Save the Children

HEALING THE INVISIBLE WOUNDS OF WAR

A roadmap for addressing the mental health needs of children and young people affected by conflict

Report on the Wilton Park Dialogue

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Save the Children fights for children every single day. Because every child should be able to make their mark on the world and build a better future for us all.

We stand side by side with children in the toughest places to be a child. We do whatever it takes to make sure they survive, get protection when they're in danger, and have the chance to learn.

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Some names have been changed to protect identities.

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Cover photo: Tamer, 11, is a Syrian refugee living in a camp in Lebanon.
(Photo: Louis Leeson/Save the Children)

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Foreword

By Professor Alastair Ager, Deputy Chief Scientific Advisor,
Department for International Development

Exposure to conflict, violence and insecurity can have a major psychological impact on children. Addressing this is all the more pressing in light of the current global context, where we face an unprecedented scale of humanitarian crises and migration. The UK aid strategy commits 50% of our aid to fragile states and regions, and protecting children remains a policy priority.

The distress children may face during times of conflict can last well beyond the end of the conflict, unless appropriate help is provided. I recall a particular time I was in Mafraq, a city in Jordan just ten miles from the Syrian border. Its population had been swollen by the arrival of nearly 80,000 refugees. The youth at the centre I was visiting – like young people the world over – were preoccupied with images of cute animals, were clad in their favourite football team shirts, and had an avid interest in modern technology and a keen love for music. As our team was getting ready to interview these new arrivals, a scuffle started between two boys. This seemed a pretty standard part of adolescence too, until one boy raised a large rock to strike the other, his sudden reaction and contorted expression a hint of his intense sense of powerlessness and frustration. This boy was experiencing toxic stress – and removal from the direct threats of the war wouldn't immediately relieve it. Children need tailored support to get over the shocks of war, including the daily stressors they face as a result of it.

There has rightly been growing attention to mental health and psychosocial support in humanitarian contexts over the last several years. But we now need to come together and take a giant leap forward to consider how interventions can be replicated and taken to scale to reach all those needing support, building on provision across the education, health and protection sectors.

I wish to thank Wilton Park and Save the Children for partnering with the UK Department for International Development (DFID) on this Dialogue. I also wish to thank all of the experts from around the world who brought their varied experiences to the table. As a result of this collaboration, we now have a roadmap that provides an important starting point for us to push forward together in concerted action.

Introduction

By Kevin Watkins, Chief Executive, Save the Children

The founder of our organisation, Eglantyne Jebb, once said "all wars, whether just or unjust, disastrous or victorious, are waged against the child". Eglantyne created our organisation to respond to the needs of children affected by war – specifically, by the humanitarian blockade imposed by the UK on aid for children in Germany and Austria. Nearly 100 years later, we continue to put the protection of children in armed conflict at the heart of our agenda.

357 million children across the world now live in conflict-affected areas. In the last year or so, I have had an opportunity to meet children Save the Children works with in north-east Nigeria, Yemen, Somalia, northern Uganda, and Cox's Bazar in Bangladesh, where we are responding to the Rohingya crisis.

The phrase 'affected by conflict' somehow fails to do justice to their experiences.

Children in armed conflict today are bombed, treated as collateral damage, and subjected to heinous crimes, including rape, abduction and forced recruitment into militias. Humanitarian blockades prevent vulnerable children from receiving help and life-saving medicines. Our research in conflicts such as Iraq and Syria has revealed heartbreaking accounts of children terrified by the shelling and airstrikes, anxious about the future, and distraught at not being able to go to school. The majority of children we spoke with show signs of severe emotional distress.

The prolonged exposure to war, stress and uncertainty means that many children are in a state of toxic stress – the most dangerous form of stress response. It occurs when children experience strong, frequent or prolonged adversity without adequate support, and can have immediate and hugely detrimental effects, including increases in bedwetting, self-harm, suicide attempts and aggressive or withdrawn behaviour. If left untreated, the long-term consequences are likely to be even greater, affecting children's mental and physical health for the rest of their lives.

Education has a distinctive role to play in supporting children severely distressed by violence – but it cannot be 'education as usual'. A few years ago I had an opportunity to spend some time in the Bekaa Valley area of Lebanon interviewing Syrian refugee children, many of them from Ghouta. I was there to develop a plan aimed at getting these children into education. Looking back, I now recognise that we failed to address what, for many of these children, was perhaps the biggest single challenge in returning to education – their desperate need for help in coping with their psychological and emotional issues caused by conflict.

The roadmap that this report sets out for addressing the mental health needs of children and young people affected by conflict is incredibly important. Huge thanks to all those involved in the Dialogue, and DFID and Wilton Park in particular, for making it happen. It is only through these kinds of partnerships that we can hope to make a difference for children who deserve our very best effort.

1 The Dialogue

The Wilton Park Dialogue, in partnership with Save the Children and the UK Department for International Development (DFID), brought together 50 experts in the field of mental health and psychosocial support (MHPSS) from 17–19 January 2018 to discuss challenges and ways forward in responding to the mental health needs of children and young people affected by conflict in the Middle East and globally.[1]

Current data has revealed that more than 357 million children and adolescents are living in areas affected by conflict globally. This means that one in six children live in countries affected by conflict and by 2030 the share of the global poor living in conflict-affected situations will be at 44%.[2]

Save the Children's 2017 report *Invisible Wounds: The impact of six years of war on the mental health of Syria's children*[3] was the first comprehensive report into the MHPSS needs of children living under daily conflict inside Syria. It revealed that millions of children were living in a state of 'toxic stress' due to prolonged exposure to conflict. The damage to an entire generation of children could soon become permanent as toxic stress can disrupt the development of the brain and increases the risk of physical health problems such as diabetes, heart disorders and mental health conditions in adulthood. Adding to this, despite the existence of common frameworks for MHPSS responses in general, a specific child focus is under-developed and as of today no international guidelines for responding to children and young people's MHPSS needs in a humanitarian setting exist.

