized in this study*
2015-present	*Cameroon, Chad, Ethiopia, Democratic Republic of Congo, Kenya, Uganda, Tanzania*	*UNHCR*	*Capacity building in refugee primary healthcare settings*	
2007-2009	*Brazil*	*The Equilibrium Programme (TEP)*	*Community-based programme was developed to specifically serve traumatized and neglected*	*TEP assisted 544 children and adolescents, 50.4% (274) on treatment*

			children and adolescents in the city of São Paulo.	*or completed the treatment plan (30.7% referred to other treatment centres), 43.8% children/adolescents were reintegrated into families (original or step-families) and 6.25% relocated with their families outside the city.*
Ongoing	*Bangladesh*	*Action Against Hunger*	*Improvement of women and child refugee's mental health and wellbeing by providing nutrition-specific and nutrition-sensitive programming alongside providing other services including psychosocial support.*	*To date more than 350,000 people have received mental and psychological support to treat stress and overcome trauma.*
2017-present	*Worldwide; Jordan*	*UNICEF*	*Working with children to address the trauma of displacement, and in 2017 provided psychosocial support, including child-friendly spaces and community and school-based interventions* *Makani (My Space) centres in Jordan have provide children, youth and parents, with access to safe learning opportunities - as well as integrated community-based child protection, early childhood development, life skills and social innovation training.*	*3.5 million children reached worldwide; more than 150 Makani Centres in Jordan supporting 177,000 children, youth and parents.*
2016-2017	*Lebanon*	*IRC*	*Healing Classrooms are as intervention aimed at strengthening the role that teachers play in promoting the psychosocial recovery and well-being of children during and after crises.*	*During the 2016-2017 school year, IRC delivered one or two cycles of Learning in a Healing Classroom retention support programming to*

				over 4,300 Syrian refugee children in Lebanon's Bekaa and Akkar regions.
Ongoing	*Iraq, Jordan, Lebanon, Syria*	*IRC*	*The programme, Ahlan Simsim ('Welcome Sesame" in Arabic) is aiming to be the largest early childhood intervention in the history of humanitarian response. There are three components to the intervention including providing educational content, home visits and child education centres.*	*Review in progress*
Ongoing	*Uganda*	*Healthright International*	*The programme provides support to the mental health of pregnant women and young mothers in post-conflict areas. Developed via local community consultations, the programme utilizes a step by step approach, where clinicians are freed up to deal with the most difficult cases and bring recovery to more and more patients.*	
Ongoing	*Worldwide*	*Plan International*	*Child and adolescent friendly spaces provided where children and adolescents can access psychosocial counselling, support networks, life-saving information, and be referred to other services. Parenting courses are also provided to help caregivers develop skills to cope with crises.*	
Ongoing	*Worldwide*	*MSF*	*Provision of mental health and psychosocial support through group sessions or individual consultations. Psychiatric treatment is usually integrated into general medical care and in*	*In 2017 alone, MSF ran 462 projects in 72 countries and provided 306,300 individual mental health consultations and 49,800 group*

			some projects specialised clinicians treat patients with severe mental illness.	*mental health sessions.*
Use of technology				
Ongoing	*Afghanistan*	*International Psychological Organisation*	*In addition to providing counseling, IPO have an online video psychological counseling portal that helps them reach out to patients who cannot walk-in.*	
Ongoing	*Lebanon*	*Khoutweh Khoutweh*	*An electronic mental health intervention with 15 minutes per week of remote (phone or message) guidance by a trained non-specialist "e-helper"*	
Use of self-help interventions				
Ongoing	*Worldwide*	*WHO*	*The Self Help Plus intervention is intended to be relevant for coping with any type of adversity, including chronic poverty, endemic community and gender-based violence, long-term armed conflict, and displacement.*	*Review in progress*

The development of the MISP will help determine the optimal interventions for the future.

4. Financing for parental and carer mental health to improve early childhood development in emergency and conflict settings.

An analysis on the financial requirements for MHPSS in humanitarian settings is greatly needed. In Humanitarian Response Plans, funding for psychosocial support is not earmarked, and is often integrated in Education, Protection and Health budgets. Understanding the financial requirements for executing MHPSS would also allow for domestic governments to properly budget for these services beyond emergency settings and provide long term funding in post-conflict environments and therefore a sustainable recovery.

