Mental health and psychosocial support in humanitarian settings: reflections on a review of UNHCR's approach and activities

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Mental health and psychosocial support activities are increasingly becoming a core component of humanitarian response and support for displaced persons in emergencies. However, recognition of the mental health and psychosocial impacts of conflict, disaster and displacement is relatively new within the sphere of humanitarian assistance. This paper, therefore, describes and expands on findings from a review of the UN Refugee Agency's engagement with mental health and psychosocial support for refugees. While this review specifically focused on one agency within the humanitarian field, it should be useful to many humanitarian agencies working in the field as the number of displacement scenarios grow and mental health and psychosocial aspects of displacement are increasingly evident. This review identified three key themes; 1) engaging with mental health and psychosocial support in humanitarian settings as an approach and as a set of interventions was found to be a useful framework; 2) challenges in measuring and evaluating mental health and psychosocial support activities, and the ways in which these challenges influence mental health and psychosocial support in humanitarian settings is discussed; and 3) limitations in provision of clinical mental health services were evident.

Keywords: humanitarian settings, mental health and psychosocial support, refugees

Key implications for practice

- Low and middle income countries host more than 80% of the world's refugees.
- Mental health and psychosocial support approaches are an emergent and important lens for all sectors in the humanitarian field.
- Forced displacement situations are increasing and protracted, creating anxiety and depression that needs to be addressed.

Introduction

Mental health and psychosocial support (MHPSS) activities are now considered an integral part of any humanitarian response. As a result, MHPSS activities and concerns were to be found at the forefront of responses to humanitarian emergencies in recent years, including; the 2010 earthquake in Haiti; displacement from Libya in 2011; and the ongoing humanitarian crisis in Syria. However, recognition of the mental health and psychosocial impacts of conflict, disaster and displacement is relatively new within the humanitarian assistance sphere. Until the late 1980s, the primary concern of humanitarian response was the provision of services to meet basic, material needs of displaced persons. Mental health and psychosocial problems of refugees were rarely, if ever, discussed or addressed. A number of events and processes, presented below, precipitated interest and investment in MHPSS concerns within humanitarian settings, resulting in the expansion of actors, interventions and research that currently characterises the field.

It is within this context of development that traditional humanitarian organisations are faced with the need to assess the role of MHPSS within their activities to support displaced and conflict affected individuals and communities. Therefore, the United Nations High Commission for Refugees (UNHCR) undertook a review of its involvement with MHPSS activities in order to understand and examine its engagement with, and adoption of, best practice and guidelines in the field, as well as to better understand UNHCR's current and potential position in the field of MHPSS activities. The review, commissioned by UNHCR's Policy Development and Evaluation Service (PDES), was published in 2013 and referred to herein as *'the UNHCR review'*. This paper will provide background on the development of the field of MHPSS activities, as well as a brief description of the positioning of MHPSS within UNHCR, and its relation to protection activities to contextualise the UNHCR review and identify its antecedents. Following this, the paper will explore three core themes that have emerged in the course of the UNHCR review, noting their relevance to UNHCR and concurrent or subsequent policy and programming changes. The three selected themes are: 1) the distinction between a MHPSS approach and MHPSS interventions; 2) the role of monitoring, evaluation and research in the field of MHPSS activities; and 3) neglected topics in MHPSS, including clinical mental health services. These three themes are discussed with reference to the specific relevance of these themes to UNHCR and its approach to MHPSS. This synthesis and discussion aims to bring some of the themes identified in the UNHCR review to a wider audience, recognising some of the challenges and opportunities that exist for the broad range of actors engaged in MHPSS activities, as well as highlighting some of the subsequent findings of the author and evaluation manager since the UNHCR review was published.

Background

Development of the MHPSS field

MHPSS in humanitarian responses has developed substantially over recent years. Initial discussions of, and approaches to, addressing the mental health needs of populations affected by traumatic events, torture and conflict emerged following World War II. These approaches adopted a psychiatric lens, with a focus on refugees who had been resettled from Europe. Primarily they focused on clinical interventions to address the treatment needs of these refugees (Ager, 1993; Agger, 2002). Beyond this, there was little to no recognition of, or response to, the mental health and psychosocial needs of individuals and communities living within humanitarian contexts until the 1980s (Harrell-Bond, 1988; Ratnavale, 1983). This has since shifted substantially in both thinking and practice, with a number of key influences.