Against this backdrop, this Wilton Park Dialogue looked to build on the recommendations from the 2015 landmark UNICEF symposium held in The Hague, *Growing Up in Conflict: The impact on children's mental health and psychosocial well-being.*[4]

The goals and objectives of the Dialogue were to:

1. discuss and evaluate good practice in MHPSS for children and adolescents during and after conflict, lessons learned globally and innovations from new programming
2. share best practice for making programmes multi-sectoral, coordinated and integrated with humanitarian missions
3. discuss the challenges of implementing MHPSS programmes and how to address these, including age and gender sensitivities, stigma, accessing difficult-to-reach areas and strengthening national capacity, with a focus on the Middle East
4. develop a global roadmap setting out the priority pathways needed, likely challenges and solutions, and necessary collaborations for scaling up MHPSS programming for children and adolescents affected by conflict.

2 Conference discussions: Setting the scene

There are significant challenges in addressing the MHPSS needs of children and adolescents. These were highlighted during the three days of dialogue and were addressed in the development of a global roadmap.

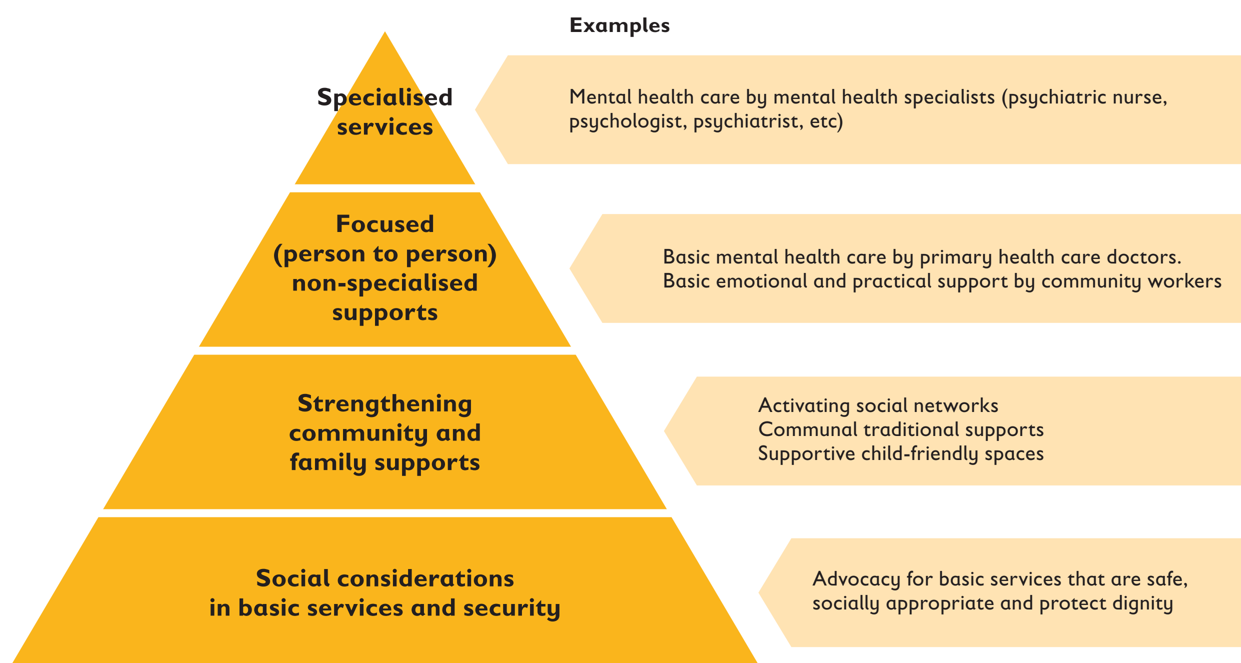
This section summarises the key issues highlighted and discussed by participants in the conference.

Children's exposure to conflict can vary significantly and range from witnessing the destruction of their homes, schools, communities and the death of their loved ones, to experiencing conflict at school, or with their peers. Given the scale of needs, MHPSS programming requires more **nuanced and innovative approaches** to address existing challenges as well as to provide **strong evidence to identify what works**, including how and when it may be possible to go to scale.

Caution is needed in the way MHPSS is articulated, and how mental health prevalence figures are reported. In low-resource countries facing protracted and complex conflict, it is more important to understand the full spectrum of MHPSS issues and treatments rather than overall numbers receiving a clinical diagnosis. Not all children who experience conflict are traumatised by it. Stakeholders working in the field of MHPSS should distinguish between those living with anxiety and stress and others who have serious mental health needs and/or developmental disorders and require a more specialised response. Too many stakeholders use 'psychosocial support' as a catch-all term, but do not carefully try to differentiate what it is that is being delivered and why and to whom.

Stakeholders need to better understand how to organise and deliver MHPSS across a layered system of complementary support that meets the needs of different groups as illustrated in the intervention pyramid deveolped by the Inter-Agency Standing Committee (IASC) (see diagram below). All layers of the pyramid are important, but particularly so

FIGURE 1 INTERVENTION PYRAMID FOR MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN EMERGENCIES[5]



in protracted and complex conflicts, and should ideally be implemented at the same time. Addressing this full MHPSS spectrum is paramount to ensure children and adolescents receive the correct support. Whether it is mental illness, psychological disorder or long-term psychological stress, the scale of the issue in communities affected by conflict is not currently being adequately addressed, hence the need to develop a global roadmap towards better practice that can be supported across agencies and donors.