Historical Trends in Financing

Funding for mental health services in conflict and humanitarian settings originates from a variety of Government and private sources, flowing through various channels before reaching those in need. Development assistance for mental health (DAMH), which is categorized as financial and in-kind resources that are transferred from development agencies to low- and middle-income countries with the primary purpose of maintaining or improving mental health, has experienced an increase from USD $18 million in 1995 to USD $132 million in 2015.[40] In 2018, global financing to mental health reached USD $161.1 million[41], an all-time high. However, despite these increases, DAMH has never exceeded 1% of DAH[42].

DAMH is directed to various sectors, ranging from health, education, government and civil services and humanitarian aid. The humanitarian aid sector received varying amounts of funds for mental health through the years but it has remained the second largest segment of DAMH after health funding from 2009-2013.

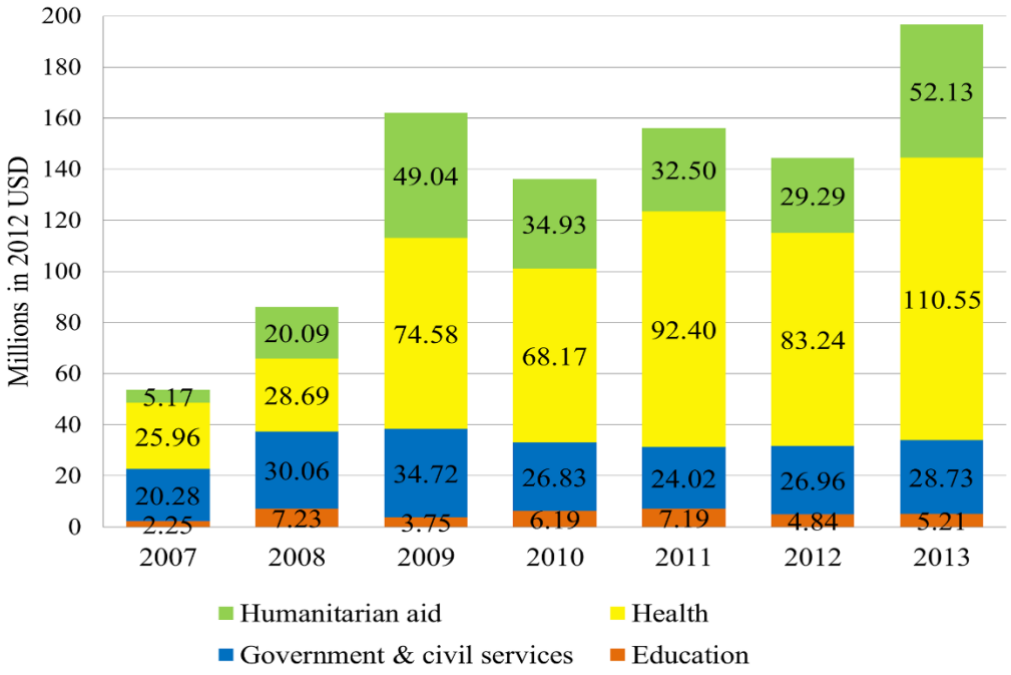

Figure 3: Annual DAMH by sector, 2007-2013. Source: Gilbert B.J., Patel V., Farmer P.E., Lu C. (2015) Assessing Development Assistance for Mental Health in Developing Countries: 2007–2013

This analysis on mental health funding was further extended to illustrate the amount the of DAMH that is allocated for child and adolescent mental health (DAMH_CA).[43] Between 2007 and 2015, US$190.3 million was disbursed to projects that improved the mental health of children and adolescents, accounting for 12.5% of DAMH over the total period. The humanitarian aid sector received the largest cumulative DAMH_CA for this period, totaling at US$77.2 million, or 40.5% of total DAMH_CA. This analysis found that most DAMH_CA targeted temporary or short-term humanitarian assistance to children and adolescents in disasters or conflicts and channeling the assistance through NGOs. Assuming at least some of these funds are directed to programmes that benefit parents and carers, this suggests that there is a strong case to be made for seeking additional funding through a focus on humanitarian aid and to leveraging this funding to 'build back better'.