One influence was that a number of humanitarian emergencies in the 1990s brought MHPSS issues to the fore, highlighting the mental health needs of affected people and therefore, increasing the demand and attention to the integration of MHPSS activities within humanitarian action. For example, the humanitarian response to the crises in Bosnia-Herzegovina and Croatia was a turning point in terms of inclusion and emphasis on the MHPSS component of humanitarian response (Agger, 2002). A second influence was the theoretical and conceptual work in the field, for example, the Psychosocial Working Group (PWG) advanced understanding of the impact of conflict and displacement on individuals and communities (Psychosocial Working Group, 2003). These efforts fed into principles that now form the basis of the *Inter-Agency Standing Committee (IASC) MHPSS Guidelines on mental health and psychosocial support in emergency settings* (IASC, 2007), and have informed policy and practice in the field. The PWG worked on core principles for delivering MHPSS programmes, including the commitment to human rights in MHPSS work, i.e.

participation, do no harm and building on existing communal resources Another influence on the field was the emergence and consolidation of a substantial evidence base demonstrating the mental health and psychosocial needs of displaced persons. Research literature expanded rapidly from the 1980 s (Steel et al., 2009).

Finally, improved coordination and interagency collaboration, stemming from the 2005 establishment of the IASC MHPSS Task Force, also contributed toward increased attention to these activities within the humanitarian community. The *Guidelines*, released in 2007, have had a considerable conceptual and practical impact on definitions and practices in the field and are one of the central influences on the shape and nature of the MHPSS field today.

UNHCR and MHPSS

It is against this backdrop, and in recognition of the changing nature of displacement, that UNHCR began to consider the role of MHPSS within its approach and response to humanitarian settings. One factor informing consideration of MHPSS within UNHCR was recognition of the changing nature and scope of forced displacement. The focus of humanitarian assistance and support to refugees from the 1970s onwards was initially centred on refugees in rural camp settings, primarily in Africa (Pantuliano, Metcalfe, Haysom, & Davey, 2012). From the 1990s onwards, large scale displacement has occurred in middle income, developed settings, including Eastern Europe, North Africa and the Middle East (Spiegel, Checchi, Colombo, & Palk, 2010). Rapid urbanisation is also shaping the nature of displacement, in terms of the challenges of addressing displacement and protection in urban environments, which has been increasingly recognised by humanitarian actors (Guterres & Spiegel, 2012). Until 2009, when UNHCR promulgated its '*Policy on refugee protection and solutions in urban areas*' (UNHCR, 2009), the agency was solely focused on working in camps and mostly within emergency settings. The gradual recognition of the need to address the protection needs of urban refugees, with more and more refugees displaced to urban settings, as well as refugees who were moving out of camps and into cities, or simply avoiding camps, provoked UNHCR to reconsider how it works in cities. At the time of writing, it is estimated that 60–70% of the world's refugees are living in urban areas of various sizes (UNHCR, 2012). It is only in very few of these cities that refugees are officially given the right or documentation to work in the formal sector, with access to national health and education services also often limited. These limitations can cause distress and negative coping mechanisms among refugees. Thus, MHPSS issues may be a particularly pressing concern in urban areas, where provision of humanitarian support for vulnerable individuals may be limited and social support networks are spread out and more difficult to access than in camp based settings. The need for outreach methods in urban settings that engage communities in identifying and addressing stressors, and to reconsider the meaning and provision of protection in an urban setting, brought MHPSS to the fore. This shift also informed changes in the role of community services within UNHCR, discussed further below (Discussion: contributions of the review to UNHCR policy and practice).