Donor interest in the issue has risen, reflecting its increasing prominence. Important recent examples include the MacArthur Foundation's $100m support to Sesame Workshop and the International Rescue Committee to address toxic stress issues among Syrian children through education in emergencies. DFID is also funding MHPSS interventions across various conflict-affected states, including Syria, Lebanon and Yemen, as well as research initiatives that include a focus on mental health in the humanitarian context, such as Research for Health in Humanitarian Crises (R2HC) in partnership with the Wellcome Trust.[6] However, there is recognition that far greater investment is required to match the magnitude of need.

Questions remain as to whether the current financing model for MHPSS work is sufficient, sustainable and funding the most appropriate approaches. A notable challenge is that emergency funding requires agencies to immediately start delivering 'services'. This is at the cost of allowing sufficient time for capacity building or integration of MHPSS across sectors. Another challenge is that joint needs assessments do not strongly feature MHPSS across sectors and there is not always ownership of it – often it is viewed as a protection or health sector issue. This means that integrating MHPSS across a wider range of clusters does not happen, especially due to competition for funding. Emergency funding can also be very short-term and does not recognise the medium- and long-term consequences of a conflict setting and the implications on service design and delivery.

A graduated approach, across all four layers of the MHPSS intervention pyramid is required, with some services needing to be sustainable long after the immediate emergency has ended.

Also, as interest and programmes scale up, there are concerns as to the levels of duplication (for example, many protection sector agencies setting up child-friendly spaces in close proximity, all delivering psychosocial support through recreational activities). The Dialogue discussed whether donors could encourage thoughtful multi-sector consortium bids, as this would encourage integration rather than competition across sectors and organisations. This collaborative approach is important given the limited funding globally. War Child's recent publication *Reclaiming Dreams*[7] advocates prioritising MHPSS in humanitarian funding and called for a commitment to ring-fencing 1% of aid for MHPSS work in crisis responses, although there are practical difficulties in tracking such spending.

"How can you run a programme for refugees for a few months when they'll be displaced for years? The average period of displacement for refugees these days is 10–25 years, and most psychosocial support programming lasts for only ten-week cycles."

"We need to move from NGO competition to collaboration. The current funding opportunities are not set up to support genuine collaboration."

"There are many new funding applications and many new organisations working on MHPSS, but duplication and quality are real issues."

It was well noted that a growing number of agencies are delivering MHPSS interventions. The 2017 annual meeting of the IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings[8] had the largest attendance to date.

"We're moving towards a tipping point of having MHPSS properly factored into our emergency responses."

However, not all work occurs across the full spectrum of MHPSS needs, or across the full age range for infants, children, adolescents and young people. And with various similar approaches and tools being used by different agencies, work is needed to assess how do we know what works, what can be replicated and taken to scale, and how to reduce duplication and address the wide range of different MHPSS needs, rather than a sub-set.

3 Case studies of innovation

Over the three-days of the Dialogue, various individuals and organisations presented current work. Below we highlight three different types of innovative work.

BEYOND SELF-REPORTS: EVALUATING MHPSS PROGRAMMES WITH STRESS BIOMARKERS

Dr Catherine Panter-Brick, Professor of Anthropology at Yale University, presented her research on using stress biomarkers to provide objective evidence of how well MHPSS interventions can alleviate 'toxic stress' in the body. By using biomarkers to reveal the biological signature of adverse experiences and track responses to an intervention, this study is the first – beyond self-reporting – to test the effectiveness of a brief, scalable programme seeking to improve psychosocial well-being.

The project evaluated the Advancing Adolescents programme implemented by Mercy Corps, funded as part of the No Lost Generation initiative and launched in 2013 in response to the Syria and Iraq crises. This eight-week intervention offers structured, group-based activities to alleviate profound stress, enhance psychosocial support and strengthen learning skills. It serves both Syrian and Iraqi refugee and host-community youth in areas heavily affected by conflict and forced displacement. Participants (8–15 year olds) explicitly learn how trauma and stress affect the mind, the body and the brain, and acquire behavioural strategies for stress attunement.

Panter-Brick and her colleagues assessed whether the programme could actually help to regulate levels of chronic stress. They put in place a mixed-method survey, combining mental health questionnaires, stress biomarkers, and experimental tests of cognitive function. For biomarkers, they measured cortisol levels in hair samples. Cortisol is a hormone secreted to regulate energy and psychosocial stress, which can be measured in strands of hair to track the cumulative effects of stress in an individual's body.

Fieldworkers, led by in-country partner Dr Rana Dajani, engaged young people in the study and sampled hair at three time-points (before and after the intervention and at 11-month follow-up) for both participants and non-participants. They hired local male and female hairdressers to give young people a professional haircut, and shipped hair samples for analysis at the University of Western Ontario in Canada.

A robust evaluation showed that the programme had positive impacts. Young people who had engaged in Advancing Adolescents reported fewer symptoms of stress and mental health difficulties, compared with youth in the wait-listed control group. In terms of feelings of insecurity, benefits were sustained 11 months later. Findings from hair cortisol concentrations also demonstrated benefits of this programme.

This work demonstrates that effective interventions can improve not just self-reports of insecurity, stress and poor mental health, but can also change and regulate stress in the body. It helps us to understand the processes of recovery from past trauma and current insecurity, and shows that even brief interventions to improve day-to-day environments can protect adolescent health and development.[9]

#ME/WE SYRIA: CHANGEMAKERS AND STORY TELLING

#MeWeSyria (a programme of #MeWe International Inc) is a refugee-led informal education and community engagement platform that leverages processes of storytelling and inter-personal communications as a tools for healing and community building.

