International Medical Corps Operational Guidance on Providing Mental Health & Psychosocial Support Services for Children in Humanitarian Settings, Including Advanced Mental Health Care

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1 Introduction

Why is child mental health important?

Estimates from the 2019 Global Burden of Disease study indicate that globally, more than 1 in 10 individuals aged 5 to 24 years old live with a mental health condition[1]. This age period carries about one-fourth of the mental burden of all ages[2]. For those living in humanitarian settings affected by war, armed conflict, climate crises, natural or manmade disasters and political or community violence, the mental health risks and burden on wellbeing are heightened[3] and expected to worsen for children, adolescents, older persons, and those with underlying health conditions[4].

Mental health and psychosocial support services (MHPSS) were often limited before a crisis. Now, these fragile settings are often faced with a destruction of public health and social service infrastructure, fragmented families, and depleted community resources with children and families on the move after forced displacement from their homes and livelihoods. The evidence is clear that living in an emergency, crisis, or post-conflict humanitarian setting places mental health risks and burden on children[5],[6].

MHPSS is increasingly considered essential in humanitarian response for children in humanitarian settings[7] and multiple systematic reviews have indicated a positive impact of psychological and psychosocial interventions[8],[9]. However, the evidence is still inconclusive on the effectiveness of many advanced MHPSS interventions in improving internalizing symptoms in children and some studies have found that some psychosocial programs have negative unintended consequences such as increasing depression[10]. Ensuring the effective provision of advanced mental health care should therefore be a priority for all responding to the mental health and wellbeing of children, adolescents and young people, hereafter referred to as "children" for reader ease.

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[1] Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2019 (GBD 2019) Disease and Injury Burden 1990-2019. Seattle, United States of America: Institute for Health Metrics and Evaluation (IHME), 2020.

[2] Kieling, C., Buchweitz, C., Caye A., et al. Worldwide prevalence and disability from mental disorders across childhood and adolescence: Evidence from the Global Burden of Disease Study. *JAMA Psychiatry*. 2024;81(4):347-356.

[3] Bennouna C, Stark L and Wessells MG (2020) Children and adolescents in conflict and displacement. In Song SJ and Ventevogel P (eds.), *Child, Adolescent and Family Refugee Mental Health: A Global Perspective*. Cham: Springer International Publishing.

[4] IPCC, 2022

[5] Miller KE and Jordans MJ (2016) Determinants of children's mental health in War-Torn settings: Translating research into action. *Current Psychiatry Reports* 18, 58

[6] UNICEF (2021) *UNICEF Humanitarian Action for Children 2022: Overview*. Geneva, Switzerland: UNICEF.

[7] Meyer S and Morand M-B (2015) Mental health and psychosocial support in humanitarian settings: Reflections on a review of UNHCR's approach and activities. *Intervention* 13, 235–247.

[8] Purgato M, Tedeschi F, Betancourt Theresa S, Bolton P, Bonetto C, Gastaldon C, Gordon J, O'Callaghan P, Papola D, Peltonen K, Punamaki RL, Richards J, Staples Julie K, Unterhitzenberger J, Jong J, Jordans Mark JD, Gross Alden L, Tol Wietse A and Barbui C (2020) Mediators of focused psychosocial support interventions for children in low-resource humanitarian settings: Analysis from an individual participant dataset with 3,143 participants. *Journal of Child Psychology & Psychiatry* 61, 584–593.

[9] Tol WA, Song S and Jordans MJ (2013) Annual research review: Resilience and mental health in children and adolescents living in areas of armed conflict–A systematic review of findings in low- and middle-income countries. *Journal of Child Psychology and Psychiatry* 54, 445–460.

[10] Bangpan M, Felix L, Soliman F, D'Souza P, Jieman A-T and Dickson K (2024) The impact of mental health and psychosocial support programmes on children and young people's mental health in the context of humanitarianemergenciesinlow-andmiddleincomecountries:Asystematicreviewandmeta-analysis.CambridgePrisms:GlobalMental Health,11,e21,1–16

Purpose and use of the operational guidance

Multiple recent reports from across the world in humanitarian settings have highlighted the real-world challenges for children needing access to specialist mental health services in humanitarian settings[11],[12]. When specialized services are offered, there is often a lack of: consistency; on-going monitoring and follow-up; links to social services, case management, family, and communities; and tailored approaches specific to child mental health with many clinicians relying on the use of adult interventions for children. When not feeling sufficiently trained, many staff may shy away from engaging with children. Even if advanced mental health care is available, there are often issues around predictability and sustainability of service provision, largely due to wider country contexts in government, health and academic investment and approaches to workforce capacity building of mental health specialists.

This Operational Guidance was therefore commissioned by IMC to help staff and partners across emergency, conflict, and post-conflict humanitarian settings to engage in supportive, nurturing environments that optimize children's mental health and wellbeing and protection. To ensure locally relevant, comprehensive, and sustainable MHPSS strategies for children with all levels of mental health support, this guidance offers practical information and tools to engage with and care for the mental health needs of children. Differing from standards, which are mandatory and enforceable, this guidance is aspirational in intent and is not exhaustive. This guidance refers to statements that suggest or recommend specific professional behaviors, activities, approaches or conduct for clinicians providing specialized MHPSS care.

The purpose of the Operational Guidance on Child MHPSS is to:

- Support MHPSS clinicians, advisers and supervisors in providing advanced mental health care to children in humanitarian settings

- Present an operational framework that ensures and enhances the quality of MHPSS programs to provide ethical engagements that "do no harm" to reduce suffering and improve the mental health and psychosocial wellbeing of children with advanced mental health needs in humanitarian settings

- Support care providers in engaging across the socio ecological system, with the child or adolescent at the center, surrounded by their caregivers and families, communities and broader society and culture

- Provide guidance on MHPSS interventions and approaches for specialized mental health, protection, and social services

[11] IMC (2024). Assessment of Practice Trends and Gaps in IMC MHPSS Clinical Service Provision for Children.

[12] Global Child Protection Area of Responsibility. Assessment of options for humanitarian child protection actors to assist children and adolescents who need specialized mental health services. Apr 2023. Available online at: https://cpaor.net/sites/default/files/2023-11/MHPSS%20and%20Options%20for%20Child%20Protection%20Actors%20April%202023_Cambridge%20Education_Final%20Report.pdf

- Emphasize the critical role of supervision in the provision of ethical and effective mental health care for children with specialized MHPSS needs

Use of this guidance will help to improve support for children with specialized MHPSS needs, facilitate referrals to ensure that mental health needs are addressed, and enhance the implementation of effective MHPSS interventions that reduce the potential for further harm.

Who should use the guidance?

The primary audience for the guidance is psychologists, psychiatrists, nurses and physicians who provide specialized mental health care. Psychosocial support workers and case managers including those in child protection and gender-based violence sectors will benefit from the guidance in developing supervisory protocols and programming. While developed for the IMC, the guidance can also be used by partners and other agencies operating in humanitarian settings, including non-governmental organizations (NGOs), local and national governments, civil society organizations and communities. The guidance will establish a common approach to the provision of clinical mental health services and help to strengthen coordination amongst MHPSS actors as well as with sectors intersecting with mental health teams.

This guidance will:

- Highlight the importance of providing MHPSS for children in humanitarian settings.
- Guide staff on how to engage with the mental health needs of children
- Provide resources on MHPSS interventions that may be appropriate for children with mental health needs in humanitarian settings
- Provide guidance on the provision of mental health care for children in humanitarian settings, regardless of theoretical orientation or clinical presentation

This guidance will not:

- Provide training that will make actors into child mental health specialists
- Teach manualized psychological interventions or any specific types of treatments
- Equip MHPSS advisers or counselors to diagnose mental health conditions or prescribe medication

How the guidance was developed

This guidance was developed following an *Assessment of Practice Trends and Gaps in IMC Child MHPSS Clinical Service Provision*, including a review of grey literature and academic research. In addition, a series of consultations was held with technical experts within IMC spanning MHPSS, health, child protection, and gender-based violence sectors representing programs across the Middle East & Europe, West & Central Africa, and East regions[13].

Key informants in the MHPSS technical and administrative consultations oversee programs across all four layers of the IASC MHPSS Intervention Pyramid (below) if available and have

[13] IMC. Assessment of practice trends and gaps in IMC Child MHPSS clinical service provision. 2024.

specialized clinical training in mental health. The guidance is in line with the following key sources for international principles and standards that underpin the guidance.

Figure 1. Principles and standards underpinning the guidance

Resource	Principles and standards
Global Multisector Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings (2021)	**Standard 10.** Children and their caregivers experience improved mental health and psychosocial wellbeing
Operational Guidelines on Community Based Mental Health and Psychosocial Support in Humanitarian Settings: Three-tiered Support for Children and Families (field test version)	**Standard 10.** Children and their caregivers experience improved mental health and psychosocial wellbeing **Standard 17:** Children live in communities that promote their well-being and prevent abuse, neglect, exploitation, and violence against children before, during, and after humanitarian crises
Minimum Standards for Child Protection in Humanitarian Action (2019)	**Standard 10.** Children and their caregivers experience improved mental health and psychosocial wellbeing
IASC MHPSS Minimum Services Package	**Standard 10.** Children and their caregivers experience improved mental health and psychosocial wellbeing
Sustainable Development Goals	**Goal 3.** Good health and well-being

How is the guidance structured?

The guidance serves as a general framework to support best practices for those engaging in specialized MHPSS care for children in humanitarian settings. Incorporating both practice and principles, the guidance will guide the design and implementation of programming as well as the effective engagement with children's mental health needs and strengths.

This operational guidance consists of three sections:

- **Understanding children's MHPSS strengths and needs**: This section describes the continuum of mental health concerns that may be expressed by children in humanitarian settings, as well as an overview of child developmental processes and the interplay between cognitive, physical, social, emotional, and behavioral development in the expression of distress or suffering.

- **Operational Framework for Children Needing Advanced MHPSS Care**: This section convenes core approaches of using strengths-based, child-focused, trauma-informed, socio-ecological, developmental life course models with the IASC MHPSS Intervention Pyramid to create a multi-layered Operational Framework that responds and reflects upon the MHPSS needs of children in humanitarian setting, with a focus on children with advanced MHPSS needs.

- **Supervision and Training Framework:** This section provides a critical component to the overall guidance, highlighting the need to prioritize supervision and training throughout the duration of intervention to uphold ethical standards and ensure effective mental health support. This framework will cover key components of the process of supervision and engaging in training as well as content specific to child mental health.

2 Understanding children's mental health and psychosocial strengths and needs

Mental health and psychosocial wellbeing of children in humanitarian settings

Children living in humanitarian settings have often been exposed to violence, separation from or loss of loved ones, poor living conditions, poverty, food insecurity and loss of a means of survival[14]. With daily lives upended and main supports facing their own stress, many children experience difficulty sleeping, fatigue, worry, and physical pain. For most children, these problems are manageable and may improve over time, but for others, they are more chronic, persistent and can disrupt their developmental trajectory.

Also, for children in emergency, crisis, or post-conflict settings, attrition stressors that can impact one's sense of wellbeing such as uncertainty, ambiguous loss of loved ones, traumatic or violent loss of loved ones, cultural bereavement, separation from culture, community, and daily life, threats to one's worldview of safety and humanity, can all impact a child's expression of distress. These are normal responses to extremely challenging situations and should not be pathologized[15].