Moreover, UNHCR engaged with MHPSS work from the perspective of protection, recognising the overlap between MHPSS and protection concerns. UNHCR's mandate is protection; the provision and meaning of protection has evolved in UNHCR's 63 year history. The legal definition of the term '*protection*' refers to the protection of human rights and physical security that should normally be provided by one's own government. The absence or removal of this protection is often the impetus for becoming a refugee or an internally displaced person

(IDP). The legal commitments of protection include ensuring the right of a refugee to enter a county and that s/he will not be involuntarily returned to a country where s/he could be persecuted. Legal commitments also entail the registration and documentation of the refugee in the country of asylum and a process of certifying that the person does indeed qualify for refugees status ('*refugee status determination*') and is thereby eligible for the rights and benefits accorded to a refugee, including the possibility of being resettled to a third country.[1] Outside of camps, the documentation of refugee status has been useful in allowing refugees to enrol their children in school, access health services and qualify for employment in some places. Traditionally, UNHCR's protection work has invested in the '*3 Rs*': registration and documentation of asylum seekers and refugees; refugee status determination; and resettlement to third countries. Protection activities also included repatriation of refugees where and when possible, as well as working with governments to create more favourable, national legislation regarding refugees.

While the provision of these legal services and the resultant documents are foundational to the wellbeing of a person, the importance of these services may be eclipsed by the significant mental health and psychosocial needs that emerge in the course of displacement. MHPSS activities are a way to prevent protection risks and promote community support for vulnerable individuals at risk. Additionally, symptoms of mental distress may be caused by protection concerns, for example, cases of female adolescent suicide in a province in Afghanistan were found to be a result of forced early marriage, indicating how protection concerns can result in serious mental health and psychosocial issues.[2] Conversely, substance abuse problems can lead to increases in violence, including sexual and gender based violence (SGBV), indicating that addressing mental health and psychosocial issues can result in improved protection (Feseha & Gerbaba, 2012). Provision of MHPSS activities help refugees, or internally displaced persons, to cope and adjust to their communities of exile and to become functional, contributing members of these societies, despite any discrimination and exclusion they may face. In both urban and protracted displacement contexts, refugees need to sustain their lives within precarious circumstances.

Methods

Following UNHCR's participation in shaping the *IASC Guidelines*, UNHCR identified a need to review and assess how the *Guidelines* were being implemented by the agency. Moreover, the *UNHCR Review* emerged from the Deputy High Commissioner's concern that UNHCR was not adequately addressing MHPSS within its activities. The *Review* was conceived as an overarching review of policy, approaches, perceptions and activities within UNHCR, rather than an evaluation of a specific set of interventions or programmes, and was seen as an opportunity to map existing practice. This objective guided the selection of methods and overall approach of the review. The *UNHCR Review* combined methods including literature and policy reviews, in-depth interviews with key informants and an online survey of UNHCR staff. This methodological approach was developed to balance two imperatives: 1) the rigour required in order to reach conclusions and provide recommendations; and 2) the combination of selected methods allowed triangulation of findings. Also taken into consideration, the feasibility and acceptability of particular approaches within the confines of an operational evaluation, for example, the *Review* did not include a representative sample in the survey, which would have required significant efforts in participant selection and follow-up. A Steering Committee, comprised of senior level MHPSS experts within UNHCR and other

key agencies, was established to provide methodological and operational guidance throughout the review.

Literature and policy review

The *UNHCR Review* included an in-depth analysis of academic literature focusing on MHPSS issues and review of reports and guidelines from other UN agencies and non-governmental organisations (NGOs), including policy analysis of UNHCR policy guidelines in relevant sectors. The lead consultant conducted 47 telephone and in person interviews with UNHCR staff and individuals responsible for MHPSS programmes at other UN agencies, e.g. the International Office for Migration (IOM), UNICEF, the International Committee for the Red Cross (ICRC), NGOs such as Save the Children and Médecins sans Frontières (MSF), and academics in the field of MHPSS research. Purposive selection of key informants was used (Marshall, 1996), ensuring that the key informants selected were well positioned to address the specific objectives of the review. The evaluation manager selected UNHCR staff members as key informants, based on mapping of ongoing MHPSS programmes. Moreover, Steering Committee members provided names of key MHPSS focal points and experts from a wide range of humanitarian agencies, selecting individuals who had expertise implementing, supporting or evaluating MHPSS in humanitarian settings.