#MeWeSyria borrows from traditions of storytelling and narrative therapy, syncing skill-building with psychosocial well-being in an integrated curriculum that relies on experiential and peer-to-peer learning. The #MeWe programme for refugee youth intentionally integrates therapeutic frameworks, borrowing from narrative therapy, to focus more specifically on self-awareness, trauma recovery, and restoration of control and agency in a context of perceived powerlessness.

The programme operates through training 'replicators', who are selected by #MeWeSyria staff and local partners, and who adapt the programme for people aged 15–24 in their communities.

Local community-based organisations host #MeWe as part of other youth and community initiatives, thus ensuring sustainability, relevance, and continued engagement of #MeWe beneficiaries after they have been through the programme.

Replicators go through a six-day training course, after which they design and present localised action plans to conduct the programme in their communities. Action plans are unique to each site, and flexible in terms of session time and length, and duration of the programme, so long as they conduct the minimum required hours of #MeWe activities with each cohort.

Each #MeWeSyria club will go through 30 hours of activities over the course of eight to ten weeks, after which time they will remain engaged through community projects, mentoring new cycles of #MeWe beneficiaries, and specific community storytelling events at which they can share their videos and storytelling pieces. The replicators conduct multiple cohorts throughout the year.

To measure impacts, a team of psychologists and neuroscientists at Beyond Conflict, NorthEastern University and #MeWe International Inc. have designed a special #MeWe psychometric scale to assess participants' behavioural changes. This was piloted with a sample of 55 participants in Gaziantep, Turkey, and showed promising growth points related to beneficiaries' perceived stress, and collaborative leadership capacities.[10]

SESAME SEEDS: RESTORING HOPE AND OPPORTUNITY FOR CHILDREN IN THE MIDDLE EAST

The Sesame Seeds programme won the MacArthur Foundation 100&Change competition for a $100 million grant to "make measurable progress toward solving a significant problem of our time". This enabled the International Rescue Committee and Sesame Workshop (the non-profit organisation behind Sesame Street) to create the largest early childhood intervention in the history of humanitarian response, specifically to support Syrian children and young people displaced in the Middle East region. The programme aims to mitigate some of war's most harmful consequences and empower today's children to be tomorrow's nation builders.[11]

Delivered through mass media and direct services, the programme uses proven techniques to transform children's learning and social-emotional skills and mitigate the effects of toxic stress. Through extensive research, Sesame Seeds has developed a solution that is intense enough to be life-changing but cost-effective enough to be scalable. It has three components:

1. **Mass media**: a locally-produced television programme, broadcast and made available on digital platforms, to reach 9.4 million children in Iraq, Jordan, Lebanon and Syria, with engaging characters with whom children can relate,
2. **Home**: a home visits programme to support approximately 800,000 caregivers, through trained outreach and community health workers and supportive digital content to promote caregiver responsiveness, early learning, mental well-being and resilience.
3. **Centres**: a nurturing care and early learning programme to transform community sites and formal and informal schools, and train and coach frontline staff to provide 250,000 children with age-appropriate and play-based learning to promote language, literacy, numeracy and social-emotional skills.

Formative research and initial testing of the existing Arabic Sesame Seeds content support the creation of the educational framework focusing on the needs of young children and their caregivers affected by displacement, as well as the broader regional mass media component. Beyond the pilot phase, the approach and the research will inform and reshape services being offered in the wider humanitarian system. Research topics will include, for example, how young children and families respond to and engage with the content and materials, which delivery platforms are most effective, and how behaviour change and learning outcomes are affected by multimedia materials in these settings. To measure the impact, an evaluation will take place integrating a randomised control trial in the implementation phase. This trial will assess the intervention's impact on physical development, literacy and numeracy knowledge, and socioemotional skills.

4 A global roadmap

Over the three days of dialogue, challenges were identified and these led to agreement on four key pathways to a global roadmap to addressing the MHPSS needs of children and young people affected by conflict.

The four pathways are:
1. Multi-sectoral programming and coordination
2. Engaging young people
3. Supporting caregivers
4. Strengthening national capacity.

1. MULTI-SECTORAL PROGRAMMING AND CO-ORDINATION

LEADERSHIP

MHPSS traditionally falls under the scope of child protection, and needs to be integrated across other sectors, such as education, health, shelter and nutrition, if it is to be effective. MHPSS interventions have the potential to support all sectors in a sustainable way. A key challenge is who takes responsibility or the lead. Unless there is a significant change in the current humanitarian architecture around cluster co-ordination,[12] which involves competition around funding pools, it is going to be difficult to meaningfully integrate MHPSS programming and reduce existing gaps or duplication.

COORDINATION

Field-level coordination on MHPSS varies from country to country. The coordination chapter in the IASC MHPSS Guidelines needs to be strengthened; and the name used for MHPSS coordination groups in countries needs to be changed to MHPSS Technical Advisory Group, to make it clearer that this group will support all clusters with technical input. MHPSS Coordination Groups do exist in the official humanitarian architecture but they are rarely used. One solution could be that they are mandated by the IASC MHPSS Reference Group.

Participants agreed that all level 3 emergencies should have an MHPSS Technical Advisory Group and that we need globally deployable technical experts as MHPSS surge capacity. In particular, technical expertise is needed in MHPSS for children and adolescents – something that has been absent to date. The MHPSS Technical Advisory Group should sit under the inter-cluster group, not under one specific sector. A potential way to move forward with this suggestion would be to conduct a case study from one country on how a MHPSS Technical Advisory Group would work.

Cluster coordinators should be trained to understand MHPSS for children so they can see how it fits in with their sector – simple measures such as giving coordinators a checklist on how MHPSS fits in with their sector would be a step forward. Buy-in is needed from the wider humanitarian architecture on these groups, and agreement and understanding that technical MHPSS groups are needed at field and country levels.