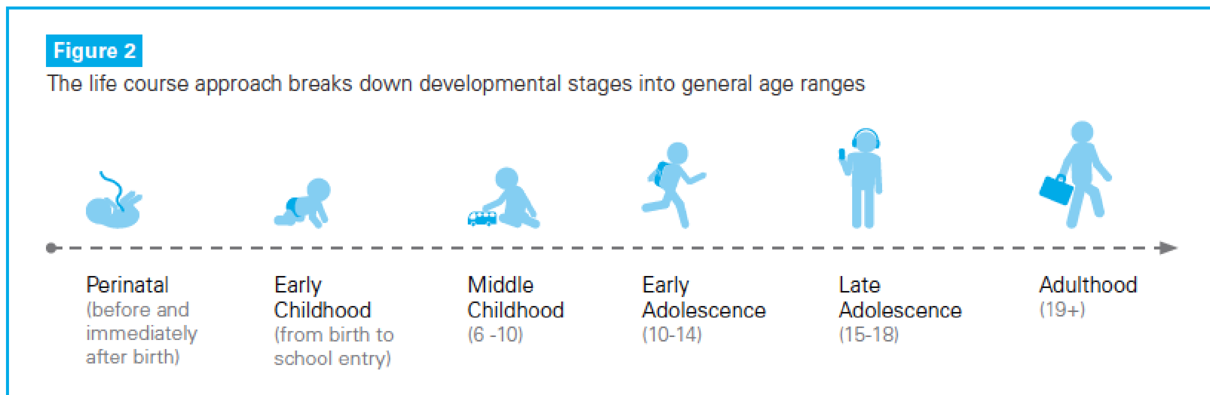
Child development overview

A developmentally informed, lifespan approach to mental health and psychosocial wellbeing acknowledges that children's mental health, wellbeing, and risk and protective factors are influenced and shaped by their developmental stage and the environment around them. MHPSS practitioners should always account for the developmental needs and strengths of Infants, young children, adolescents and young persons[16].

[14] UNICEF (2021). *UNICEF Humanitarian Action for Children 2022: Overview*. Geneva, Switzerland: UNICEF

[15] Song S, Ventevogel P (2020) Principles of the mental health assessment for refugee children and adolescents. In Song SJ and Ventevogel P (eds.), *Child, Adolescent and Family Refugee Mental Health: A Global Perspective*. Cham: Springer International Publishing.

[16] MHPSS Minimum Service Package



Source: UNICEF, 2022. Global Multi Sectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings, New York: UNICEF

Though highly influenced by culture and context, children develop social-emotional, behavioral, cognitive, and linguistic milestones as they age. Understanding the developmental stage of a child is critical in understanding when to be concerned about a child's behaviors or words and how to engage in a manner that is appropriate to their developmental level. The age and development of a child, along with other parts of their identity, their genetic and hereditary constitution, and the relationships with family, peers, community, and cultures around them, will impact their social, emotional, behavioral, cognitive, and physical expressions of distress or suffering. The following are a sampling of general cognitive, social-emotional, and behavioral milestones:[17]

Developmental milestones according to age

Ages 0-2 years

- Preference for familiar people, stimuli, and face-to-face interactions
- Early behavioral and emotional self-regulation based on establishment of regular activities and routines.
- Use of crying to express basic needs (hunger, thirst, comfort, etc.)
- Emergence of language skills
- Development of attachment relationships

Ages 2-5 years

- Temper tantrums (related to language and self-regulation skills)
- Memory grows
- Ability to describe others (by physical and emotional characteristics)
- Private speech (talking to themselves out loud)
- Physical maturation (feeding and toileting oneself)

Age 6-11 years

[17] Guerra NG, Williamson AA, Lucas-Molina B. Normal development: Infancy, childhood, and adolescence. In Rey JM (ed), IACAPAP e-Textbook of Child and Adolescent Mental Health. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2012. Available online at: https://iacapap.org/_Resources/Persistent/a03cefc8676b19280f6ffe958aeb11996ad0277d/A.2.-DEVELOPMENT-072012.pdf

- Better self-control and selective attention
- Self-esteem influenced by cultural factors and gender differences
- Development of metacognition (thinking about thinking) and monitoring one's thoughts and actions
- Increasing emotional development, regulation and coping
- Friendships based on trust, kindness, support and mutual hobbies

Adolescent transition is a dynamic process of neuronal and neurobiological changes that affect one's cognitive, social, emotional, and behavioral development. During this period, adolescents tend to rely on peer groups for identity development, emotion regulation, and sense of self. As the "logical" part of their brains are not fully developed until age 24, adolescents may engage in risky behaviors that minimize the consequences of their actions, and may be confused and unsure how to manage any strong emotions.

Ages 12-18 years

- Increased self-consciousness and cognitive distortions
- Frequent fluctuations in self-esteem and emotional experiences
- Self-esteem increases in dimensionality: academic or work performance, social competencies and peer/romantic relationships
- Normal mild-to-moderate variations in mood and behaviors
- Importance of peer group conformity
- Participation in risky behaviors (drug and alcohol abuse, acts of aggression)
- Friendship quality depends on prosocial characteristics (mutual trust, loyalty, support)

The above are normal developmental processes. Fluctuations in mood, irritability, defiance, difficulty focusing, withdrawing socially or engaging in risky behaviors may all be part of normal child and adolescent development. Caregivers and staff should be concerned about a child's mental health needs when behaviors or emotions increase in frequency and intensity, as well as affect daily functioning socially, academically, or interpersonally. Below is a list of some common signs that may cause one to consider whether additional mental health evaluation is needed.

Signs of mental health concern according to age

Ages 0-5 years

- Crying, screaming more intensely and more frequently
- Unusually clingy attachment to caregivers or others
- Indiscriminate attachment to strangers
- Regression in behaviors such as bed-wetting after having mastered this
- Changes in eating or sleeping habits that are outside of typical development
- Difficulty soothing
- Overly fearful of going to specific places

Ages 6-9 years:

- Similar reactions to the above
- Intense fear of places, people, activities or global worries limiting functioning
- Sudden school refusal
- Unexplained physical symptoms
- Persistent avoidance of social engagement
- Change in eating habits (refusal to eat or wanting to eat all the time)
- Sadness and fear are often expressed as aggression and anger

Ages 10-14 years

- Similar to the above
- Feeling sad, guilty, lack of energy, irritable, not wanting to do things they previously enjoyed, change in sleep (too little or too much), physically slower than normal, difficulty concentrating
- Thoughts of suicide (active, for example, "I want to take these pills and never wake up again" or passive, for example, "Life would be better without me")
- Self-harm behavior (for example, cutting, burning)
- Prolonged and sustained withdrawal from all social and family relationships
- Chronic drug and/or alcohol use affecting functioning
- Changes in school performance or engagement

Ages 15-17 years

- Similar to the above
- Irritability and aggression, defiance
- Leaving the home for long periods of time
- Withdrawal from activities, friends, family activities
- Foreshortened sense of the future (for example, a belief that they will die by a particular age)
- Lack of interest in a future
- General disengagement from life
- Low self-esteem and negative sense of self

For more information, refer to:

- Guerra NG, Williamson AA, Lucas-Molina B. Normal development: Infancy, childhood, and adolescence. In Rey JM (ed), IACAPAP e-Textbook of Child and Adolescent Mental Health. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2012.

3 Operational Framework on Providing MHPSS Services for Children in Humanitarian Settings Including Advanced Mental Health Care

Objective 1	Child-friendly approaches are upheld throughout engagement with MHPSS actors
Objective 2	MHPSS staff are equipped with the necessary competencies, tools and support to provide mental health care to children
Objective 3	Supervision and training procedures are in place to provide ethical, effective care

Objective 1. Child-friendly approaches are upheld throughout engagement with MHPSS actors

Underlying the framework are general approaches that all actors interacting with children in humanitarian settings should engage in. These are core approaches and concepts for anyone working with children to understand and uphold.

Core concepts

Engage in child-friendly and family-based approaches

Engaging in child-friendly approaches means communicating with children at an age-appropriate level, choosing locations that are comforting and engaging for the child, showing the child with respect and protecting their autonomy to have a voice on decisions about their wellbeing. Staff should approach children in a manner that encourages the child to explore instead of fearing punishment. When meeting with caregivers or other actors, communication should be child-centered, inclusive, and supportive.

Parents, caregivers (foster parents, kinship caregivers, teachers), siblings and other family members play a critical role in creating a nurturing environment where children can grow and develop. Engaging the family is an important part of caring for the child, since the child will spend most of their time cared for by another. If MHPSS staff note that the caretaker is struggling with their own wellbeing, providing support to the caregiver can both directly and

indirectly improve the wellbeing of the child[18]. Caregivers should be provided psychoeducation and referred to available resources on the developmental aspects of emotion expression, for example, for grief, loss, and distress.

Use a strengths-based approach

Mental health challenges such as distress or despair, show that a child's ability to cope has been stretched. Even though a child may be suffering from a mental health concern, they continue to have individual and collective strengths, including the agency to shape their own wellbeing and develop alternative ways of coping. Resilience, the ability to function in the face of adversity, is a dynamic process that can be learned—it is not a static trait[19]. Children are productive agents of change in their own lives. It is crucial to embrace the core belief that even if they are experiencing problems, children have the strengths, skills, resources, and capability to effect positive change in their lives if allowed and encouraged to do so. Additionally, it is important to appreciate the valuable skills and experiences that children, young people, and their families hold. Recognizing these assets is key to being alongside with them to co-produce solutions. Children, young people, and their families should be viewed as part of a wider set of systems and relationships. Hence, this kind of cultural change is required in social care and children's services, as well as across all sectors of IMC that work with children, young people and their families.

Engage in trauma-informed support

Living in humanitarian settings, whether emergency, conflict, or post-conflict, can expose children to potentially traumatic events such as forced displacement from their homes, unexpected or violent loss of loved ones, witnessed or experienced violence or humiliation. This, in addition to the daily life stressors of housing and financial instability, uncertainty of the future, fragmented communities, social systems and supports, breakdown in the cultural fabric, and lack of educational opportunities and the right to play, can affect the mental health and wellbeing of a child.

A normal response to abnormal events, such as living in war or armed conflict settings or being displaced due to climate crisis, is for children to either "act out or zone out" as described in the section above (c.f. Child Development). Understanding this, staff should take a trauma-informed approach that shifts from the question of "what's wrong with you" to "what has happened to you?" This shift moves towards a more compassionate approach that understands the effect of adversity on a child's mental health and wellbeing.

A trauma-informed approach serves to resist re-traumatization, realize the widespread impact of trauma, recognize the signs and symptoms of trauma, and fully integrate knowledge about trauma into policies, procedures, and practices[20].

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[18] Backhaus, S., Blackwell, A., Gardner, F. The effectiveness of parenting interventions in reducing violence against children in humanitarian settings in low- and middle-income countries: A systematic review and meta-analysis. Child Abuse & Neglect, 2024, in press, available online at: https://www.sciencedirect.com/science/article/pii/S0145213424002400

[19] Tol, Song, Jordans. 2013.

[20] SAMHSA or other TIA

When engaging with children in humanitarian settings, staff should focus on key principles of a trauma-informed approach:

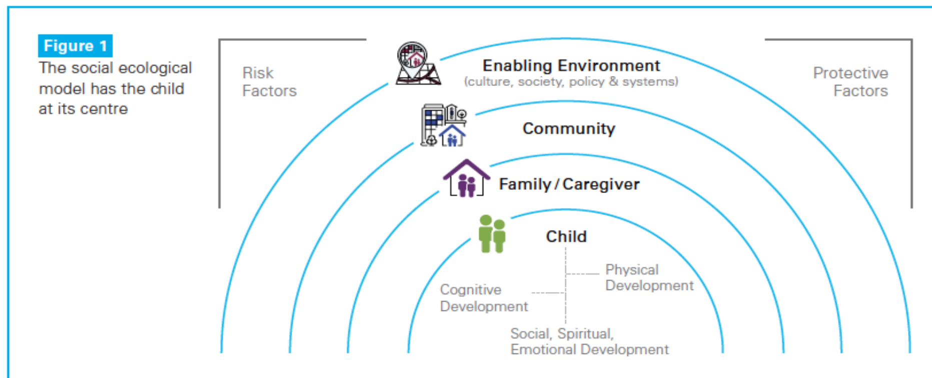
Figure 3. Six Principles of Trauma-Informed Approach

Source: Practical Guide for Implementing a Trauma-Informed Approach. Substance Abuse and Mental Health Services Administration, 2023.