Online survey

In addition, an online survey was distributed to UNHCR Community Services and Protection staff, focusing on attitudes towards MHPSS activities and mapping MHPSS activities across all sectors, according to the way MHPSS activities are categorised within the 4Ws (who is where, doing what, when) MHPSS mapping tool (IASC MHPSS Reference Group, 2012). Despite distributing the survey to over 400 individuals, there were only a total of 144 complete responses, representing 55 country operations. Anecdotal evidence indicates that online surveys conducted within comparable evaluations and reviews have similarly low responses rates. However, this creates potential resultant biases that no or low response introduces, including the key point that respondents may be more likely to be interested and engaged with MHPSS activities. Also, respondents may differ from non respondents in ways, unknown to the authors, which can affect the validity of data. As such, the survey results are presented when the finding could be triangulated through other sources, such as key informant interviews or review of policy documents.

Results: Three Themes

The following three sections are based on the data collected specifically for the *UNHCR Review*. Subsequently, a discussion of policies and processes associated with MHPSS within UNHCR, since the UNHCR review, is presented.

Theme 1: MHPSS approach and MHPSS interventions – a framework

In the course of the review, key informants noted that the distinction between MHPSS as an *approach* and MHPSS as a set of *interventions* is a useful framework for thinking about MHPSS within UNHCR. The distinction between a *MHPSS approach* and a *MHPSS intervention* is drawn from Terre des Hommes' framing of psychosocial issues and its experience integrating psychosocial programming across the organisation. In this framework, a psychosocial approach is defined as *'a way to engage with and analyse a situation, build an intervention, and provide a response, taking into account both psychological and social elements, as well as their interrelation.'* A psychosocial intervention is defined as *'composed of one or several activities that aims to increase the coping capacity of children, families and communities, and to reinforce their integration within society'* (Terre

des Hommes, 2010). Adapting this to a displacement context, the concept of functioning (i.e. the ability to complete daily tasks, fulfil social roles and participate in the household, family and community) can be included alongside that of coping.[3] As such, a psychosocial approach (which is in line with many good humanitarian practices described throughout the *Sphere Handbook* (Sphere Project, 2011) can be integrated into any programme, and ensures that the programme also protects dignity, improves psychosocial wellbeing, and achieves its primary objectives, such as nutrition or shelter. A psychosocial intervention, in contrast, is a programme whose primary objective is to improve psychosocial wellbeing, for example, group counselling, or an integrated intervention that may address other primary outcomes (such as nutrition or livelihoods) alongside psychosocial objectives. The terms *MHPSS approach* and *MHPSS intervention* were adopted in the course of the UNHCR review, to emphasise the need to promote integrated mental health and psychosocial programming within UNHCR.

The MHPSS approach recognises that modes of delivery of key humanitarian services have significant implications for mental health and psychosocial wellbeing of affected persons within a humanitarian context. This formulation of MHPSS activities has resonated with UNHCR, which is unique as an organisation in that it spans a wide range of humanitarian actions, with protection as its core mandate. UNHCR's 2013 *'Operational Guidance Mental Health & Psychosocial Support Programming for Refugee Operations*,' clearly delineates the distinction between a MHPSS approach and MHPSS interventions throughout, highlighting that MHPSS is *'relevant for all actors involved in the protection of and assistance to refugees*' (UNHCR, 2013a). One example of the relevance of this framework emerges in International Medical Corp's (IMC) assessment of MHPSS needs amongst Syrian refugees in the Za'atari camp, Jordan. The needs assessment identified a number of shelter and camp management concerns as central to priority MHPSS needs and outcomes. For example, a key recommendation that emerged was the need to improve shelter and camp orientation, in order to make the camp a safer place and reduce anxiety and stress associated with concerns over camp conditions (IMC, 2012). As such, employing a MHPSS approach within camp coordination, management and shelter sectors was seen as essential in addressing core MHPSS issues within the population. Specifically, the delineation of a MHPSS approach has made MHPSS more accessible and understandable to UNHCR staff working within a range of domains, bringing MHPSS from the domain of psychologists and psychiatrists to a broader audience, who are engaging, through training and orientation workshops, with MHPSS as a lens through which to approach their work in a range of sectors. Within the sectoral nature of UNHCR's work, promotion of understanding and integration of a MHPSS approach within all of UNHCR's work has been described as effective and relevant.