DEFINITIONS

In order to improve definitions of MHPSS for children and adolescents, and to better understand how MHPSS can feature in different sectors, a sub-group should be formed under the IASC MHPSS Reference Group for a limited time period. This would focus on developing age- and gender-appropriate packages, standards, tools and training across the full spectrum of children's and adolescents' MHPSS needs, and would provide inter-agency know how to the MHPSS Coordination Groups and Technical Advisory Groups in the field. It would hold technical expertise on MHPSS for children and share this through capacity building. This includes developing the MHPSS indicators that each humanitarian sector should incorporate.

TARGETING MARGINALISED GROUPS

There was a recognition that many agencies do not know how to include children with disabilities and those with severe mental health problems and developmental disabilities in most programming, including MHPSS programming. There was also a recognition that many stakeholders are unaware of the UNICEF series of booklets, including *Children with Disabilities in Humanitarian Action: Child protection*, which reference inclusive techniques.[13] Significant steps need to be made to ensure organisations and individuals are trained on these booklets. Other groups that fall between sectors, and are not adequately addressed by current MHPSS programming, include children who have experienced sexual and gender-based violence and children associated with armed groups. Donors should be more proactive and support better co-ordination and multi-sectoral programming by requiring these groups to be identified within funding applications. No longer is it adequate for organisations to make multiple similar funding applications to concentrate on delivering psychosocial support activities through child protection programmes that fail to address the needs of children and adolescents who are in need of mental health and psychosocial support.

In order to improve understanding, service delivery and co-ordination, one solution could be to develop a roster of MHPSS technical professionals, experienced mental health practitioners who have field experience as well as formal professional qualifications, who could surge in to emergencies. The practitioners would need to have a child- and adolescent-focused MHPSS background and be able to also address moderate-to-severe cases, including children with existing mental health needs and their parents. This surge team could be managed by an NGO serving as an inter-agency lead. Surge capacity would upskill MHPSS practitioners in-country and work as part of the MHPSS Technical Advisory Groups.

RECOMMENDATIONS

- MHPSS coordination groups in countries need to change to MHPSS Technical Advisory Groups to ensure consistency of standards and quality of all MHPSS work cross-sectorally.
- All level 3 emergencies should have an MHPSS Technical Advisory Group.
- A MHPSS child/adolescent sub-group should sit under the IASC MHPSS Reference Group for a limited time period to focus on developing packages, standards, tools, training, etc.
- Donor dialogue would help to influence the need for standards and guidelines.
- A roster of MHPSS technical experts should be developed to provide surge capacity.

PHOTO: LOUIS LEESON/SAVE THE CHILDREN

Zeina, 11, is a Syrian refugee living in a camp in Lebanon.

2. ENGAGING YOUNG PEOPLE

The starting point for any thinking around engaging young people must be a better understanding of the developmental differences between younger and older young people, and how context also impacts their developmental milestones. This is important so that we understand the developmental milestones that would 'normally' be seen for a particular age range; what 'difficult' normal behaviour we see; and what 'abnormal' behaviour may be seen, particularly in the context of living under conflict or violence. Children and young people of different ages have very different MHPSS needs, yet there is little real recognition within the child protection sector, where psychosocial support is usually delivered, of how young people engage, learn and are motivated to engage. There is also insufficient recognition of the great diversity within young people, leading to the exclusion of many young people outside the mainstream, such as young people with disabilities.

> "For adolescents and young people, what matters is their future trajectories. They're not so concerned about the past and the current."

Although we have a 'bulging' young population, and in many locations young people are the dominant sector of the population, young people consistently report they do not feel they belong and that they feel excluded. Why do some young people who know about our programmes choose not to engage, and what are the implications for their psychosocial well-being and mental health?

> "Approximately only 20% of the young people populations that we work in actually engage in our programmes. What about the other 80%?"

The traditional approach is not proactive in trying to engage fully with the most vulnerable or disengaged young people. The status quo method of using local community leaders (who may be biased and in most cases do not represent the most excluded groups of young people) to recruit participants accidentally reinforces inequality in service provision. The question was raised that if a programme is only reaching a small proportion of young people, then how can it be called strategic? How do we design relevant and age- and gender-appropriate MHPSS programmes that genuinely engage the most vulnerable? To make our programming more relevant we need to use approaches that young people use – for example, use more technology in discussing and addressing MHPSS needs and delivering MHPSS awareness in science information, because the language of 'resilience' and 'trauma' used by MHPSS services alienates many young people.

> "They are not beneficiaries, but participants in their own lives."

There is a need to see young people as the experts in their own worlds, and use their lens to design MHPSS activities. It is a transformational idea to see young people as experts and would go a long way to meeting some of the psychosocial support needs around a sense of belonging, and feeling connected and empowered in their own lives. It could make young people feel they are not beneficiaries but are participants in their own lives.

There is a dominant negative language used around young people in the Middle East and other regions where they have been associated with extremist groups. This is particularly evident from the programming 'asks' from donors around how to use MHPSS programming to counter violent extremism. There are large funding pots linked to countering violent extremism work, but they have a very narrow perspective with a focus on 'security' that prevents them from supporting the majority of young people, who don't engage in violence and are not extremist. This narrative overlooks the fact that the majority of young people are peaceful and trying to find the best path possible in their lives. Donors and humanitarian agencies fail to engage with them as the positive driving force and assets that they can be.