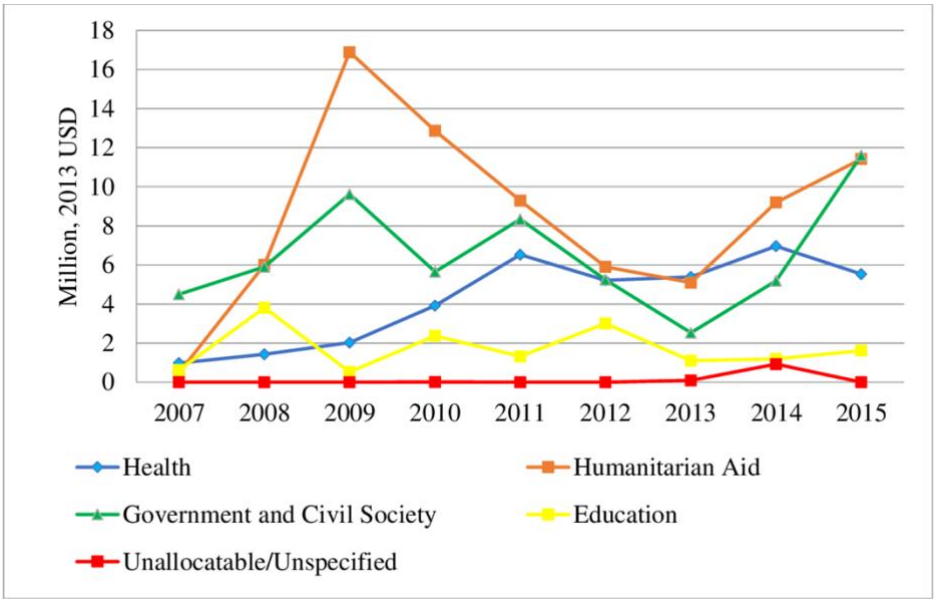

Figure 4: DAMH_CA by sector 2007-2015. Source: Lu C, Li Z, Patel V (2018) Global child and adolescent mental health: The orphan of development assistance for health. PLoS Med 15(3): e1002524. https://doi.org/10.1371/journal.pmed.100252.

An analysis done in 2011 investigated funding for MHPSS activities in humanitarian settings further examined the multisector nature of mental health interventions and financing. The report found that between 2007 and 2009, countries affected by humanitarian crises received US$224.3 billion in funding (at 2008 values); out of this $226.1 million was provided for programmes that included MHPSS activities. The sectors that received this funding varied - from HIV/AIDS control to education.[44]

	% of total funding
Sexually transmitted infection control (mainly HIV/AIDS)	36.9%
Emergency and distress relief	13.3%
Social or welfare services	5.4%
Medical services	5.2%
Other or not reported	3.8%
Human rights	3.5%
Primary education	2.9%
Civilian peace-building, conflict prevention, and resolution	2.6%
Landmine clearance	2.6%
Population policy and administration management	2.4%
Total	78.6%

Figure 5: Sectors that received the most MHPSS funding between 2007 and 2009 in countries affected by humanitarian crises. Source: Tol WA, Barbui C, Galappatti A, Silove D, Betancourt TS, Souza R, et al. (2011). Mental health and psychosocial support in humanitarian.

Analysing global humanitarian flows show an increase in funding from Government and private sources since 2013, reaching an estimated high of US $27.3 billion in 2017 (see figure 5).[45] Multilateral organisations (mainly UN agencies) are the first channels of aid for almost half (49%) of all humanitarian funding from private and Government sources. However, volumes of funds vary greatly on the UN agency; for instance, the WFP received US$5.2 billion (36% of UN funding) and UNHCR received US$3.7 billion (26% of UN funding) - these two agencies accounted for 61% of all funds. While assistance to IOM, UNOCHA and UNWRA decreased (by 29%, 11% and 12%, respectively).[46]

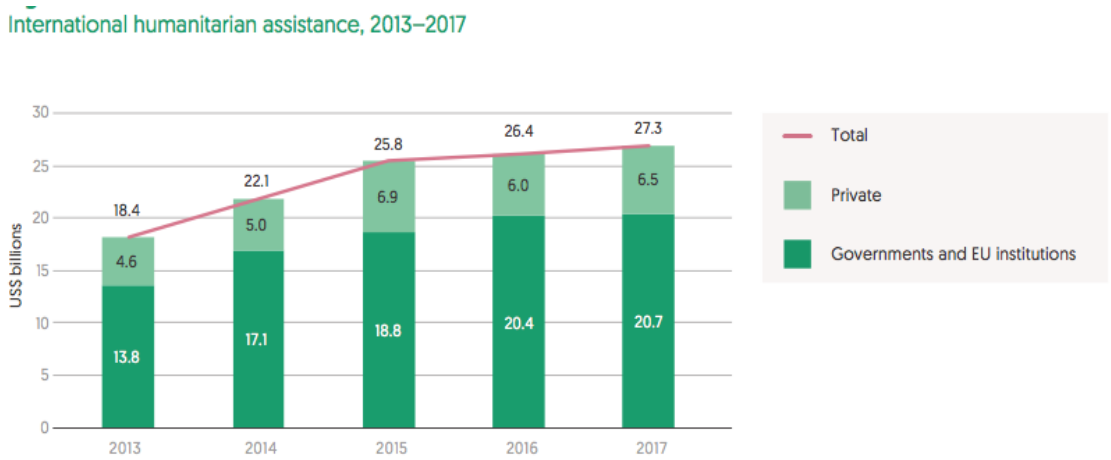

Figure 6: International humanitarian assistance, 2013-2017. Source: Development Initiatives (2018). Global Humanitarian Assistance Report 2018.