There is a risk, however, in adopting this framework, and emphasising a MHPSS approach. As Ager, Strang and Wessells (2006) point out,*'in some circumstances psychosocial considerations may become a 'cross-cutting issue,' meaning one developed across all projects and programs. . ..Nevertheless, it seems unlikely that such psychosocial concerns will always comprehensively and effectively be met by such means*'. Integration of a MHPSS approach across sectors can be a way to bring the principles and objectives of MHPSS activities to the fore across all programmes. However, it is also evident that MHPSS interventions are needed to achieve key goals and reach groups with specific MHPSS needs. UNHCR's Operational Guidance recognises this, stating that a *'MHPSS approach alone will not be able to address more complex problems, although it may contribute to prevention of such problems, and create fertile ground for MHPSS interventions where these are*

needed' (UNHCR, 2013a). While integrated approaches in humanitarian settings are ideal, the structure of the humanitarian system and humanitarian response makes integration of cross-cutting issues across sectors challenging. If MHPSS needs are only addressed through a MHPSS approach, there is a risk that the issue will disappear from view. It does, however, keep this lens at the forefront of the toolkit for UNHCR staff.

Theme 2: Challenges in measurement and evaluation

The UNHCR review also highlighted a number of themes in the area of measurement and evaluation of MHPSS activities. Sixty-four percent of the respondents to the online survey either disagreed or strongly disagreed with the statement, '*there are clear monitoring and evaluation systems in place to assess the impact of MHPSS activities*', indicating recognition of gaps in UNHCR's capacity to assess the impact of MHPSS activities. One respondent stated, '*there is limited time, resources and capacity in general to measure outcomes. The focus of reporting is on the output of UNHCR programmes and reporting (e.g. objectives and indicators do not appropriately reflect MHPSS program components).*' Another respondent wrote, '*although the impact of MHPSS support is real, the tools to assess the impact are not established, hence many people are unable to see the added value of such important interventions, especially during the emergency phase. The community services officers normally face great challenges to get the required support for such interventions.*' Another respondent discussed the barriers to monitoring and evaluation of MHPSS activities: '*impacts can only be measured if you have robust monitoring and evaluation systems in place and quantitative data is gathered alongside qualitative data from the beginning of the programme. This is difficult if you have an implementing partner who may not have these data management systems set up.*'

These responses reflect core challenges in the field of measurement and evaluation of MHPSS activities, which have impacted UNHCR's level of engagement with MHPSS activities. Firstly, there is ongoing controversy and debate around the question of how to identify and measure MHPSS needs, outcomes and impacts of MHPSS activities. The question of availability of appropriate, feasible and effective measures of needs, symptoms and disorders emerged throughout the UNHCR review and is present in the research literature. There is a wide range of measures, for both child and adult populations, which have been developed and utilised in western settings to assess functioning and common mental disorders, such as depression and anxiety. However, utilising these measures without any adaptation risks assessing for symptoms and disorders that are not locally relevant nor prevalent. The 2012 publication, *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Settings,* provides for methods to assess MHPSS needs in a variety of ways (WHO/UNHCR, 2012). This should form the basis for further development of rapid, accessible methods for selection and adaptation of measures in the field. Moreover, there is a tension between the need to adapt measures for specific settings, and the need for standardised measures, in order to generate comparable data between settings. Throughout the course of the review, it became evident that the current MHPSS indicators in the UNHCR's results based management system are not adequate for the purpose of either monitoring or evaluation.