Work within a socio-ecological enabling environment

The social-ecological model emphasizes the structures and networks in which a child is embedded. Starting with the child at the center, the model is comprised of three concentric circles of family, community, and culture/society that safeguard wellbeing and support optimal development.[21]

Figure 4. Socio-ecological model



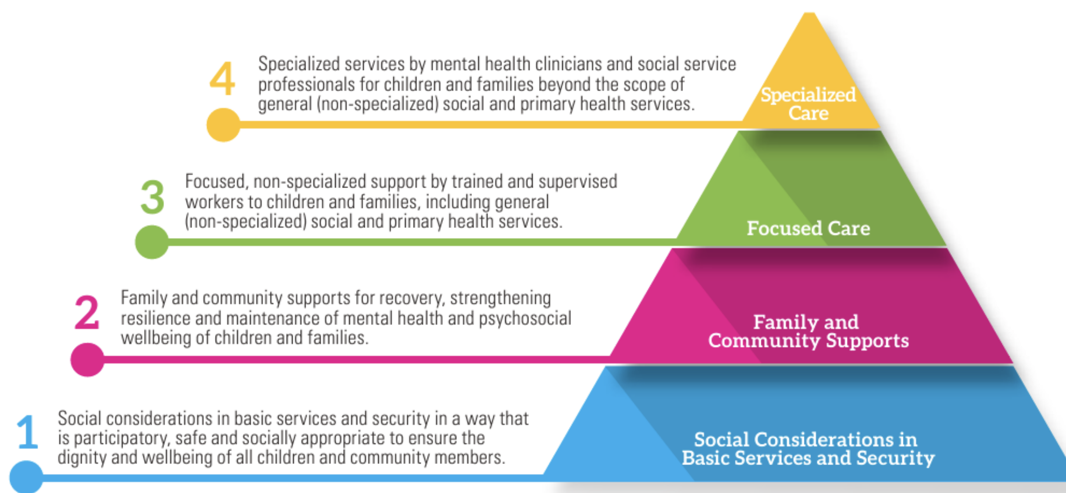
[21] United Nations Children's Fund. Brief on the Social Ecological Model. New York, UNICEF.

MHPSS programs should apply the social ecological model throughout clinical care and supervision, including understanding the bi-directional influences of each element of a child's system and the effect on children's mental health and psychosocial needs. Different sociocultural contexts will influence the expectations on how a child should behave or how they express emotions.

Support a community-based, multi-layered approach that prioritizes the least restrictive setting or intervention needed

The Inter-Agency Standing Committee (IASC) MHPSS Intervention Pyramid is widely used to organize a multi-layered support approach to the comprehensive package of MHPSS interventions for children in both development and humanitarian settings[22]. The base of the pyramid consists of community support and works up towards fewer people specialized services.

Figure 5. IASC MHPSS Intervention Pyramid



For more information, refer to the UNICEF Community-based MHPSS Guidelines

While in practice, a program may have interventions within one layer of the pyramid or multiple interventions across the pyramid, all providers of MHPSS care should have an understanding of what services are provided at each level. Children's MHPSS needs are dynamic, changing over time and contexts, so they may move up and down the pyramid depending on their changing MHPSS needs. Moreover, the layers are complementary and work in conjunction with other layers to ensure a comprehensive approach to addressing children's mental health needs.

[22] Inter-Agency Standing Committee (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.

As an example, the UNICEF Community-Based MHPSS Guidelines have described how mental health and social service providers can best support a child needing specialized care, as well as ways to support the family/caregiver and community surrounding the child (refer to the following table).

Figure 6. IASC MHPSS Pyramid Layer 4 Tiers of Intervention

IASC MHPSS PYRAMID LAYER 4 SPECIALIZED CARE; CLINICAL MENTAL HEALTH CARE AND PROFESSIONAL SOCIAL SERVICES FOR MNS DISORDERS, DEVELOPMENTAL DISABILITY, SERIOUS DISTRESS OR SERIOUS PROTECTION VIOLATIONS

TIER OF INTERVENTION		
Child	**Family/Caregiver**	**Community**
Ensure referral and access to appropriate clinical MHPSS care and professional social services for children with MNS disorders or exposed to serious protection violations Facilitate the management and support of children with MNS disorders or serious protection risks (e.g., assisting their access to medications and follow-up appointments) Provide children support and psycho-education to help them manage and cope with distress, MNS disorders or disabilities Support children with MNS disorders or disabilities to participate in their communities and lives in meaningful ways	Ensure referral and access to clinical MHPSS and professional social services for caregivers/ family members with MNS disorders or exposed to serious protection violations Assist referral and access of vulnerable families to therapeutic interventions (e.g., psychotherapy) and specialized social services Provide psycho-education and build capacity of parents and other caregivers (e.g., teachers) to respond to the support needs of at-risk children Build capacity and support the work of mental health and social service professionals, (e.g. school psychologists, clinical social workers) with at-risk children and families	Work with health and mental health professionals to support and strengthen available, accessible, high-quality[19] clinical MHPSS care within health and mental health systems (e.g., hospitals, child and adolescent mental health units, community mental health centres) for children, caregivers and families Promote quality standards for clinical care of MNS disorders (e.g., mhGAP training for mental health care providers[20]) Raise awareness among specialized care providers of complementary community supports (social services, protection, psychosocial outreach) to strengthen multi-layer, comprehensive services for at-risk children and families Develop mental health promotion and stigma reduction campaigns with persons with MNS disorders or disabilities

19 Quality-focused and specialized MHPSS care includes care and services that are accessible, well-coordinated through functional referral systems and inclusive of all children regardless of age, ethnicity and disability. Quality care for MNS disorders follows the standards laid out in WHO and UNHCR, 'Mental Health GAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies', 2015.

20 The Mental Health Gap Action Programme (mhGAP) was launched by WHO in 2008 to increase the allocation of financial and human resources for care of MNS disorders and increase coverage of key interventions in low- and middle-income countries. Source: www.who.int/mental_health/mhgap/en/.

Source: Community-based Mental Health and Psychosocial Support in Humanitarian Settings - Three-tiered support for children and families. Operational Guidance. UNICEF

Approaches in practice

Practitioners working with children who have MHPSS needs should uphold these principles. Below is a chart providing a few examples of how principles may be displayed in practice, but the list is not exhaustive. Practitioners are encouraged to have discussions with peer colleagues, advisers, and supervisors, around the implementation of these principles in your context.

Figure 7. Approaches in practice

Approach	How the approach is displayed in practice
Child-friendly, family-based approaches	● Interview and communicate with the child and caretaker during mental health assessments (not only the adult) ● Consider how family dynamics may be affecting the child's mental health ● Speak to the child with respect and in ways that show promotion of agency in a developmentally appropriate way
Strengths based	● Be mindful of how you discuss difficult behaviors and child mental health issues in front of the child ● Highlight one strength for the child and communicate that to the child and caretaker ● Assess a child's inner strengths as well as family, cultural, and community resources
Trauma-informed care	● Allow the child choices, when possible (for example, where to sit, what intervention to engage in), to support agency it is crucial to provide age-appropriate options that align with their developmental stage and safety needs. ● Engage in transparency, informing the child who is doing what, when, where, and how the information will be used ● Maximize collaboration among referrals, caretakers, and MHPSS providers
Socio-ecological enabling environment	● Evaluate the influence of a child's family, school, peer, community, and cultural relationships on their mental health and wellbeing ● Engage in family- and community-level interventions when appropriate ● Support protective factors within the child, family, community and culture
Multi-layered approach	● Ensure that multiple interventions across the IASC MHPSS pyramid are conducted (for example, someone receiving psychiatric medication should also be engaged in psychological counseling) ● Monitor and follow up with referrals up and down the IASC pyramid ● Engage in family- and community-based approaches throughout all interventions of the IASC pyramid.

For more information, refer to the

- MHPSS Minimum Service Package, which provides a foundation for the strengthening and scale-up of MHPSS activities[23]
- UNICEF Community-Based MHPSS Guidelines

Objective 2. MHPSS staff are equipped with the necessary competencies, tools and support to provide specialized mental health care to children

Competencies

Effective engagement with children and families requires competent, well-managed staff who are equipped with appropriate skills and behaviors to support the mental health and psychosocial wellbeing of children in humanitarian settings[24]. Competencies are the knowledge, skills, and behaviors required to perform a task and can be viewed as "basic 'soft' skills" required to effectively work in a team or group setting, regardless of a person's culture or background.[25]"

For staff engaging in MHPSS work with children in humanitarian settings, there are two sets of competencies: core and technical. Core competencies typically include communication, collaboration, and cultural awareness. Technical competencies are specific knowledge, skills, and qualities needed to provide mental health care and psychosocial support for children in humanitarian settings. Both types of competencies are integral to ensuring ethical standards and providing effective and beneficial care. WHO and UNICEF have developed competency frameworks and packages to address foundational competencies for MHPSS, CP, and education sectors working with children

WeACT EQUIP Core Competencies

1. Non-verbal communication
2. Verbal communication skills
3. Rapport & relationship building
4. Empathy, warmth & genuineness
5. Supporting the reframing of the child's negative thoughts & feelings
6. Ability to identify and understand the child's daily life problems or needs
7. Problem solving – applies problem solving techniques for the child's daily life problems
8. Safe identification of child abuse, exploitation, neglect, violence, & self-harm
9. Giving feedback to the child
10. Acknowledges and promotes child's agency in the session

[23] https://www.mhpssmsp.org/en/lesson/what-mhpss-msp#page-1

[24] CHS Alliance. Core Humanitarian Competency Framework Available online at: https://www.chsalliance.org/get-support/resource/core-humanitarian-competency-framework/

[25] IFRC Humanitarian Health Competency Matrix. Available online at: https://www.cambridge.org/core/journals/prehospital-and-disaster-medicine/article/ifrc-humanitarian-health-competency-matrix/817687B7D68C3FC7E2BD71B43C235757

11. Behavior management – Demonstrates behavior management skills
12. Organizes group work effectively (Group)
13. Ability to be inclusive (Group)

Technical MHPSS Competencies are more specific skills needed to engage in MHPSS techniques, for example[26]:

- Behavioral activation techniques
- Cognitive techniques
- Interpersonal techniques
- Motivational enhancement techniques
- Problem solving techniques
- Stress management & relaxation techniques

Supervisors and technical advisers can use this document to ensure their work and their staff have met competencies to engage in a manner that will not create unintended adverse consequences. When staff are not equipped with core and technical competencies, they may act in ways they feel are helping the child. However, their actions may actually be more problematic. Most staff working in MHPSS already have these core competencies in working with adults. There are overlapping competencies when working with adults and children, with a major difference being an understanding of child and adolescent development and the impact that has on a child's thoughts, feelings, and actions.

For further information, please refer to these references:

- Karadzhov D, Lee J, Hatton G et al. Identifying core global mental health professional competencies: A multi-sectoral perspective. Cambridge Prisms: Global Mental Health, 2024. pp 1-9.
- EQUIP online platform (2022). Guidance on competency-based training and competency assessment tools. Available in Arabic, English, Spanish, Other languages.