Humanitarian structures are not set up to deal with young people. There is a lack of technical experts working on young people. This means we have a significant gap both in MHPSS practitioners and young people practitioners, which does not support strong, relevant, contextualised programming. We need to build a cadre of 'young people experts' from people who have, for example, worked in prisons, social services or with gangs, to be strong peer mentors. We also need to challenge

our expectation that young people come to our programmes. We need to take our work to them, through consistent outreach and mobile work going to their spaces. We need to develop mechanisms by which the humanitarian community can examine its own means of exclusion. For example, we need to ensure programming hours are accessible. Many programmes in Za'atari Refugee camp in Jordan, for example, operate between 10am and 3pm, when many young people are working.

One promising advance is to teach young people about their own neurobiology – how their brains and bodies respond to threat. Young people also need to be supported to feel a sense of belonging and connectedness. The need to belong becomes even more imperative if your social networks crumble.

Offering tight social bonds, power, a role and a voice, and promising tangible social change – something governments and aid actors fail to provide – can be deeply empowering for young people. Programming must support a sense of belonging in local communities while empowering young people to be positive actors in their own lives.

RECOMMENDATIONS

- MHPSS workers and designers of MHPSS activities need to understand the specific age-relevant needs of young people and their diversity.
- There must be a concerted effort to identify the most excluded young people, and gain a better understanding of the root causes of their exclusion and its effects on their mental health, so that we can design appropriate and relevant interventions. This includes identifying how current humanitarian standards, policies and structures contribute to their exclusion.
- We need to invest in a cadre of youth experts, and see young people themselves as experts in their own lives in humanitarian contexts.
- We must proactively articulate how young people can be a positive driving force in their communities if supported appropriately.
- Young people should be engaged in relevant, innovative ways.

PHOTO: LOUIS LEESON/SAVE THE CHILDREN

Haten, 16, fled the conflict in Syria and is now living in Lebanon.

3. SUPPORTING CAREGIVERS

CAREGIVERS' WELL-BEING

There is a recognition that current interventions tend to focus more on caregivers' *knowledge* than their *well-being*. This needs to change. A social-ecological lens looks holistically at a caregiver's situation, including relationships between caregiver couples, family dynamics, and negative coping mechanisms such as substance abuse and self-harm. Interventions focusing on knowledge and 'doing the right thing' run the risk of coming across as judgemental towards caregivers in distress who know what to do but are still not able to do it.

CASCADING OF MHPSS-RELATED INFORMATION

To improve existing programming it is important to make key concepts in MHPSS accessible and understand how stress and anxiety affect caregivers' own bodies and minds. To ensure equal access, it will be necessary to develop materials that are not literacy dependent. Local champions should be promoted and given access to materials so they are not reliant on the humanitarian sectors for dissemination. For example, evidence shows that behaviour change in caregivers can be achieved, and at scale, through the use of social media, radio, etc. It is important to communicate the same concepts and techniques to children, caregivers and local staff, as this gives them a shared language to talk about experiences and reactions, demystifies, de-stigmatises and normalises stress reactions, and can aid in bringing family and community members closer.

HOLISTIC CAREGIVER SUPPORT

Multi-sectoral engagement is crucial for holistic support, scale and maximising entry points for support to meet the MHPSS needs of caregivers. Two strands should be particularly explored:

i) integrated case management, where child protection case management is linked with MHPSS interventions (for example, building on advancements in nutrition, where caregivers' well-being is emphasised for successful results for children)

ii) keeping a self-reliance and livelihood perspective on caregivers' well-being, being mindful of the impact that being stuck in a cycle of dependency has on psychosocial well-being and mental health.

This reinforces the lesson that MHPSS programming cannot just sit under one sector, such as child protection, but must be embedded multi-sectorally. It is equally important to design interventions that enable layered support: information material may be sufficient for the majority; discussion groups and more focused support needed for some, and more intensive higher-level support may be necessary for the most affected caregivers.

In the context of protracted conflicts, there is recognition that the concept of a caregiver needs to be diversified beyond parents, for example, grandparents, older siblings and other family members can play key roles. It is also necessary to engage with caregiving professionals such as teachers and health professionals. As the number of child-headed households increases, not enough attention is being paid to exploring and addressing the MHPSS needs of children and young people who are caregivers or to siblings' roles in caring for each other and how children are affected by siblings displaying distress.

RECOMMENDATIONS

- It is important to focus on caregivers' well-being and MHPSS needs, not only on their parenting knowledge.
- Language used, techniques and knowledge shared should be mirrored with children, caregivers, families and frontline workers such as teachers, so communities including the I/NGO community share common knowledge and terminology and help to destigmatise MHPSS issues.
- Multi-sectoral, multi-layered approaches, which are relevant to local communities and support all the needs of caregivers, are needed.
- It is important to diversify the concept of a caregiver beyond parents to include family members such as grandparents, siblings, aunts and uncles.

4. STRENGTHENING NATIONAL CAPACITY

Despite the recent growth and prioritisation of MHPSS service delivery to try to meet the needs of communities living in conflict, there has not been significant growth in ensuring there are enough well-trained, supervised and experienced MHPSS practitioners. Staff, partner staff and volunteers are normally trained to deliver individual agencies' manualised short-term psychosocial support programmes, but have little capacity to work independently outside those programmes.

Likewise, building a strong professional or para-professional cadre specialised in child and adolescent mental health has not been meaningfully addressed globally. Donors and organisations tend to focus on short-term capacity-strengthening training lasting a few days; and focus primarily on Levels 1 to 3 of the IASC MHPSS intervention pyramid. This training can lack consistency and quality and fail to follow the IASC guidelines. Recognising that there are pre-existing regional and global shortages of mental health professionals, particularly for paediatric care, we now need to prepare professionals with additional tools to work with children affected by the levels of traumatic experiences we are witnessing.