Another common challenge in capturing the impact of programmes is the lack of baseline data. For example, child friendly spaces are often assessed using methods that do not compare children's wellbeing to a point in time prior to the emergency, or prior to the establishment of the child friendly space, as these data rarely exist (Ager & Metzler, 2012). As such, evaluations can only draw limited conclusions as to the impact of the specific activity implemented. These evaluations are unable to distinguish broader trends in improved psychosocial

wellbeing due to time lapsed from the emergency, or other improved social conditions, compared to the actual impact of the intervention itself. As a field, there have been notable advances in evaluation of MHPSS interventions, for example, high quality, randomised controlled trials of specialised interventions have been implemented and findings have strongly influenced the field (Bass et al., 2013; Bass, et al., 2006; Bolton et al., 2003). However, methods to assess more commonly implemented interventions in the field of MHPSS in humanitarian settings lag behind. MHPSS activities may not constitute a single activity, or intervention, that can be evaluated using existing approaches. Evaluation methods to capture the impact of diffuse and broad interventions are also needed in order to adequately capture the true scope of the impact of MHPSS activities.

These challenges are noted as primary concerns in the field, given the common connection between rigorous evaluation and continued funding, and the role of monitoring and evaluation in bringing to light MHPSS needs in affected communities. In the course of the review, a MHPSS expert from one of UNHCR's implementing partners noted, '*donors are always saying: what about the outcomes? Mental health, it's not like a vaccination campaign where once the child is vaccinated, they're OK. I think that is one of the reasons that organisations or even donors stay away from mental health because they feel like they can't measure it, they can't somehow pin it down. So I think we even have the bigger responsibility there to really show impact.*' Lack of evidence generated in high quality evaluations was cited numerous times by UNHCR staff as a primary reason for lack of support for MHPSS activities within UNHCR, and therefore is particularly important for moving UNHCR's work in this area forward. For example, one senior manager noted the difficulty defending MHPSS activities compared to more '*concrete*' and traditional humanitarian functions, such as provision of jerry cans or food ratios, saying '*if you're going to put these [MHPSS] programmes on a solid footing with UNHCR we're going to need some way of defending it through evidence and proper evaluation and I didn't feel that we have that yet.*' Increased strength and coherence in the MHPSS field relies, at least in part, on continued efforts to document MHPSS activities and show their impact on individuals and communities.

UNHCR's engagement with MHPSS activities would be strengthened through improved connections between research and practice, and between researchers and practitioners. As one academic expert reflected, '*current research is just not very illuminating in terms of strengthening practice. . .it's not what practitioners really want to know. It's not going to actually tell you, what's the comparative value of doing interpersonal therapy as opposed to cognitive behavioural therapy, as opposed to strengthening livelihoods. There's very few data that will answer those questions. There's even less that will answer questions about what would happen if you used much more holistic measures and were much more sensitive to culture, and took a look at stressors that people often name as being the greatest. . .things like, lack of livelihoods and ability to fulfil your role as a parent.*' Impacts of MHPSS activities are often less obvious and apparent than impacts of other humanitarian interventions, yet careful and structured evaluation can bring to light important impacts of these activities, making visible many of the potentially invisible, yet significant, benefits of MHPSS interventions within humanitarian contexts. However, many of the rigorous evaluations that have been conducted have focused on interventions that are not commonly implemented in field settings. A review of the field of MHPSS activities found that the most commonly implemented interventions in humanitarian settings between 2007 and 2010 were basic counselling activities for individuals, facilitation of community support for vulnerable individuals and child friendly spaces (Tol et al., 2011). Whereas a systematic review of intervention studies showed that research focused primarily on

interventions that fall within the category of focused, non specialised and specialised supports, in other words, interventions that are at the top of the *IASC Intervention Pyramid* (see Fig. 1) (IASC, 2007) and are infrequently implemented in the field. The current level of evidence regarding the most commonly implemented interventions is low. In order to address this, collaborations between academic researchers and practitioners are needed in order to rigorously answer the most relevant research questions in the field. An academic expert consulted for the UNHCR review reflected that this needs to be a two-way exchange: '*researchers need to start asking questions that are relevant to practitioners, and be better at reaching out with their research results to the world of practice. . ..And on the other side from a practitioner's perspective, I think there needs to be more attention to evidence based practice.*'

Theme 3: Challenges in provision of clinical mental health services

The UNHCR review identified a number of areas that are relatively neglected within the field of MHPSS research, interventions and policy: clinical mental health services, and substance and alcohol use. This discussion focuses on the former aspect, while recognising that literature and data from the review indicated that alcohol and other substance use is a significant issue in many humanitarian settings, as it can be a form of coping, leading to harmful use or dependence (Streel & Schilperoord, 2010). Further, alcohol and substance use interventions are not commonly supported, even though it is important that further engagement with MHPSS activities continue to support, advocate for and fund alcohol and substance use prevention and treatment activities.