Communication best practices

In relatively unpredictable and fragile settings such as humanitarian environments, numerous children and families may be struggling with emotional or psychological distress or suffering, needing care. Humanitarian workers and clinicians are likely limited and often have to see as many people as possible.

Communicating effectively with children and families will help staff:

- Develop a caring relationship with the child and caregiver
- Help the child feel respected, safe, and empowered
- Gather sensitive information that can inform care and treatment
- Share information with children and caregivers in a way they can understand

[26] EQUIP Overview of Competencies

How one communicates with a child or their caretaker is essential in conducting efficient assessments and providing ethical and effective care to children and adolescents with specialized mental health needs. While many people may believe that engaging with a child is the same as an adult, there are actually many differences.

In order to promote safety, trustworthiness and empowerment, staff should be mindful of their own verbal and non-verbal communication when engaging with children and their family. Below are some best practices to guide communication[27]:

Communication best practices

- Be nurturing, comforting and supportive
- Speak to children in a developmentally-appropriate manner
- Help children feel safe and connected to an adult
- Pay attention to non-verbal communication
- Respect children's opinions, beliefs, and thoughts

Be nurturing, comforting and supportive. Regardless of a child's emotional state or behavior, all staff should convey a level of support and nurturing to children. This may look like a gentle smile, bending down to talk to the child at their eye level, or using a calm tone at a slow pace. Children do not need to be touched to convey care, especially if there is not an already established relationship with them as many children may be reluctant to be touched.

Speak to children in a developmentally appropriate manner Children in humanitarian settings may have witnessed or experienced violence, injustice, and upheaval. Depending on their development, details and personal opinions about the context or situation are not helpful to the child. There is a fine balance between withholding details to not confuse or overwhelm the child while also being honest and trustworthy. For example, it is okay to tell a young child that their uncle died in the war, so they are not left wondering what happened to him. It would be overwhelming to a child if you told them details about the violence or your opinions about the warring factions.

Help children feel safe and connected to an adult. The area of the brain that is responsible for logic, reasoning and decision-making is not as developed in a child's brain as the emotional part of the brain. For this reason, children may not be able to put into words what they are feeling or how to manage them. This is one reason why the role of a caring adult is so critical to child development. Compassionate adults whom a child feels connected to are able to help the child manage their big emotions. Creating a space of emotional safety means children feel comfortable sharing their thoughts and feelings without judgment.

Pay attention to non-verbal communication.
Due to a child's cognitive and verbal development, children may show they are distressed by changing their body posture, looking away or down, wringing their hands or fingers, shaking, or

[27] Adapted from t United Nations Children's Fund (UNICEF) and International Rescue Committee (IRC), "Caring for Child Survivors of Sexual Abuse Guidelines", Second Edition, UNICEF, New York, 2023.

crying. Non-verbal behaviors can often be clear in communicating when a child is overwhelmed or having difficulty with regulating an emotion. They may take longer pauses to resist answering or shift from side-to-side in their seat. As well, you are also communicating non-verbally with your behaviors—if your body becomes tense or you look away to write or type while they are talking, they may interpret your behavior as negative which will affect their willingness to trust and talk with you.

Respect children's opinions, beliefs and thoughts
Children have a right to express their opinions about what has happened and any decisions made on their behalf, even if it differs from the caretaker or staff. To help a child feel heard and cared for, staff can explore the child's ideas and opinions about the causes of their feelings or how certain experiences may have impacted them. These conversations about a child's thoughts and feelings may be the only time they have shared these with a supportive adult.

For more information, refer to:

- mhGAP: General Principles of Care for People with Mental, Neurological and Substance Use Conditions in Humanitarian Settings
- United Nations Children's Fund (UNICEF) and International Rescue Committee (IRC), "Caring for Child Survivors of Sexual Abuse Guidelines", Second Edition, UNICEF, New York, 2023.

Psychological first aid for children

Psychological First Aid (PFA) is a set of skills and competences implemented during and immediately after stressful events. Children in humanitarian settings may experience similar situations such as displacement or separation from families for example, but may react differently based on developmental level, temperament, and past experiences. PFA responds to a person's basic needs with respect and dignity. Regardless of how specialized one's mental health background is, all staff engaging with children in humanitarian settings can benefit from engaging in PFA for children in crisis.

There are four main action principles of PFA:

- ***Prepare*** for how you will respond when you do not have the answer, take time to reflect internally, and gather trusted, reliable information
- ***Look*** for individuals in need of immediate attention, as well as at the environment, to ensure safety and ask helpful, compassionate, non-intrusive questions
- ***Listen*** to, and acknowledge, the concerns of children and caregivers, paraphrase and validate feelings
- ***Link*** children and caregivers to people, resources, and service providers who can address their needs, reflect on existing coping strategies, share information and services

Assessment of mental health concerns for children, adolescents, and youth

Before the assessment

Preparing a child and his/her family for a mental health assessment should start well before the assessment process since there may be ambivalence due to stigma, privacy, and unfamiliarity. Since the mental health assessment is likely the child and family's first contact with mental health care, referral sources should explain the reasoning for the referral and what to expect.

Choose a safe, child friendly location that supports open communication. Before meeting with a child, care should be taken in creating a child-friendly space with culturally appropriate toys, art materials or a space to comfortably sit on the floor or chair. Such spaces may not be appropriate for older adolescents. Children and adolescents should be given a choice of where they would like to meet, or where they would like to sit.

Figure 8 Considerations in Humanitarian Contexts

- If only tents/caravans are present, clinicians and support staff can try to walk in private with the child
- Children and their parents can be asked to choose a location where they feel safe and comfortable
- Best attempts should be made to allow adequate time to conduct a thorough assessment
- Parents should always be approached first, then the child to obtain consent for a child's mental health assessment and describe the process, including risks (of eliciting stressful emotional responses) and benefits (developing a plan to ease emotional or behavioral distress)
- Parents and children should be told that they can share as much or little as they are comfortable with
- Support staff will play a critical role in maintaining the continuity and quality of care

Source: Song, S. & Oakley, J. *Conducting the Mental Health Assessment for Child and Adolescent Refugees.* In Eds. Song S & Ventevogel P. Child, Adolescent & Family Refugee Mental Health: A Global Perspective, New York: Springer, 2022.

Gather as much sensitive information from caregivers, other providers or referrals sources, and documents as possible, to reduce the child having to retell their story multiple times. Care should be taken to not overemphasize the mental health concern on the individual child but rather understand their concern in the context of the family and community surroundings. Clarify the purpose of the assessment from the referral source (for example the psychosocial support worker, CP or GBV counselor, or community health worker) to gain an understanding of how the child's emotional or behavioral issues have been understood, expressed and managed thus far, as well as critical information about the family and context that could be causing or contributing to the mental health concern. Understanding why the child is brought in now will help the MHPSS staff to be focused during the assessment.

Review documents
MHPSS clinicians should review any information provided from the referral, attentive to exposure to humanitarian emergencies, conflicts, or community violence to contextualize distress and to identify protective factors. Any forms, such as consent for treatment or mental health questionnaires should be given in the family's language of proficiency

Starting the mental health assessment

Focus on initially developing a strong alliance, including understanding the child's priorities, conveying a sense of warmth, and engaging in cultural humility since an alliance is key to a comprehensive assessment. Before delving into the assessment or asking about their life experiences, take some time to help ease the child's potential discomfort. Being interviewed by an adult can be an unfamiliar experience. Asking about their favorite pastimes or hobbies, toy, music, or food can help build rapport before beginning the assessment. Developing an alliance can help with the ultimate goal of reaching, together with the child and caregiver if available, a shared understanding of a child's mental health strengths, needs, and goals of care.

Explain to the child and caretaker the practical and administrative aspects of an assessment. Children are aware of their surroundings and oftentimes understand and hear much more than what adults may think. Clearly and simply explaining the purpose of your meeting, why you want to speak to them, length of the interview, mental health provider's role, expectations from the assessment and the confidentiality rules and limitations, are all helpful in showing respect to a child. To minimize feeling singled out, you can normalize the situation. For example, you can tell the child that there are many others ("children", "kids your age", "families", "people in your situation") who have had the same kind of thing happen to them and your role is to see how you can help them.

Figure 9. Engaging the child and family in an MHPSS assessment

Do ✅	Do Not ❎
Prepare a safe, confidential, child-friendly space	Take children into an environment that is not comfortable to them
Explain to the child why you want to speak with them	Assume children do not care or are not able to understand why you are meeting
Interview the child	Only interview the caregiver or referral source
Allow children to relay however much or little they feel comfortable with	Force a child to answer a question they do not want to
Speak respectfully with a child and acknowledge their capabilities	Talk down to children since they understand more than adults often believe

Screening and assessment tools

While mental health questionnaires may be a quick way to gather information prior to an interview, clinicians should be mindful to use scales that are culturally and contextually validated. Many children and families will be unaccustomed to using questionnaires, and when administered by an MHPSS worker, some children may look to their caregiver or another for guidance on whether the clinician can be trusted. Many scales are used for research purposes and are not necessarily informative of diagnosis. If scales are used, they may be more appropriate for monitoring progress rather than for diagnosis.

The IASC has selected the following quantitative measures of mental health distress to be considered for screening and assessment[28]. Global and regional MHPSS advisers should review the IASC monitoring and evaluation framework to determine how to select the evaluation tools that would be useful for each context.

For more information:

- Inter-Agency Standing Committee (IASC), The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: with means of verification (Version 2.0), IASC, Geneva, 2021.

Figure 10. IASC selection of screening tools for children in humanitarian settings

EXAMPLE FINDING	EXAMPLE RECOMMENDATION
6–11 years	Child Psychosocial Distress Screener (CPDS)
	Strengths and Difficulties Questionnaire (SDQ)
	Revised Child Anxiety and Depression Scale-25 (RCADS-25)
12–17 years	Child Psychosocial Distress Screener (CPDS)
	Strengths and Difficulties Questionnaire (SDQ)
	Alcohol Use Disorders Identification Test (AUDIT)
	Revised Child Anxiety and Depression Scale-25 (RCADS-25)
18 + years	Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
	Patient Health Questionnaire (PHQ-9)
	Generalized Anxiety Disorder (GAD-7)
	PTSD Checklist for the DSM-5 (PCL-5)
	Psychological Outcome Profiles (PSYCHLOPS)

Source: WHO. Psychological interventions implementation manual, Annex 5.

[28] IASC common monitoring and evaluation framework for mental health and psychosocial support in emergency settings with means of verification (version 2.0). Geneva: Inter-Agency Standing Committee; 2021 Available online at: https://interagencystandingcommittee.org/sites/default/files/migrated/2021-09/%20IASC%20Common%20Monitoring%20and%20Evaluation%20Framework%20for%20Mental%20Health%20and%20Psychosocial%20Support%20in%20Emergency%20Settings-%20With%20means%20of%20verification%20%28Version%202.0%29.pdf

Basic components of a mental health assessment

Even though MHPSS clinicians in humanitarian settings are often limited in number with time constraints, clinicians should allocate 2-hours for an initial evaluation with the child, caregiver, referral source and the clinician. This allows for observation of the interaction between child and caregiver, which can give information about relational strengths and struggles.

If the child is under 13 years old, an interview with the caregiver can be conducted first, then with the child individually or together based on the child's preference. If the child is over 14 years old, the adolescent is typically interviewed first then the parents next as they have more developmental awareness of their emotional concern and may feel criticized by a caretaker if they openly discuss their concerns. Time is reserved at the end for all parties to return to discuss the formulation, which includes the socio-cultural impact on a child's emotional and behavioral wellbeing, as well as discuss potential care plans or interventions for going forward.