It is very difficult to isolate the amount of funding directed towards parental and carer mental health. A study examined 10 years of ODA from 2002- 2011 for reproductive activities including family planning, HIV/AIDS and sexually transmitted diseases, maternal and newborn health, comprehensive abortion care, and GBV interventions, in conflict-affected countries. The findings were that the ODA for these reproductive health activities to 18 conflict-affected countries increased by 298%, from US$ 303.5 million in 2002 to US$ 1.2 billion in 2011, with an annual average of US$ 747.0 million a year; this equates to 3% of all ODA during

the study period.[47] The conflict-affected countries that received the largest annual average per capita reproductive health ODA were Uganda (US$ 8.1), Timor-Leste (US$ 6.7) and Liberia (US$ 5.4) and the countries that received the smallest were Colombia (US$ 0.2), Myanmar (US$ 0.4), and Sri Lanka (US$ 0.7).[48] However, despite this increase of overall funding during this period, most of these funds were directed to HIV/AIDS activities, with over half (56.3%) of the 298% increase in ODA during this period due to an increase in HIV/AIDS funding[49].

Future Sources of Finance

One of the most recent developments in financing for MHPSS has been the identification of mental health as one of the ten humanitarian grand challenges i.e. key priorities following an exhaustive process of consultation of individuals from governments, the private sector, non-governmental organizations and those affected by humanitarian emergencies (e.g. those born in refugee camps or working closely with refugees)[50]. This prioritization exercise was designed to guide the direction of future donor investment in humanitarian aid.

There are a variety of ways to advocate for increase funding for MHPSS in disaster and conflict settings. First, international development donors must prioritize mental health and integrate mental health into emergency response planning, with a special focus on prevention, promotion and holistic, life-course approaches. Second, national governments should allocate the recommended amount of public health budgets to mental health as described in the Lancet Commission on sustainable development (LICs - 5%, HICs -10%). National governments that host refugees need to consider the mental health of those refugees as part of their mental health planning.

Focusing first on accelerating donor funding, one way to increase more humanitarian aid to mental health services (including for parental and carer mental health) would be to engage with pooled funds managed by OCHA. These include the Central Emergency Relief Fund (CERF), which can cover emergencies anywhere in the world, and Country Based Pooled Funds (CBPF), which cover crises in specific countries. Contributions to the CERF and CBPFs have grown substantially in recent years. The CERF has increased from US $480 million in 2014 to US $555.3 million in 2018,[51] and CBFS from $486 million in contributions received in 2014 to $833 million in 2017. As CBPFs have the ability of fund local and international NGOs directly, this increase in funding is crucial to assist work on the ground level. CERF funding has been directed towards improving mental health in emergency settings, but examples are limited; for example, funds have gone on to enable humanitarian partners to provide critical psychosocial support and protection services in Nigeria,[52] and to provide psychological support to 7,944 children and adolescents (4,756 boys and 3,188 girls) in Myanmar.[53]

Another example of a pooled fund that could be engaged further (with a focus on child, and potentially parental and carer mental health) is Education Cannot Wait (ECW), established during the World Humanitarian Summit in 2016. ECW is a platform dedicated to making education a priority in the humanitarian agenda by using pooled funds from state and non-state actors and donors. They have invested US $134.5 million in crisis-affected countries and support programmes at the country level with the help of 60 partners including UN agencies and NGOs. In the first year of operation, funds have gone on to agencies to provide 75,000 children with psychosocial support.[54]

ECW is about to start a global replenishment campaign to mobilise $1.8 billion USD, including $673 million for its global trust fund for the period 2019-2021. This campaign will include a high-level pledging event at the 74th session of the UNGA in September-October 2019. However, there is a current need to secure further commitments: of the $673 million trust fund replenishment target, there is a current gap of $572 million. A number of key donors in the field of Education in Emergencies and Protracted Crises are yet to commit support to ECW for the period 2019-202. This is a crucial time to advocate for programmes that have mental health elements for children (and their parents and carers) in humanitarian settings.