There is currently no agency that has an explicit focus on children with more severe mental health problems, developmental disorders and substance misuse issues. This means that there is both a lack of advocacy on the issue and a lack of systematic programme content development and testing. One immediate way forward would be to set up an inter-agency pool of senior MHPSS professionals, who could be deployable as surge capacity or on a roster basis. This would support I/NGO interventions to focus across all layers of the IASC MHPSS intervention pyramid and provide comprehensive services to all in need.

> "We need the human resource capacity to deliver this work."

The IASC MHPSS pyramid is the starting point to think about the different layers of skill needed. This is necessary to ensure national strengthening can reach caregivers, community volunteers, multi-sectoral staff, psychosocial workers and specialised mental health workers. The national capacity needed should be visualised in a fluid way: each layer (or organisation, or professional) should understand not only what their role is but how it supports the overall flow of the interventions in the pyramid, flowing up and down as and when needed. A key question asked at the Dialogue was: Have we managed to meaningfully build national capacity at any of the levels for child and adolescent MHPSS needs?

> "Are we trying to walk a path we don't have the right shoes for?"

While there may be fewer individuals requiring help at levels 3 and 4, the increasingly violent and protracted conflicts of recent years expose ever greater numbers of children to severe crisis experiences – including sexual violence, trafficking, torture, and witnessing and directly experiencing violence, poverty and deprivation. The need is increasing, therefore, for focused (individual or group) support for children suffering from severe distress. We need good specialist services as well as confident skilled and supervised staff at layers 1, 2 and 3. Ideally, as people are mentored and coached, staff can move up the pyramid and as they gain more experience, more skills and more training, they can, in turn, mentor less experienced people.

> "We need to develop a stepped care approach – but what does that actually look like on the ground?"

Other challenges were recognised. For example, the siloed efforts by organisations (for example, with staff trained on that organisation's manuals only), reinforced by donor aims and requirements and short-term funding cycles, allows only short-term

training. Wide donor engagement is needed to support significant longer-term upskilling in the MHPSS arena. The humanitarian sector has unhelpfully moved away from multi-disciplinary teams, where children and adolescents could be offered 'wrap-around' services through social work, young people work, and mental health, health and education services. Perhaps humanitarian agencies are not the most appropriate to lead this capacity-strengthening exercise, which requires lateral relationships with academic and government partners.

> "We need to see beyond the agency imperative, and look at the individual need level."

Developing collaborative, multi-partner, lateral relationships could support continuing professional development, with integration into mainstream systems, legitimising of training with recognised accreditation, and ensure supervision and reflective learning on the job. Given the global context, with the level of protracted conflicts that children, adolescents and their families are living in today, capacity strengthening needs to be both immediate and long term. There is a need to look towards tech companies' boot camps[14] and examine whether intensive 12-week training programmes could be an initial stage, either as an alternative to four-year degree courses, or as a helpful addition. There is also the need for well-trained supervisors, and for service delivery and funding applications to ensure MHPSS staff have individual and group supervision.

RECOMMENDATIONS

- We need to comprehensively identify crucial gaps.
- Skills and knowledge need to be developed on co-designing age- and gender-sensitive activities together with communities, instead of training staff on manualised 8–16-week programmes.
- A pool of senior child and adolescent MHPSS experts on a deployable surge capacity or roster should be established. These experts will support emergency responses and longer term strengthen national capacity in the longer term.
- Use innovation from tech companies running 12-week boot camps to support building capacity and look for further creative models, such as 'A Guide to MHPSS for Barefoot Psychologists', which could support work in remote locations like Syria and Libya.[15]
- An inter-agency MHPSS staff training package on child and adolescent needs should be developed.
- We need to advocate that donors fund MHPSS capacity building and value long-term capacity training.
- Capacity building needs a broader focus, and should include clinical and counselling skills, leadership, management, proposal writing, supervision and coaching.

Samira, a Syrian refugee, outside her home in a camp in Lebanon.

PHOTO: LOUIS LEESON/SAVE THE CHILDREN

NEXT STEPS

Save the Children is committed to taking this Dialogue forward, and proposes to:

- work with MHPSS.net and the IASC MHPSS reference group to widen out this dialogue into a series of four webinars. These global webinars, to be hosted via MHPSS.net, will follow the four suggested pathways outlined here, inviting a wider range of experts and specialists to add their voice. The aim will be to seek collaborations and partnerships on how to continue to develop this roadmap.
- through the inception period and strategy development of our new global centre on MHPSS for children and their families in fragile and humanitarian contexts, work closely with the IASC MHPSS reference group and aim to fill the gap in child-focused MHPSS (see box below).

Possible collaborations could take the form of:

- donor meetings, to advocate and discuss how funding streams can better support the work that is needed, reduce duplication and support the collaboration across agencies and sectors, and longer-term capacity building of a MHPSS cadre.
- initiating a temporary working group specifically on child and adolescent MHPSS programming and staff capacity building, which feeds into the global IASC MHPSS reference group.
- work with organisations focused on children and young people to discuss how to ensure individuals with more severe mental health disorders, developmental delays and disabilities are advocated for and no longer fall between the cracks.
- learn more from our experts on young people, sexual and gender-based violence and disability, and bring them to the discussions.

Wilton Park proposes to:

- include MHPSS learnings within their future Youth Dialogues and explore further dialogues with Save the Children on responses to young adolescents associated with armed groups and violent extremism in the Middle East and the needs of adolescent girls in humanitarian settings.

DFID proposes to:

- host a roundtable discussion as a follow-on to the Wilton Park Dialogue, to share outputs with wider civil society and gain traction on taking forward the recommendations.

GLOBAL CENTRE FOR CHILD-FOCUSED MHPSS

Save the Children Denmark has secured four-year Danida funding to establish a Global Centre on Child-Focused MHPSS. The aim of the Centre is to provide a platform for research, learning, innovation, advocacy and capacity development within the field of rights-based MHPSS for children and their families in fragile and humanitarian settings.