Children may ask what information provided by the child in the interview will be shared with others, such as the caregiver. MHPSS staff should follow confidentiality rules, as children need a safe space where they can openly share difficult aspects of their lives without the threat of other's judgment. MHPSS staff should let children know that what is discussed between staff and child will be confidential, unless the child is a harm to themselves, others, or is in grave danger.

The basic components of a mental health assessment will be informed by the child themselves, as well as caretaker, referral source, or documentation if available. Even in humanitarian settings, care should be taken to ensure collateral information is obtained.

Figure 11. Components of a mental health assessment

Reason for referral	Detail concern: when did it start, how long did it last, how often does it occur, what causes it to worsen or get better
Birth and developmental history	To assess for neurodevelopmental conditions like intellectual disability, autism spectrum disorder, learning disabilities
Substance use history	Past and present
Medication use	Past and present
Presence of physical symptoms	Review of symptoms: constitutional (fever, weight changes), eyes, ears/nose/mouth/throat, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, skin, neurological, psychiatric, endocrine, hematologic, and allergic factors
Past medical history	Any medical issues past or present such as epilepsy, head injury, systemic illness

Risk of suicide or self-harm	Thoughts or ideation of suicide, history of self-harm behaviors (for example cutting or burning)
Psychosocial information	Family structure, family and peer relationships, living situation, adverse experiences (potentially traumatic, abuse, environment, type of parenting), academic performance
Resilience	What has helped the condition, inquire what life was like prior to the humanitarian context, solicit positive personal characteristics and behaviors, understand parental well-being and social supports

Socio-ecological assessment

The family and community in which a child is embedded will be stressed by humanitarian settings with exposure to violence, loss of loved ones, forced separation or displacement, and the changes in family roles, expectations, and engagement. MHPSS clinicians can ask about the family's overall strengths and obtain a sense of daily life, which gives a lens into family norms and expectations. A clinician may explore stressors to the family, family roles, caregiver-child attachment, and style of parenting. As well, the context in which the child is embedded should be evaluated including home and school environments. Consider gender as a factor affecting experiences—such as gender roles, discrimination, and risks of gender-based violence. Contextual factors related to a child's identity, including disability status, religion, race, and sexual orientation. Recognizing how gender intersects with these factors can highlight a child's unique challenges. Identifying past traumatic experiences, exposure to violence, and peer involvement is critical for addressing emotional and psychological wellbeing. Identifying and prioritizing the child's basic needs, such as housing, poverty, school enrollment, food security and safety, can be a critical step to understanding a child's mental health needs. Identifying a child's past and ongoing potentially traumatic experiences, exposure to war-related events, community violence, abuse, and migration, school inclusion and peer-involvement are all critical due to their influence on emotional and psychological wellbeing.

Diagnosis

Standardized classification systems such as the Diagnostic and Statistical Manual (DSM-5) and the International Statistical Classification of Diseases and Related Health Problems (ICD-11) have been criticized for a reductionistic perspective that overlooks the social and cultural context in which the behavior is expressed. Despite considerable challenges with this standardization of categorized mental health problems, it is the best model we have currently and can function as a guide for clinicians in selecting treatment options[29]. Providing services within the MHPSS field, including CP and GBV, should involve local actors grounded in contextual risks and problems while offering basic PSS services. Taking a dimensional approach that views mental health along a continuum from well-being to more serious disorders can balance treatment and care with a promotion and prevention approach to lower the suffering

[29] Song S. & Ventevogel P. Principles of the Mental Health Assessment of Refugee Children and Adolescents. In Eds; Song S. & Ventevogel P., Child, Adolescent and Family Refugee Mental Health: A Global Perspective, New York: Springer, 2022.

from mental health conditions. This approach should also address the specific needs related to gender and other identity factors, converging social and biological determinants of mental health problems throughout the life course.

Formulation

The formulation is the integration of the above information into a distilled narrative that describes a working explanation of the various socio-ecological and biological influences on a child's mental health concern and care plan. The formulation describes the signs, concerns, and areas of resilience, embedding these in family, social, and cultural contexts. The formulation can and should involve the child and family in a developmentally appropriate way, for feedback and discussion, as it can and should change with more understanding of the child and context.

Conducting a comprehensive, well-informed assessment is integral to the formulation of understanding a child's mental health concerns and potential care plan. For example, a child who presents with difficulty focusing, poor concentration, hyperactivity, and difficulty obeying his/her parents could be in distress due to a normal response to loss of loved ones and community, witnessing violence or potentially traumatic events, exhaustion from daily life hassles, bullying by peers, anxiety of the ambiguous loss of loved ones, prolonged grief, depression, sleep disorders, language and learning disabilities, absence seizures, autism spectrum disorder, hyperthyroidism, attention-deficit hyperactivity disorder, and many more. While these may all present with a similar mental health issue, they have different intervention strategies, spanning attachment-focused, interpersonal or social interventions, or behavioral, trauma-focused, cognitive approaches, anti-seizure medication or psychotropic medication. A thorough assessment can therefore give a detailed understanding to match the child's needs with the best intervention.

Figure 12. Broad types of mental health problems

Category of mental health problem	Potential symptom/problem
Internalizing (emotional)	• Sleep problems • Avoidance of certain situations • Physical presentations of distress
Externalizing (behavioral)	• Acting out • Aggression • Defiance/yelling
Neurodevelopmental	• Physical overactivity • Attention impairment • Language delay

	● Repetitive behaviors ● Impaired social reciprocity
Somatic/body-brain	● Sleep problems ● Feeding and eating disorders ● Bedwetting ● Somatoform and related disorders

Source: Thapar & Pine, 2015. Child and adolescent development. In Eds; Thapar A, Pine D, Leckman J, Scott S, Snowling M, Taylor E, Rutter's Child and Adolescent Psychiatry: Sixth Ed. John Wiley & Sons Ltd.

For more information, refer to:

- Song, S. & Ventevogel, P. Child, Adolescent & Family Refugee Mental Health: A Global Perspective, New York: Springer, 2022.
- Cultural Formulation Interview (CFI), American Psychiatric Association, 2013. Diagnostic and statistical manual of mental disorders (5th ed.)
- Thapar, A., Pine, D. S., Leckman, J. F., Scott, S., Snowling, M. J., & Taylor, E. (2015). *Rutter's Child and Adolescent Psychiatry: Sixth Edition*. John Wiley and Sons Ltd.

Structure of follow-up mental health sessions

If conducting supportive sessions, staff can engage the child in fun and creative non-directive activities, such as drawing a general picture or placing various toys, dolls, or puppets in front of them for them to choose. While drawings can be a useful starting point to learn about what a child is thinking and feeling, staff should not make assumptions or inferences solely based on a drawing (for example, using a dark color or scribbling wildly does not always indicate a negative feeling).

More directive activities can also be used, especially if rapport has already been established and you have a good relationship with the child. However, these directives are not art therapy. Staff should not ask the child to draw a representation of a distressing incident. Staff can engage the child in drawings, with prompts below:

- Draw a house, a person, or a thing, or to
- Draw a picture of the family doing something.
- Draw daily activities
- Draw a safety circle (put inside the circle what/who makes them feel safe and draw things outside the circle that scare them)
- Draw a worry brain (draw a big head/circle and have the child section off parts of the circle with a feeling that is proportionate to how much it is impacting them)
- Draw a feelings body (draw an outline of a body and go through to ask how different parts of their body feel: head, shoulders, heart, stomach and legs)

Staff can then ask questions, such as “Tell me about the house; What is the family doing here; Who are the people here?” If children do draw about a distressing incident, staff can acknowledge the basic feeling associated with the drawing, then engage in the above “safety circle” to help children focus on what they do have control over and how they can soothe when a difficult emotion emerges. Note that drawings are just one example of ways to engage a child or adolescent. Below are further ideas based on a child's developmental level.

Figure 13. Engagement approaches based on age

Age	Communication approach	Engagement approach
0-3 yrs	Communicate directly with the caregiver. For children older than 18 months, inform them about each next step	Work in a dyadic approach if possible (with a caregiver and the child together)
3-5 yrs	Use concrete, simple words in a calming tone	Use imaginative play, songs, and repetition, drawing, dolls
6-9 yrs	Use simple language and explanations that allow them to ask questions	Use drawing, dolls, toys, and books
10-14 yrs	Ask questions and solicit feedback to show respect for their ideas	Engage in conversation, offer “fidget” materials or art supplies
15-17 yrs	Talk respectfully and present options or different perspectives	Engage in conversation, mindful to be non-judgmental

Closing of sessions

Engaging with children who are struggling with emotional, psychological, or behavioral issues requires the clinician to be sensitive to the effect of the session after it is over. Ten minutes before a session ends, the clinician should help transition the child to the end of the time with you. Care should be taken to not start conversations on topics that will take longer to process. If the child is engaged in strong emotions towards the end of the session, the clinician can engage the child together in grounded exercises such as deep breathing, to help the child feel emotionally safe by the end of your session.

Mental health interventions

Role of culture and context in mental health interventions

Culture and context are at the core of identity formation, expression of emotional and behavioral issues, and expectations of a child. Given this, interventions to support the mental health and wellbeing of a child in humanitarian settings should be culturally embraced and aligned with a child’s worldview and understanding. Many psychological interventions

developed in non-humanitarian or highly resourced settings may not therefore be appropriate for these children.

Scalable MHPSS packages for low-resource settings

Humanitarian and health actors from the WHO, IASC and others have introduced MHPSS packages to be used in low-resource settings. Many of these evidence-based low-intensity psychological interventions do not require advanced professional degrees and can be delivered by paraprofessionals. However, those with specialized mental health training can also use these interventions with children.

Although scalable MHPSS intervention packages have made exceptional contributions to the care of adults in humanitarian settings, there remain major limitations on the applicability for children in humanitarian settings. Initially developed for adults, these interventions are slightly modified (if at all) to be appropriate for children. However, caregiver well-being has clear impacts on a child's mental health and well-being, and engaging caregivers with psychological support can also improve their child's wellbeing.

Examples of WHO MHPSS packages used in low-resource settings can be found in Table 2, with UNICEF's Building Lifelong Opportunity for Mental Health (BLOOM) psychological intervention for 5–10-year-olds experiencing behavioral and emotional difficulties forthcoming.

Figure 14. WHO MHPSS package interventions for children and caregivers in low-resource settings

Example WHO psychological interventions (including digital programmes) developed for different target groups with specific problems in low-resource settings.

WHO PSYCHOLOGICAL INTERVENTION[a,b]	FORMAT	TARGET POPULATION
Caregivers Skills Training (CST)	Group	Caregivers of children with developmental disabilities, including autism
Doing What Matters in Times of Stress	Self-help (digital, book)	Adults with psychological distress
Early Adolescent Skills for Emotions (EASE)	Group	Young adolescents with psychological distress
Group Interpersonal Therapy (IPT)	Group	Adults with depressive symptoms
iSupport	Self-help (digital, book)	Carers of people with dementia
Problem Management Plus (PM+)	Individual or group	Adults with depression or anxiety
Self-Help Plus (SH+)	Group/multi-media self-help	Adults with psychological distress
Step-by-Step (SbS)[c]	Digital self-help	Adults with depression
Thinking Healthy	Individual	Mothers with perinatal depression

[a] All these examples are (or will soon be) available to download from the WHO Institutional Repository for Information Sharing (https://apps.who.int/iris/).

[b] All the interventions developed by the WHO Department of Mental Health and Substance Use can be found on their page on scalable psychological interventions (https://www.who.int/teams/mental-health-and-substance-use/treatment-care/innovations-in-psychological-interventions).