There are a number of donors who have increasingly invested in MHPSS and could potentially be encouraged to give more. At present, increasing health funding for MHPSS can be best linked to the Universal Health Coverage agenda as well as efforts to improve health system strengthening: key components of current discussions on health and areas of potential additional funding.

Working with over 27 LMICs, and with plans to engage with 50 more following a replenishment cycle, the World Bank's Global Financing Facility (GFF) has expanded the funding envelope for work addressing the needs of those experiencing conflict and humanitarian emergencies. The focus of the GFF is women, children and adolescents, and historically under-funded areas including sexual and reproductive health and rights, newborn survival, adolescent health, nutrition – and in the health systems needed to deliver at scale and sustain impact[55]. There is scope for this to include mental health if countries press for inclusion of mental health in the priorities for which they request GFF funds. This was noted in the conclusions of the discussion on financing at the UK-hosted global mental health meeting. Meanwhile the Global Concessional Financing Facility (GCFF) provides support to Middle Income Countries that host refugees (and is jointly run with the Islamic Development Bank, EBRD, EIB and the UN) with a current focus on Jordan and Lebanon[56].

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) raises and invests nearly US$4 billion a year to support programs to end AIDS, TB and malaria as epidemics, and could be engaged further to advocate for funds to mental health services in humanitarian contexts. Within their sponsored programs, there are mental health elements including providing psychosocial services for survivors of GBV and into HIV programming in Papua New Guinea and South Africa[57]. GFATM has also partnered with U.S. president's Emergency plan for AIDS Relief (PEPFAR), and the World Bank, have joined forces to provide combined educational and psychosocial services to children and adolescents in areas of high HIV rates[58]. Given the forthcoming replenishment of the Global Fund on World Mental Health Day 2019 (and hosted by the French government) there is a clear opportunity to engage donors on the links between mental health and the diseases covered by the Fund.

The best means to increase bilateral humanitarian funding could be through a concerted effort to make the case for investment in MHPSS not only through the moral and health arguments but also through the development of the economic case for support and the clear link to the achievement of the goals that leading humanitarian players have signed up to under the Grand Bargain. For example, the Grand Bargain sets a global aggregated target of at least 25% of international humanitarian funding to local and national responders as directly as possible by 2020. Yet the actual share of funds received by these responders in 2017 was 2.9%. Investment in development of MHPSS local services would improve sustainability between humanitarian and development contexts and would help fulfil one of the least well advanced of the Grand Bargain targets. The donor group coordinated by the UK and the Netherlands is an important opportunity to make the case for greater bilateral and multilateral aid.

Domestic budgets to mental health must also increase, as national health budgets assign an inadequate amount of funds to mental health services considering the overall large prevalence of MNS disorders. In humanitarian contexts and in countries with large refugee populations, national governments should be assigning considerably more resources to mental health. However, this can be problematic as lower income nations with scarce financial resources are hosting the majority of refugees. In 2017, developing regions hosted 85% of the world's refugees and the least developed countries provide asylum to 6.7 million refugees - one-third of the global total[59]. Globally, government mental health spending remains on average US$2.5 per person per annum (pppa)[60]. For comparison, in 2015 the global median of domestic government general health expenditure was US$ 141 per capita, thus making government mental health expenditure less than 2% of global median of government health expenditure[61]. In LMICs these rates decrease with LICs at US$0.02 pppa and in lower middle-income countries at US$1.05 pppa, with more than 80% of that going directly towards institutions such as mental hospitals[62].

In the context of Lebanon, which is currently hosting the largest number of refugees per capita, financing mental health services remains a challenge[63]. Around half of the population are uninsured (excluding displaced Syrians and Palestinians living in camps covered by UNHCR and UNRWA) and the majority of private insurances do not provide mental health care[64]. The Ministry of Public Health has reported that 5% of the health budget is allocated to mental health, out of which around half (54%) is spent on in-patient care[65]. When mental health services are available to non-refugee populations, they are provided mainly via the private sector, increasing the burden of out-of-pocket expenditure, which remains the largest source of health expenditure in Lebanon[66].

In countries such as Jordan and Turkey, home to large refugee populations, data does not exist on domestic financial resources to mental health. In the case of Jordan, the government recently changed its policy of offering free health services to Syrian refugees. Now, Syrian refugees are charged for health services outside camps, which results in many traveling long distances to access free INGO-based services[67].