Analysis of findings from the online survey showed low reporting of activities in the areas of mental health care in primary health care services, along with low reporting of activities in specialised mental health care. Findings indicate that this is due to the limitations in provision of clinical mental health services for displaced persons, including limited activities in the field of pharmacological and non pharmacological

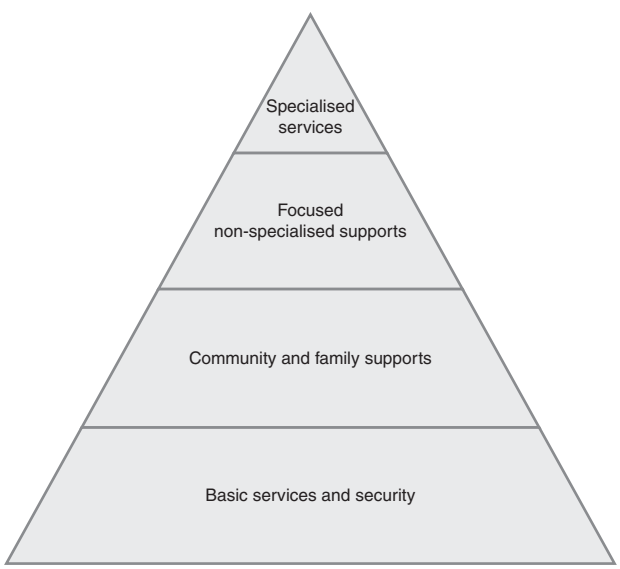

Figure 1: IASC Intervention Pyramid

management of severe mental disorders, along with gaps in referral systems to specialised mental health services. For example, non pharmacological management of mental disorders within the primary health care system was reported by 30% of respondents, and inpatient mental health care was reported by 29% of respondents, whereas MHPSS activities in the areas of education and SGBV were reported by over 70% of respondents. While this data may indicate that respondents to the online survey were less familiar with clinical mental health services provided by UNHCR or partners, this finding is consistent with previous research by Tol et al., which found, in a review of MHPSS activities between 2007 and 2010, that the five most commonly reported activities were basic counselling for individuals, facilitation of community support for vulnerable individuals, child friendly spaces, support of community initiated social support and basic counselling for groups and families (Tol et al., 2011). Moreover, challenges in providing clinical mental health care were also described in in-depth interviews with UNHCR staff. For example, UNHCR staff in Ethiopia discussed the challenges in providing psychiatric care in rural camp based settings, given there are few psychiatrists nationally, and the low quality of the scarce mental health services for Ethiopians. As such, it may be the case that without strong national mental health services to draw upon, activities in these two areas are often limited and constrained due to resources and capacity, rather than due to lack of commitment of UNHCR, or other humanitarian actors, to support these services.

Based on the *IASC Intervention Pyramid* model and other models of public mental health prevention and treatment, it is the case that clinical mental health services should, in fact, constitute a smaller percentage of activities within any given context. However, in discussions with UNHCR staff in various country settings of the review, it became evident that decisions about provision of clinical mental health care are not determined by needs assessments, nor in response to the prioritisation of needs, but due to the significant challenges in accessing the resources and expertise needed to provide clinical mental health services, especially mental health services adapted to cross-cultural settings. There are some partner organisations that provide clinical mental health services in collaboration with UNHCR, and others that provide these services as part of their core operations, such as MSF. In addition, UNHCR seeks to utilise national mental health services to provide services for refugees. However, there are still considerable challenges in mobilising the expertise and systems required for sufficient clinical mental health services within humanitarian settings.