[c] Carswell K, Harper-Shehadeh M, Watts S, van 't Hof E, Abi Ramia J, Heim E et al. Step-by-Step: a new WHO digital mental health intervention for depression. Mhealth. 2018;4:34. doi:10.21037/mhealth.2018.08.01.

For more information, refer to:

- WHO & UNICEF (2023). Early Adolescent Skills for Emotions (EASE) (for children 10–14 and their parents). Available in English.
- WHO, UNICEF (2021). Helping Adolescents Thrive: Toolkit Strategies to promote and protect adolescent mental health and reduce self-harm and other risk behaviours. Available in English.
- WHO (2020). Manual on Group Problem Management Plus (PM+): Group Psychological Help for Adults Impaired by Distress in Communities Exposed to Adversity. Available in English, other languages.
- WHO (2020). Doing What Matters in Times of Stress: An Illustrated Guide. Available in Arabic, Chinese, English, French, Hungarian, Lithuanian, Spanish, Romanian, Russian, Ukrainian, Other languages.
- WHO (2021). Self Help Plus (SH+): A group-based stress management course for adults. Generic field-trial version 1.0. Available in English.
- Sangraula, M., et al. (2023). Problem Management Plus (PM+) Remote Training Manual (version 1.1). Available in English.
- WHO (n.d.). Webpage that hosts all WHO Psychological interventions. Available in English.
- WHO (2015). Thinking Healthy: A Manual for Psychosocial Management of Perinatal Depression. Available in French, English, Spanish, Other languages.

- WHO (2016). Manual on Group Interpersonal Therapy (IPT) for Depression. Available in English, Other languages.
- WHO (2016). Manual on Individual Problem Management Plus (PM+): Individual Psychological Help for Adults Impaired by Distress in Communities Exposed to Adversity. Available in Arabic, Chinese, English, French, Spanish, Ukrainian, Other languages.

Psychological Interventions

While useful, these scalable packages are not designed to be the primary treatment intervention for children with advanced mental health care. However, due to the short-term, emergency focus in humanitarian settings, many MHPSS staff are generally focused on the short training of providers on MHPSS packages rather than building practical skills with children[4]. Basic psychological interventions to manage prolonged psychological distress and common mental health conditions include:

- Cognitive behavioral therapy (CBT), including behavioral activation, cognitive processing therapy, exposure-based approaches (narrative exposure therapy), and acceptance & commitment therapy (ACT)
- Stress management/relaxation training
- Problem-solving counseling
- Interpersonal therapy
- Eye movement desensitization and reprocessing (EMDR)

Supervisors and MHPSS advisors should note that these psychological interventions require specialized training and should not be attempted without such training, as doing so could inadvertently cause further distress. For a list of evidence and practice of MHPSS interventions for children in humanitarian settings that may be of use to MHPSS specialists, please refer to the below Mental Health and Psychosocial Support for Children in Humanitarian Settings: An Updated Review of Evidence and Practice (Nov 2020)

On the next two pages is a comprehensive list of WHO psychological interventions that may be of use for children, adolescents and caregivers, from the WHO Psychological interventions implementation manual.

Figure 15. Summary of WHO recommendations for psychological treatments

PSYCHOLOGICAL TREATMENT[a]	RECOMMENDED FOR
Behavioural activation	• Adults with depression • People with dementia with depression
Behavioural intervention	• Children and adolescents with behavioural disorders, including conduct disorder
Brief interventions for hazardous and harmful substance use[b]	• Adults using cannabis • Adults using psychostimulants • People with hazardous or harmful alcohol use
Brief psychodynamic therapy	• Adults with depression
Caregivers skills training	• Caregivers of children and adolescents with behavioural, emotional or developmental disorders
Cognitive behavioural therapy (CBT)	• Adults and children with epilepsy (adjunct to antiseizure medicine) • Adults, children and adolescents with PTSD • Adults with acute traumatic stress symptoms • Adults with bipolar disorder in remission (adjunct to pharmacological interventions) • Adults with bodily distress complaints[c] • Adults with depression • Adults with generalized anxiety disorder • Adults with panic disorder • Adults with psychotic disorders (including schizophrenia) in the acute and maintenance phase • Children and adolescents with ADHD • Children and adolescents with autism and anxiety • Children and adolescents with emotional symptoms/disorders • Children and adolescents with somatoform disorder • Children whose parents have mental health conditions • People with alcohol and drug use disorders • People with dementia • People with dementia with depression • People with suicidal thoughts
Cognitive stimulation therapy	• People with dementia
Cognitive training	• People with dementia
Contingency management therapy	• People with alcohol and drug use disorder
Eye movement desensitization and reprocessing (EMDR)	• Adults, children and adolescents with PTSD
Interpersonal therapy / interpersonal psychotherapy	• Adults with depression • People with dementia with depression • Children and adolescents with emotional disorders

PSYCHOLOGICAL TREATMENT[a]	RECOMMENDED FOR
Interpersonal skills training	• Adolescents with disruptive/oppositional behaviours
Motivational enhancement therapy	• People with alcohol and drug use disorder
Problem-solving therapy	• Adults with depression and subthreshold depressive symptoms • Adults with generalized anxiety disorder • Adults with panic disorder • People with suicidal thoughts or with acts of self-harm in the last year
Problem solving skills training	• Adolescents with disruptive/oppositional behaviours
Interventions using cognitive learning techniques to enhance communication and social competencies	• Children and adolescents with neurodevelopmental disabilities
Interventions focused on social skills training and developmental behavioural approaches	• Children and adolescents with autism
Interventions focused on social skills, cognitive and organizational skills training	• Adults with psychosis and bipolar disorder and their carers • Children and adolescents with ADHD
Stress management (including relaxation and mindfulness training)	• Adults with generalized anxiety disorder • Adults with panic disorder • Adults with PTSD or symptoms of anxiety • Adults with epilepsy (adjunct to antiseizure medicine) • People with suicidal thoughts
Third wave therapies[d]	• Adults with depression • Adults with generalized anxiety disorder • Adults with panic disorder • Carers of people with dementia
Psychological interventions for people with substance use disorders[e]	• People with alcohol and drug use disorders

[a] This table includes indicated prevention for people with signs or symptoms of a mental health conditions but do not meet diagnostic criteria for mental disorder. It excludes WHO recommendations on a) treatment format (e.g. group, family, couples, digital, self-help, mutual help), (b) psychoeducation, (c) preventive universal psychosocial interventions, (d) multi-component interventions and (e) unspecified interventions (e.g. structured counselling, psychotherapy or structured psychosocial interventions). This table does not specify when interventions are recommended only for a specific severity level of the condition (e.g. mild, moderate or severe). It does not cover recommendations for combined psychotropic and psychological treatments and does not cover other required supports such as social interventions. WHO recommends that for some of the substance use disorders (e.g. alcohol and opioid use disorders), psychological treatment combined with pharmacological interventions. For a full list of WHO recommendations please see: Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders. Geneva: World Health Organization; 2023. https://www.who.int/publications/i/item/9789240084278

[b] Despite their name, brief interventions for substance use are not generic; they involve specific therapeutic techniques, including, possibly, psychoeducation, simple advice, motivational interviewing and referral.

[c] A synonym of bodily distress complaints is medically unexplained complaints.

[d] Third wave therapies include: Mindfulness based interventions, acceptance and commitment therapy, metacognitive therapy, and dialectical behavioural therapy.

[e] Psychological interventions with demonstrated effectiveness for substance use disorders include CBT, contingency management, community reinforcement approach, motivational interviewing, motivational enhancement therapy, and family orientated treatment approach.

For more information, refer to:

- WHO. Psychological interventions implementation manual: integrating evidence-based psychological interventions into existing services. Geneva: World Health Organization; 2024
- UNICEF. Mental Health and Psychosocial Support for Children in Humanitarian Settings: An Updated Review of Evidence and Practice. New York: 2020

Psychopharmacological interventions

Most children and adolescents in humanitarian settings will not need psychotropic medication. The use of a medication should not be taken lightly, as the effectiveness and ethical use of medications is dependent on a comprehensive assessment by a highly skilled psychiatrist or physician with training and experience in working with children and adolescents in humanitarian settings. The reality is that at this moment, there are very few contexts in which such providers are available.

If the MHPSS counselor has determined that the child has emergent mental health needs or serious mental health conditions that may possibly require psychotropic medication, they should ideally be referred to a child/adolescent psychiatrist. Given there are very few sub-specialized clinicians in the majority of the world, the next choice would be a psychiatrist. If not available, then children could be referred to a remote child/adolescent or general psychiatrist from within the country or region (preferable) or one from outside the region who has experience working with children in humanitarian settings. If those are not options, then the child could be referred to a physician trained in mhGAP, with supervision by a remote psychiatrist.

Best practice does not involve psychotropics as the sole intervention for youth[30]. If psychotropics are deemed critical as in cases where the child is in imminent danger of harming themselves or others, active psychosis not explained by a cultural perspective that poses a threat to themselves or others, children with mental health symptoms that significantly impair daily functioning or have a biological predisposition to their condition, then psychotropic medications should always be paired with psychological interventions, family-engagement, and coordination with case managers. Moreover, psychotropics need routine follow-up, to manage side effects, monitor progress, and evaluate whether changes are necessary. Anyone receiving psychotropic medication should meet two weeks after the initial administration of medication, then monthly thereafter. If such follow-up is not possible, strong caution should be advised on whether the risks of medication outweigh potential benefits. For further information on specific medications approved for mental health conditions in children and adolescents, refer to the below reference by Cortese et al., 2024.

[30] American Academy of Child and Adolescent Psychiatry, Recommendations about the use of psychotropic medications for children and adolescents involved in child-serving systems.

For further information, refer to:

- Cortese S, Purper-Ouakil D, Apter A et al. Psychopharmacology in children and adolescents: unmet needs and opportunities. Lancet Psychiatry, 11(2):143-154, 2024.
- American Academy of Child and Adolescent Psychiatry, Recommendations about the use of psychotropic medications for children and adolescents involved in child-serving systems.
- Lorberg B, Davico C, Martsenkovskyi D, Vitiello B. Principles in using psychotropic medication in children and adolescents. In Rey JM, Martin A (eds), IACAPAP e-Textbook of Child and Adolescent Mental Health. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2019.

Staffing and referral

Roles and Referral systems

In a case management approach, children are referred to advanced mental health care according to the referral model by the IMC MHPSS Case Management guidelines. According to the referral model, the social worker conducts a full assessment, interviews the child and caregiver, and conducts a field visit if needed. Once the need for mental health services is determined, the child is directly referred by the social worker to either a psychotherapist for additional screening or a psychiatrist if the need for a psychiatric consultation is established and given the earliest appointment.