Finally, philanthropic funding could also increase. UN agencies such as UNICEF that have a large health programme could earmark greater funds for MHPSS as can other UN agencies such as IOM, coordinated by WHO. The WHO has included in its new Special Initiative on Mental Health the proposal that donors support programmes in conflict and humanitarian settings. There are also a number of large international organisations (particularly the Red Cross movement) and INGOs that provide essentially MHPSS services and their funding could be increased either by government, philanthropic or general public donations. All too frequently their programmes are short term and there are challenges with coordination between implementing partners and also between implementing partners and host governments. These need to be addressed along with the standardisation of service provision that is the focus of the new MISP. Initiatives such as the Moving Minds Alliance demonstrate the value of coordination between philanthropic efforts and the power of collaboration on investment decisions determined according to the best quality and potential impact of programmes.

5. Summary and recommendations

There is evidence of why it is important to invest in parental and carer mental health in order to improve early childhood development. However, the evidence of what works, where and how, is limited. And the funding for such programmes also restricted.

To increase political support and funding for mental health in emergency and conflict settings, particularly for parents and carers, it will be necessary to demonstrate the need for action, examples of why interventions can have such positive outcomes, and how best to deliver such interventions in the future.

The need for action rests on severity of the impact of emergency and conflict settings and the impact of parental and carer mental health on early childhood develop, and the scale and frequency of the those affected. It requires strong and meaningful political commitment supported by adequate and effective funding to cement this argument.

To achieve this the following is recommended:

- **Championing of a coordinated programmatic approach under the MISP –** this will help ensure that a quality programme is delivered and supported in a collaborative way by the international community.
- **Investment Case** - a case for support needs to be developed to explain why investing in parents and carers mental health will positively benefit not only them but the children that they care for.
- **Donor coordination** – through the donor group co-chaired by the UK and the Netherlands, there is the potential to advocate for a focus on parental and carers' mental health - and to encourage greater coordination to improve the impact of such programmes. Similarly, through the Moving Minds Alliance or other such groups there can be coordination on MHPSS philanthropic support.
- **Involvement of the national and local authorities** at the earliest possible moment to help develop a programme that is sustainable – by the MHPSS working group on the ground coordinator and the donor group. Given the length of time refugees can expect to be living in temporary accommodation it would be helpful to take the example of Lebanon and work closely with national authorities to support parents and carers in addressing their mental health and that of their children.
- **Leverage funding through country selection**. While some countries are the focus of large increases in aid for mental health, others have suffered from lack of funds despite a willingness to reform and deliver improved services. It would be helpful to invest in advocating for the inclusion of parental and carer mental health programmes in some countries with significant resources (e.g. Syria and Iraq) in order to leverage these resources. At the same time, it would be helpful to invest in innovative programmes in one or more countries among those that have received least support. This would then enable the development of a body of evidence that makes the case for support across different settings. One means to do so will be through the WHO Special Initiative on Mental Health[68].

To accelerate action will take dedicated advocacy and campaigning prioritisation and capacity, a concerted, high level effort to engage key stakeholders, and technical material and knowhow to strengthen systems and surge capacity. There are historically important moments this year to achieve this including the ministerial meeting hosted by the Dutch government in October, with the launch of the MISP, and the Red Cross movement's development of the first, movement wide policy on mental health and planned resolution that will be launched in December. An influencing strategy will be submitted for discussion separately for development with the Bernard van Leer Foundation and partners.

Annex 1: Innovations in Delivery of Parental and Carer Mental Health Services

Use of non-specialist care providers (e.g. community workers, trained lay persons).

The mental health gap action programme (mhGAP) Humanitarian Intervention Guide (HIG)
The War Trauma Foundation
2015-16

In 2015 and 2016, a specialized NGO, the War Trauma Foundation, trained 619 staff with the mental health gap action programme (mhGAP) Humanitarian Intervention Guide (HIG), a tool designed to guide clinical decision making in humanitarian settings[69]. This development was pertinent to training and development of evidence-based interventions for humanitarian crises which largely take place in LMIC settings where in addition to the usual shortage of staff, the emergency context brings its own challenges[70]

HealthNet TPO (Health Works)
2011-present

Targeting at risk children and adolescents living in conflict areas in Burundi, Sri Lanka, Nepal, Sudan, Indonesia, the HealthNetTPO (Health Works) programme delivered a multi-tiered psychosocial care package combining mental health promotion, prevention and treatment. The three tiered programme combined elements such as peer support groups, structured group interventions to address symptoms of distress and strengthen protective factors, and treatment including individual counseling, parental support and/or a referral to a psychiatrist. Once this programme was implemented across all five countries, a series of non-randominzed evaluations found that it improved case detection and made care available to over 96,000 children in the five countries - https://www.wish.org.qa/wp-content/uploads/2018/01/WISH_Mental_Health_Report.pdf. Despite these successes, the programme has stopped operating in all countries apart from Burundi due to lack of resources.