The Global Centre for Child-Focused MHPSS will collaborate closely with other MHPSS stakeholders to address the gaps identified above, through a 'local to global' approach. This will bring together experience and expertise from key stakeholders at both local and global levels, facilitating exchange, learning and innovation to support good-quality MHPSS programmes at scale for children and their families. The Centre intends to serve as a virtual hub for bringing together key academic, humanitarian and local civil society actors in advancing children's protection, resilience and well-being in fragile and humanitarian contexts. Keeping children's development and rights at its core, the Centre will promote new advances in the field of child-focused MHPSS to serve and add value within Save the Children programmes, for our civil society partners and for the wider community of MHPSS practitioners.

Endnotes

[1] This event was part of the Wilton Park Youth Dialogues: powering the future series. This series of events aims to create a positive and action-oriented debate that focuses on young people's ambitions and opportunities in relation to employment, education, security and peace. See the agenda at https://www.wiltonpark.org.uk/wp-content/uploads/WP1581-Programme.pdf

[2] Save the Children (2018) *The War on Children Time to end grave violations against children in conflict*

[3] Save the Children (2017) *Invisible Wounds: The impact of six years of war on the mental health of Syria's children* https://www.savethechildren.org.uk/content/dam/global/reports/emergency-humanitarian-response/invisible-wounds.pdf

[4] UNICEF (2015) *Growing Up in Conflict: The impact on children's mental health and psychosocial well-being*, Report on the symposium, 26–28 May 2015, The Hague http://www.unicefinemergencies.com/downloads/eresource/docs/MHPSS/Growing%20up%20in%20conflict-20160104112554.pdf

[5] Inter-Agency Standing Committee (2008) IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings: Checklist for field use http://www.who.int/mental_health/emergencies/IASC_guidelines.pdf

[6] https://wellcome.ac.uk/funding/joint-global-health-trials-scheme

[7] War Child (2018) *Reclaiming Dreams: Prioritising the mental health and psychosocial wellbeing of children in conflict* https://www.warchild.org.uk/sites/default/files/link-files/Reclaiming%20Dreams%20-%20prioritising%20the%20mental%20health%20and%20psychosocial%20wellbeing%20of%20children%20in%20conflict._0.pdf

[8] https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings There are 49 full MHPSS Reference Group members, of which 27 are active members, plus 6 Observer members (ICRC, MSF and four donor technical organisations). Five members are classified as 'networks' (MHPSS.net, InterAction, INEE, ACT Alliance and ICVA), with 7 UN agencies (UN Migration Agency/IOM, UNHCR, WHO, UNICEF, UNRWA, UNFPA and OCHA). The International Federation of Red Cross and Red Crescent Societies' Reference Centre for Psychosocial Support is a member, alongside 30 international NGOs.

[9] Dajani R, Hadfield, K, van Uum, S, Greff, M & Panter-Brick C, (2018). Hair cortisol concentrations in war-affected adolescents: A prospective intervention trial. *Psychoneuroendocrinology* 89:138-146. http://www.psyneuen-journal.com/article/S0306-4530(17)31207-6/fulltext [Open access]. Macphail, J, Niconchuk, M & El-wer, N (2017). Conflict, the brain, and community: A neurobiology-informed approach to resilience and community development, in: Phillips, R, Kenny, S & McGrath, B (Eds) (2018) *The Routledge Handbook of Community Development, Human Rights and Resilience*. London, United Kingdom. Panter-Brick, C, Dajani, R, Eggerman, M, Hermosilla, S, Sancilio, A & Ager, A (2017). Insecurity, distress, and mental health: Experimental and randomized controlled trials of a psychosocial intervention for youth affected by the Syrian crisis. *The Journal of Child Psychiatry and Psychology*. Oct 2. http://onlinelibrary.wiley.com/doi/10.1111/jcpp.12832/full [Open access].

[10] https://dangerville.wordpress.com/mewesyria/

[11] MacArthur International, 'Sesame Workshop & International Rescue Committee Awarded $100 Million for Early Childhood Education of Syrian Refugees', press release, 20 December 2017

[12] Clusters are groups of humanitarian organisations, both UN and non-UN, in each of the main sectors of humanitarian action, eg, water, health and logistics. They are designated by the IASC and have clear responsibilities for coordination. https://www.humanitarianresponse.info/en/about-clusters/what-is-the-cluster-approach

[13] UNICEF's *Including Children with Disabilities in Humanitarian Action* consists of six booklets designed for field staff and others involved in humanitarian work.is to make sure that children and women with disabilities, and their families, are included in humanitarian action. The booklets provide practical tips and offer entry points for making sure that the needs of children with disabilities are taken into account in humanitarian responses. http://training.unicef.org/disability/emergencies/

[14] Tech boot camps are three days to eight weeks of intensive, accelerated educational programs that teach beginners development skills so they graduate quicker with appropriate skills, knowledge and attitudes compared to traditional college or university courses.

[15] https://dangerville.wordpress.com/mewesyria/

HEALING THE INVISIBLE WOUNDS OF WAR

A roadmap for addressing the mental health needs of children and young people affected by conflict

Report on the Wilton Park Dialogue

The Wilton Park Dialogue, in partnership with Save the Children and the UK Department for International Development, brought together 50 experts in the field of mental health and psychosocial support in January 2018. Together they looked at challenges and ways forward in responding to the mental health needs of children and young people affected by conflict in the Middle East and globally.

This report presents the global roadmap developed by the Dialogue, setting out the priority pathways needed, likely challenges, solutions and necessary collaborations for scaling up mental health and psychosocial support programming for children and adolescents affected by conflict.

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