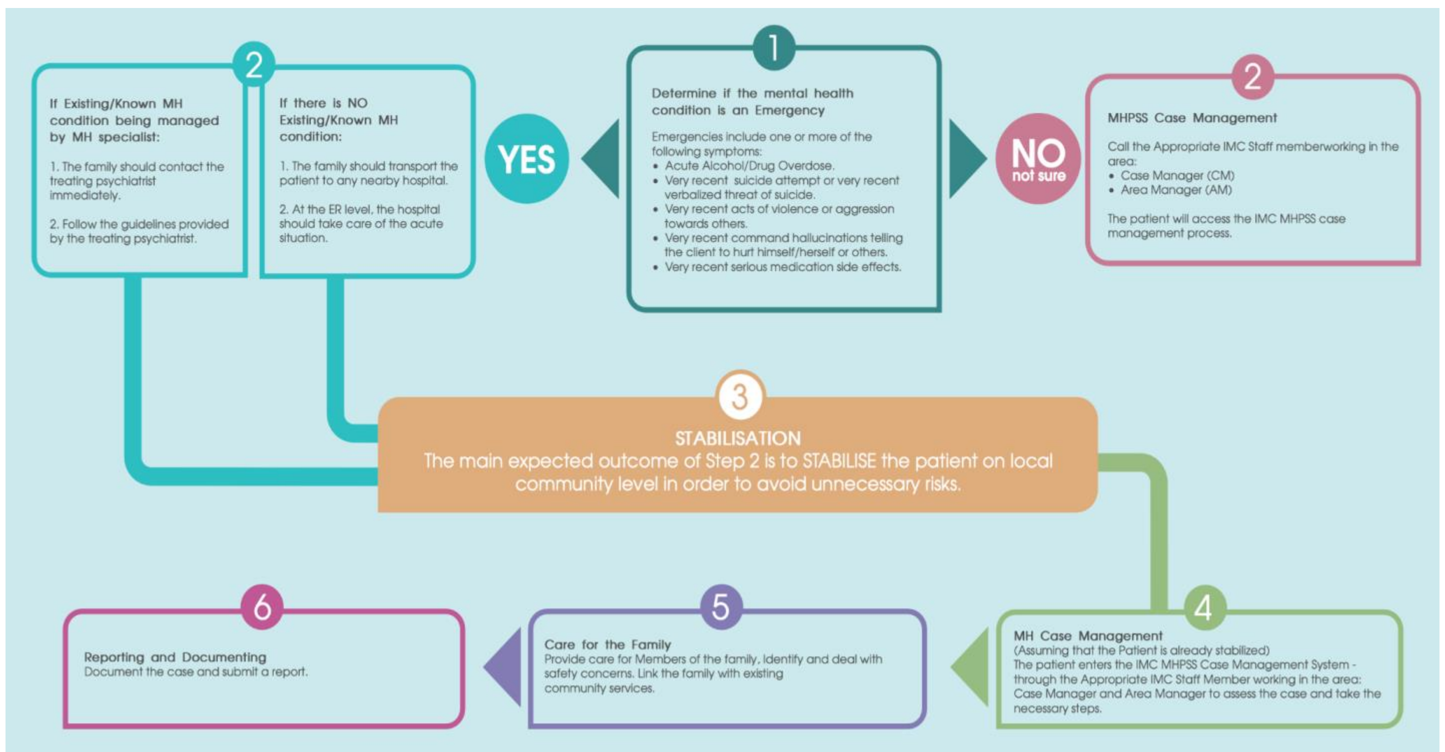
Psychosocial Support Workers (PSW), Community-Health Workers (CHW), Child Protection (CP) counselors and Gender-Based Violence (GBV counselors) and community volunteers can be trained in the identification and appropriate referral to the MHPSS team. As well, they could use the ReachNow tool, developed by War Child Holland, which uses illustrated vignettes depicting the most common, culturally relevant indicators of childhood psychological distress as well as decision-making diagrams to guide community members towards seeking further support.

In order to minimize unnecessary referrals to the mental health team and to help staff feel better equipped to manage MHPSS concerns, CP case managers could learn basic MHPSS skills that are commonly encountered in child protection. The forthcoming UNICEF Guidance on the Integration of MHPSS into Child Protection Case Management has guidance and modules to develop MHPSS skills during CP case management. As well, non-specialists could be trained in using the Friendship Bench, which provides basic CBT with an emphasis on problem solving therapy, activity scheduling, and peer-led group support.

Communities and families are important referral points to the MHPSS team as well and should be included in psychoeducation and outreach through stigma reduction approaches and fostering a culture of empowerment in supporting their children.

Moreover, MHPSS clinicians and staff should actively engage with other sectors to provide additional support to the child if necessary. If there are concerns for gender-based violence such as early marriage, or child protection violations such as abuse or neglect, MHPSS staff should refer to GBV and CP, respectively, for additional support. The aim is for each country to have all components of a comprehensive MHPSS referral system, to be able to respond to serious and emergent child mental health needs, such as below:

Figure 16. MHPSS referral system for mental health emergencies



Source: IMC MHPSS Department, Process of Mental Health Emergency Referrals, Lebanon

Once a referral is made to the MHPSS team, the referral source should maintain awareness of when specialty mental health care is being provided and the outcomes of such care throughout the duration of the case. MHPSS focal points should aim to have monthly coordination of care meetings where case managers, MHPSS advisers, supervisors, and mental health clinicians meet to discuss cases. For any complex cases, including a child in need of hospitalization due to suicide attempt, deliberate self-harm, agitated psychosis, aggressive behavior and intoxication or overdose, the mental health adviser should be informed.

However, having all roles within the referral system does not ensure quality of care. Each participant within the MHPSS intervention system for a child needs to understand the roles, responsibilities, and available supports (including family, community, and specialist) to ensure appropriate referral and facilitate engagement throughout the referral and treatment process.

The problem arises when one link in the referral process is not knowledgeable on child mental health issues and is unequipped to appropriately communicate with, assess, and identify children with mental health needs.

For further information:

- War Child Holland, ReachNow. Available online at: https://www.warchild.net/documents/262/220420_WCH_REACHNOW_CO-BRANDING_DETECTION_TOOL_EN.pdf
- IMC MHPSS Minimum and Comprehensive Quality Standards, 2023.
- IMC MHPSS Guidelines for Psychiatrists (Lebanon), 2019
- IMC MHPSS Process of Mental Health Emergency Referrals (Lebanon)
- MC Guidelines for Providing Technical Support for MHPSS Staff (Lebanon)

Objective 3. Supervision and training procedures are in place to provide ethical, effective care

Supervision and Training

Ethical provision of mental health care

Supervision is the process of improving the capacity of MHPSS clinicians to provide appropriate, effective and ethical care to children in humanitarian settings. Consistent, supportive supervision is critical to safe and effective MHPSS programming and essential to the wellbeing of MHPSS service providers[31]. Integral to supervision is training, both on providing supervision as well as technical support. Ongoing training is critical for supervisors, advisers, MHPSS workers and counselors to maintain staff competence and confidence and promotes improved mental health outcomes for children. Supervision is comprised of both process (with whom, how frequent, and how) and content aspects (what should be assessed and what are the themes of the supervisory sessions).

Figure 17. What supervision is and is not (adapted from the Integrated Supervision Model)

What supervision is	What supervision is not
A safe, supportive, confidential and collaborative space	The time to resolve administrative issues (such as timesheets / contracts etc.)
A place where supervisees can openly discuss difficulties and successes	Only a means of monitoring the supervisee's performance
A place where supervisees receive clear and constructive feedback that builds technical capacity	The only type of staff care that organizations should make available

[31] International Federation of Red Cross and Red Crescent Societies Reference Center for Psychosocial Support, Integrated Model for Supervision Handbook. Available online at: https://supervision-mhpss.org/resources/ims-handbook/

A place for mutual learning between supervisor and supervisee/s	Fault-finding, judgmental or punitive
A space for joint problem solving and learning	Hierarchical, top-down, overly instructive
A place to identify and respectfully challenge bias and/or prejudice	A time for fault-finding, judgmental or punitive reactions

Source: IMC MHPSS Supportive Supervision Roadmap

Role of supervision

An effective supervisor supports professional reflection and independent self-discovery so supervisees can develop professional skills and personal development. The supervisor should foster self-reflection to identify the areas in which more training or experience is needed, challenge bias, stigma or prejudice that could affect their work, and solicit feedback to influence change in their work[32]. Supervisors should be available for consultation when staff have an MHPSS concern they are concerned about.

Ensuring training for MHPSS staff working with children who are not mental health experts

Adequate staffing for the number and service needs of children with mental health concerns is foundational to their safety. A sufficient number of child protection counselors and mental health and psychosocial support staff ensures timely intervention and effective risk management for children with high-level or emergent mental health needs. For this reason, having a senior supervisor dedicated to providing child mental health supervision independent of other administrative or advisory roles may help ensure quality of care and identify specific training needs.

Frequency and types of supervision

Supervision time should be budgeted in all workplans and proposals with a corresponding indicator to ensure dedicated allocation of associated funds. IMS trainings should be systematically rolled out across countries with significant MHPSS presence, who could then cascade training through a train-the-trainer model.

MHPSS technical advisers and country-level MHPSS coordinators should convene a minimum of twice a year to discuss training and practice gaps and develop cross-country refresher trainings on topics already covered, or on newly agreed upon topics. MHPSS technical advisers play a key role in supporting their MHPSS focal points to ensure they are demonstrating skills expected as supervisors and should support in their country-level counterparts in developing a routine supervision schedule and mapping of who, what, when, how, and how often. Supervision can be conducted in several different ways either in person or remotely, including[33]:

[32] Falender, C. A. (2018). Clinical supervision—the missing ingredient. American Psychologist, 73(9), 1240. https://doi.org/10.1037/amp0000385
[33] McBride K, & Travers A., Integrated Model for Supervision for Mental Health and Psychosocial Support. IFRC, 2023. Available online at: https://supervision-mhpss.org/

Figure 18. Types of Supervision

Type of Supervision	Description
Individual	1:1 meeting between the supervisor and supervisee lasting about one hour. A supervision session may begin with the supervisor and supervisee creating an agenda together of what should be discussed. It may end with the supervisor checking in with the supervisee, asking what they found useful in supervision, what they would like more support with, and discussing any actions to be completed before the next session. The structure of individual supervision sessions may differ depending on the context and circumstances. This is the gold-standard of supervision.
Group	Supervisor and two or more supervisees. It can include various activities depending on the group composition, such as role plays, case presentations, skill development activities, reflection and self-care, or more informal discussions facilitated by a supervisor. Group supervision is facilitated by a trained supervisor with expertise is managing group dynamics.
Peer	Two or more supervisees. There is no 'professional' supervisor but rather peers take a rotating approach with different peers leading different sessions. Peer supervision can help establish informal peer support and promote cohesion among colleagues. This sort of supervision should not be limited to formalized in-person meetings, but could also take place on text messaging groups, to allow for real-time posing of questions and receiving immediate feedback.
Live (direct, on-the-job, or in vivo)	Supervisor directly observes a supervisee providing MHPSS. This allows supervisors to provide specific feedback to then identify areas that require development and reinforce best practice. This type of supervision is widely recognized as an important activity to ensure the quality of MHPSS service delivery and is particularly useful to support participants in applying newly acquired skills after training. Supervision should be encouraging and positive, not be fault finding or punitive. Feedback from live observation should highlight both what worked well, as well as areas that can be strengthened, using specific examples.

In addition to the above types of supervision, case consultation or team meetings should be had, for cross-sector discussion about a case. In these case consultation meetings, specific cases, such as those with complex mental health or psychosocial needs, could be presented and discussed across MHPSS, CP, GBV, health, etc.

In a similar manner, peer supervision within the same sector can help build a collaborative approach to supporting the child. For example, a psychiatrist and psychologist could work in partnership during a mental health assessment, which not only eases the interview process for the child who does not need to repeat themselves but also allows the clinician to better understand the larger issues surrounding the child.

Although in-person supervisory sessions are preferred, there are times in which remote supervision is needed, due to security-related concerns, health emergencies, limited human resources or capacity within the organization or an organizational preference to use an external supervisor not in the same location. When remote supervision meetings are conducted, the same physical boundaries should be set-up as if the session were held in the workplace (ensuring a confidential, private area where others cannot hear information discussed).