Integration within existing services and combining delivery of services with reform of the systems of care

Mental health and psychosocial support in humanitarian settings (MH-SET)
2011-present

MH-SET was launched as a way to develop consensus-based research and intervention priorities for conflict settings. Three sets of findings have been associated with this work: (1) strengthened partnerships between humanitarian agencies and universities, (2) upgrading basic research skills of humanitarian practitioners to strengthen information gathering as part of programme implementation, and (3) increased funding for the research questions prioritized in this study[71].

The United Nations High Commissioner for Refugees (UNHCR)
2015 - present
Cameroon, Chad, Ethiopia, Democratic Republic of Congo, Kenya, Uganda, Tanzania

The United Nations High Commissioner for Refugees (UNHCR)[72] started a process of mental health capacity building in refugee primary health care settings in seven countries in Sub-Saharan Africa, ultimately aiming to decrease the treatment gap of mental, neurological and substance use (MNS) conditions in these operations.

The Equilibrium Programme (TEP)
Brazil

In Brazil, The Equilibrium Programme (TEP)[73], a community-based programme was developed to specifically serve traumatized and neglected children and adolescents in the city of São Paulo. TEP offers comprehensive mental and physical health care along with social services in a Community Sports Centre where children and adolescents receive specialized services and support for school attendance while participating in social and recreational activities with their peers. The ultimate goal of the programme was to follow maltreated children and adolescents from the streets or group shelters throughout the process of community and family reintegration. The impact of the programme was felt; TEP assisted 544 children and adolescents, 50.4% (274) on treatment or completed the treatment plan (30.7% referred to other treatment centres), 43.8% children/adolescents were reintegrated into families (original or step-families) and 6.25% relocated with their families outside the city.

Action Against Hunger
Bangladesh

Action Against Hunger, with funding from Global Affairs Canada, is working to improve the nutrition and psychosocial well-being of refugees and host populations in the district of Cox's Bazar in Bangladesh, with a particular focus on women and children. The project seeks to reach people with nutrition-specific and nutrition-sensitive programming alongside providing other services including psychosocial support. To date more than 350,000 people have received mental and psychological support to treat stress and overcome trauma.[74]

Makani Centres
UNICEF
2017-present

UNICEF has continued to work with children to address the trauma of displacement, and in 2017 provided psychosocial support, including child-friendly spaces and community and school-based interventions for around 3.5 million children around the world[75]. UNICEF also supports more than 150 Makani (My Space) centres across Jordan, supporting over 177,000 children, youth and parents, with access to safe learning opportunities - as well as integrated community-based child protection, early childhood development, life skills and social innovation training[76]. The core idea of Makani is to provide vulnerable adolescents and youth with learning opportunities, life skills training and psychosocial support services all under one roof.

Healing Classrooms
The International Rescue Committee (IRC)
Lebanon

At the IRC's education work in conflict and emergencies is Healing Classrooms, an intervention aimed at strengthening the role that teachers play in promoting the psychosocial recovery and well-being of children during and after crises. This approach is achieved through providing training, tools and specialized structured lesson plans to educators so that they are equipped to establish a classroom environment (traditional or non traditional) and use activities that promote students' well-being. During the 2016-2017 school year, IRC delivered one or two cycles of Learning in a Healing Classroom retention support programming to over 4,300 Syrian refugee children in Lebanon's Bekaa and Akkar regions[77].

Ahlan Simsim
The International Rescue Committee
Iraq, Jordan, Lebanon, Syria

Most recently, the IRC has partnered with Sesame Street (with support from the Lego Foundation and the MacArthur Foundation), to bring early learning and nurturing care to displaced children and those in host communities across Iraq, Jordan, Lebanon, and Syria. The programme, Ahlan Simsim ('Welcome Sesame" in Arabic) is aiming to be the largest early childhood intervention in the history of humanitarian response. There are three components to to the intervention including providing educational content, home visits and child education centres. NYU Global TIES Center are conducting a multi-year, evidence-based research and evaluation programme to measure the intervention, as it is intended for this programme to become a scalable model that can be replicated globally.[78]

Peter C. Alderman Program for Global Mental Health
Healthright International
Uganda