Some progress has been made in the field of clinical mental health services within UNHCR, for example, inclusion of psychotropic medicines in the list of essential medicines (UNHCR, 2011), and monitoring of mental disorders (including: severe mental disorders, alcohol and substance use and other emotional complaints) is conducted through its *Health Information System*. Moreover, the development of the joint WHO/UNHCR Guide, adapting the *Mental Health Gap Action Programme* to humanitarian settings, can be considered to a major step towards integrating and strengthening provision of mental health services within primary health care settings in humanitarian contexts.

Discussion

Contributions of the review to UNHCR policy and practice

The findings of the UNHCR review have both reflected and contributed towards policies and processes focused on MHPSS within UNHCR. The review helped frame MHPSS as a priority for UNHCR, and put it on the agenda for senior management

and decision makers. Its clear recommendations for integration and inclusion of MHPSS approaches and interventions has galvanised attention and further investment in these programmes. The issues highlighted below are examples of the growth and learning stimulated by the review, as well as examples of processes that were initiated prior to, and ongoing throughout, the course of the review. Taken in concert, they indicate that UNHCR is engaged in reflection and action around the role of MHPSS within the organisation.

As noted, in 2013, UNHCR published its *Operational Guidance on Mental Health and Psychosocial Support Programming for Refugee Operations*, providing consideration of how different sectors within UNHCR can engage with MHPSS (UNHCR 2013a). The publication identifies the potential mental health and psychosocial needs of refugees, delineates UNHCR's role in addressing these needs and outlines key principles guiding UNHCR's role in MHPSS. A joint UNHCR publication between the Child Protection Unit, in the Division of International Protection and the Public Health Section, in the Division of Programme Support and Management, indicates the increased recognition of the need to bridge protection and health approaches to MHPSS (UNHCR, 2014).

Concurrent to shifts in understanding of how protection can be provided in urban settings, UNHCR has reconsidered the role of community services officers and redefined what community based protection means. UNHCR recognised that refugees need to tap into the resources within their own families and communities to provide psychosocial support and has published guidelines on '*Understanding Community Based Protection*' (UNHCR, 2013b). Community based protection, as outlined in UNHCR's policy document on the topic,'*implies that communities engage meaningfully and substantially in all aspects of programmes that affect them, strengthening the community's leading role as a driving force for change*.' This approach largely overlaps with Level 2 activities in the IASC *Intervention Pyramid*, whereas UNHCR's Public Health Unit engages with Level 3 and 4 activities, allowing for collaboration within UNHCR within and between sectors

MHPSS tools and activities, especially those concerning the provision of basic services, security, and community and family supports, have informed UNHCR teams and their partners on how to implement these tools and activities in urban settings. Most of UNHCR's recent efforts to this effect have been to map and re-establish refugee community based structures, as well as to train refugees how to provide psychosocial services to their communities.

Conclusion

In today's landscape of displacement, it is clear that there is a consistent need for MHPSS services, while at the same time, their potential is currently under explored. This paper touches on some of the key themes that emerged from a study of UNHCR's engagement with MHPSS activities; some of the findings may be relevant to other UN and international nongovernmental organisations. Recommendations from the UNHCR review indicated that UNHCR needs to provide staff training on MHPSS for their non MHPSS staff members, including registration clerks, education programme managers, water and sanitation engineers, community outreach workers and urban planners. Additionally, UNHCR and other agencies need to continue to invest in research and evaluation to guide their staff as, at the time of writing this article, displacement figures were at the highest levels in 18 years (http://www.unhcr.org/51c071816.html). Of equal importance is the protracted status of many of these situations. Emergencies present MHPSS concerns linked to the trauma of displacement. However, when the conflict that caused people to flee does not get resolved over many years, a new set of MHPSS concerns, including

depression and anxiety, can also present. UNHCR has taken considerable steps towards engagement with MHPSS in humanitarian settings, and both the process and outcomes may be useful and instructive for other humanitarian agencies.

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[1] Less than 1% of refugees are resettled to a third country. For the most part, resettlement countries are in Europe and North America.

[2] Examples drawn from key informant interview conducted with an academic expert.

[3] Functioning refers to the ability of an individual to complete daily tasks, including self-care, fulfil relevant social roles (as a member of a household, family and community) and take part in activities, including, for example, attending religious events and providing support for community members (Bolton & Tang, 2002).

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