Key points:

- Supervisors should be independent from having additional roles as manager of those they are supervising to allow for responsibilities focused on providing supervision
- All MHPSS staff, regardless of level of specialty, should have supervision
- Individual supervision should be mandatory, with supervisors who have training specifically in child mental health. Supportive supervision should be conducted at least every month, with formal assessment annually at minimum. For new clinicians or those new to working with children, weekly or every 2-week supervision is expected.
- Group and peer supervision can be both formal and informal, through text messaging groups to provide real-time feedback to difficult clinical situations
- Live supervision, from observation/shadowing and random chart reviews, should be done quarterly and focused on growth, not punishment or shame

Training on Supervision

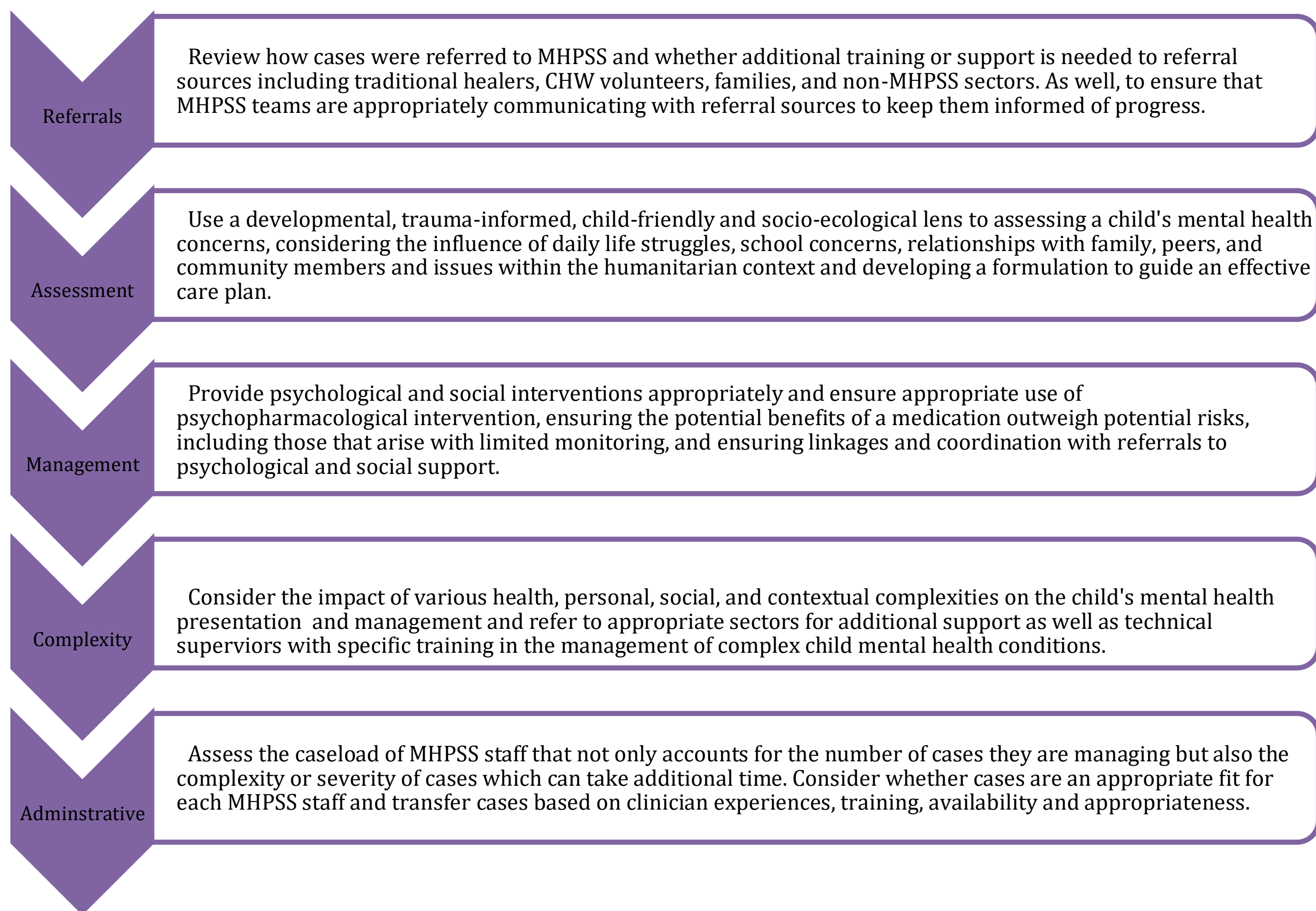
General sensitization training sessions that outline what supportive supervision is, why supervision is critical to providing effective care, expectations of the supervisor and supervisee, different types of supervision, core competencies and supervisory skills, and practical aspects to supervision should be held in a community of practice to encourage discussion on appropriate supervisor approaches per context[34].

MHPSS advisers that are trained on EQUIP competency assessment approaches can provide trainings and sensitization sessions to country office staff on what tools exist on the EQUIP platform and how they can be utilized to support skills development as part of supervisory processes. For more information, refer to:

- EQUIP- Ensuring Quality in Psychological Support Online Competency.
- IMS Supervision International Federation of Red Cross and Red Crescent Societies Reference Center for Psychosocial Support, Integrated Model for Supervision Handbook.

[34] IMC Supportive Supervision Roadmap

Figure 19. Considerations for supervisors during sessions



Content: Technical skills training

Training on child mental health engagement, assessment, and treatment should be a priority. All sectors that work with children should have basic MHPSS incorporated into field-level training packages. For regions without supervisors with a background in child mental health, quarterly trainings should be given specifically on child MHPSS. While the cascade train-the-trainer method is efficient and scalable, the nuances of care provision may get lost. This highlights the necessity of proper supervision. If possible, one "child mental health supervisor" should be engaged with the sole focus of providing supervision and training on child mental health support and care across sectors.

As additional scalable packages grow, MHPSS clinicians should receive continuing training on different approaches found to be effective for children in humanitarian settings. There are various courses that could support MHPSS clinicians across the experience and training spectrum. The WHO Course on Introducing MHPSS in Emergencies Module 7 focuses on identifying suitable tools and integrating psychological interventions into health and social sector implementation plans in emergencies. As well, a forthcoming UNICEF Operational

Guideline on the Integration of MHPSS into Child Protection Case Management will have accompanying training modules on MHPSS approaches to addressing children facing suicidal thoughts, grief, and aggression.

For more skilled psychological interventions, MHPSS advisers and supervisors can find additional training in the above section on Supportive Psychological Interventions. As well, global and regional MHPSS advisers should review the WHO Psychological Interventions Implementations Manual and the MHPSS for Children in Humanitarian Settings: An Updated Review of Evidence and Practice to determine which psychological interventions are needed for additional specialized training.

For more information, refer to:

- WHO (2022). Introducing Mental Health and Psychosocial Support (MHPSS) in emergencies. Module 7: Identifying suitable tools and integrating psychological interventions into health and social sector implementation plans in emergencies [online course]. Available in English, Polish, Ukrainian.
- IASC (2022). IASC Guidance Note: Addressing Suicide in Humanitarian Settings. Available in Arabic, Chinese, English, French, Portuguese, Russian, Spanish.
- UNICEF (2022). Mental Health and Psychosocial Support for Children in Humanitarian Settings: An Updated Review of Evidence and Practice. November 2020. Available in English.

Assessments should be administered after each training, to gain a sense of how well the material was internalized. Assessments would be specific to the training topic, and should include a series of multiple-choice questions, open response questions, as well as two cases studies for staff to review (either multiple choice answers or to discuss with the supervisor) in order to evaluate application and implementation.

Self-care and vicarious trauma

Since IMC operates in humanitarian contexts across the world, staff are working in low-resourced settings and challenging contexts not only for the children or families they are working with, but also for themselves. Supervision and training sessions should therefore be reflective of this reality, and provide training sessions on self-care, vicarious trauma and burnout, which should also be a component of supervisory sessions with staff as MHPSS clinicians working in humanitarian settings are at high risk for vicarious trauma and burnout. Working with children may also remind staff of their own childhood and may need debriefing.

All staff should have a referral list of resources to confidentially reach out to if desired. If mental health support is used, such as psychotherapy or psychiatry, IMC should offer staff such services, ensuring the provider has an understanding of the context and daily life experience for staff (for example, awareness of what leisure activities one may have access to or how it may be difficult to socialize when one is far from friends and loved ones, etc.). Supervisors should check in routinely with MHPSS clinicians to gain a sense of their level of satisfaction or fatigue. Scales can be given to staff to help identify areas of concern as per below.

For more information, refer to:

- The Professional Quality-of-Life Scale (ProQOL) is a 30-item scale that measures the negative and positive effects of responding to trauma in a professional role, including compassion fatigue, burnout and secondary traumatization. It is a self-report measure and is freely available in 26 languages and accompanied by a scoring guide.
- The Perceived Supervision Scale (PSS) is a brief 6-item cross-culturally validated measure which was specifically developed to capture the perceptions of lay practitioners towards their supervisors. It is designed for the supervisee to complete about their own experiences. High scores indicate a higher perceived degree of supportiveness in supervision.
- Professional Quality of Life Self-Care Tools is a webpage with basic handouts and materials on core concepts and fundamental skills for self-care.

Monitoring progress of supervisees

Regardless of level of specialty training or experience, all MHPSS staff should have access to supportive supervision. Relying on self-reflection and presumed behavioral change is not enough to ensure the ethical and effective provision of mental health care for children. Supportive supervisors, through individual or group processes, should engage in quality assessment through observation/shadowing, case consultations and chart reviews, monitoring for appropriate referral, effective engagement with the child and caregiver, and appropriate intervention.

As well, supervisors should engage in routine assessment of staff's clinical approach, using a standardized checklist such as the mhGAP-HIG Supervision Checklist for psychiatrists, or adapted for clinicians providing advanced mental health support for children. For psychiatrist, mhGAP-trained providers or others prescribing psychotropic medication, supervision will be critical to ensuring that the benefits of the medication outweigh the potential harm. Anyone with prescribing capacity should have at minimum, annual training and supervision on

(1) Administration of medication, including likely harm without proper assessment and follow up/monitoring and harm from indiscriminate use of medication based on availability (when effective medications are unavailable)
(2) Specific, common behavioral concerns such as suicidal behavior, self-harm, aggression, enuresis, grief and prolonged depression, extreme anxiety, and psychosis, including how to conduct a proper assessment and non-pharmacological interventions (including psychological and psychosocial interventions) first
(3) Awareness of when to prescribe, prioritizing benefit to the child as opposed to ease of practice
(4) How to provide psychoeducation to children, families, referral sources and organizations who may have limited knowledge on child development and mental health assessment, thereby encouraging the use of medication when doing so many be inappropriate
(5) How to manage one's normal feelings of incompetency at not being able to "fix" a child's serious mental health condition.

All supervisors should engage in annual review of competency skills of staff, to gather information on common areas in need of improvement to then include in refresher trainings. Refer to the below options of tools on appropriate competencies and supervision tools.

Consider various competency frameworks and tools, for example, from the

- Core Humanitarian Competency Framework. CHS Alliance.
- EQUIP- Ensuring Quality in Psychological Support Online Competency.
- IMS Supervision International Federation of Red Cross and Red Crescent Societies Reference Center for Psychosocial Support, Integrated Model for Supervision Handbook.
- WHO. mhGAP-HIG Supervision Checklist, mhGAP Humanitarian Intervention Guide (mhGAP-HIG) training of health-care providers: training manual. Geneva: World Health Organization; 2022.
- Save the Children Child Rights Resource Centre. Case Management Supervision and Coaching Package Chapter 2: Supervision practices and tools.
- GBVIMS Steering Committee. GBV Case Management Guidelines, including supervision tools, co-developed by International Rescue Committee, International Medical Corps, UNHCR, UNFPA, and UNICEF.

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