Healthright International runs the Peter C. Alderman Program for Global Mental Health, which implements a project to support the mental health of pregnant women and young mothers in post-conflict areas, starting in Northern and Eastern Uganda with plans to expand in Sub-Saharan Africa. Developed via local community consultations, the programme utilizes a step by step approach, where clinicians are freed up to deal with the most difficult cases and bring recovery to more and more patients.[79]

Plan International
Worldwide (specifically Nepal, Tanzania)

Plan International is active in over 75 countries, and operates in humanitarian settings. Plan creates safe environments for children through child and adolescent friendly spaces where children and adolescents can access psychosocial counselling, support networks, life-saving information, and be referred to other services. Parenting courses are also provided to help caregivers develop skills to cope with crises[80]. Some examples of their work in humanitarian settings include in post-earthquake Nepal in 2015, Plan established a number of adolescent friendly spaces for girls aged 12-18 that allowed girls to access their right to protection, receive sexuality education, and allowed for the needs of girls who are married, pregnant or young mothers to be addressed in a safe environment.[81] Plan has also operated in refugee camps, testing an innovative early learning programme in centres in Tanzania that focused on psychosocial support and on children's social and emotional skills.[82]

Médecins Sans Frontières (MSF)
Worldwide

After a humanitarian crises hits, MSF teams can provide mental health and psychosocial support through group sessions or individual consultations. Psychiatric treatment in MSF is usually integrated into general medical care and in some projects specialised clinicians treat patients with severe mental illness; in others where there is a lack of specialised professionals, general practitioners are trained to diagnose and treat psychiatric disorders. In 2017, MSF ran 462 projects in 72 countries and provided 306,300 individual mental health consultations and 49,800 group mental health sessions to men, women, and children.[83]

MSF has opened day centres in Paris to accommodate unaccompanied migrant children arriving in France. At the centre, young people are given assistance that includes legal aid, medical care, mental health and social services. In cooperation with several associations (ADJIE, Safe Passage and COMEDE) and lawyers from the Bars of Paris and Seine Saint-Denis, MSF teams follow up each individual situation and offer support[84].

In Greece, MSF has been working on the island of Lesbos since 2016, providing primary health care, treatment for chronic diseases, sexual and reproductive health services and mental health support. In 2018, during a group mental health activity for children between 6 and 18 years old, an MSF team observed that

nearly 25% of children had self-harmed, attempted suicide or had thought about committing suicide[85]. MSF set up an additional clinic to increase access to medical care for children and pregnant women living in adverse conditions.

Use of technology

International Psychological Organisation (IPSO)
Afghanistan

The International Psychological Organisation (IPSO) is a large network of psychological counsellors helping refugees in Afghanistan. In addition to providing counselling, help and support to patients face-to-face, they have an online video psychological counselling portal that helps them reach out to patients who cannot walk-in. The online portal was developed with the support of German Foreign Office and has proved to be an excellent tool in the rehabilitation of PTSD patients[86].

Khoutweh Khoutweh
Lebanon

The Step-by-Step programme "Khoutweh Khoutweh" in Lebanon is an electronic mental health intervention with 15 minutes per week of remote (phone or message) guidance by a trained non-specialist "e-helper". The intervention will be pilot tested, recruiting through the wider community, several primary health care centres across Lebanon, and in the family medicine departments of two Beirut hospitals. 200 participants diverse communities will be able to participate in the feasibility study. Participants can use the intervention at home from their private devices, or in private rooms equipped with tablets and wifi in some of the participating health centres. The intervention was tested through two large randomized controlled trials in 2018 to determine its suitability for Lebanese nationals and refugees living in situations of adversity in Lebanon, before larger randomized controlled trials (RCTs) in 2019, the results for both are yet to be published. The intervention goal is to reduce the mental health treatment gap for Lebanese, Syrian, and Palestinian communities living in Lebanon. Proposed as part of a stepped care system, Step-by-step could in the future increase accessibility to evidence-based care using smartphones in Lebanon.

Use of self-help interventions

Developed by WHO, the self-help plus (Epping-Jordan et al 2016) SH + intervention is intended to be relevant for coping with any type of adversity, including chronic poverty, endemic community and gender-based violence, long-term armed conflict, and displacement. It is especially targeted towards places with enormous needs but limited humanitarian access, such as Syria and South Sudan. There is an ongoing trial in South Sudan (Brown et al 2018) that would provide information on the effectiveness of a scalable, guided self-help intervention for improving psychological health and wellbeing among people affected by adversity.

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