Mental Health and Psychosocial Support for children affected by the Syria Crisis

Regional Mapping June – December 2014

Summary Report

Save the Children

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1. Introduction

The mapping of Mental Health and Psychosocial needs of Syrian refugee children and the resources available was carried out over a period during June to December 2014. The impetus for the mapping came from an internal survey undertaken by Save the Children in North Syria, Central South Syria, Lebanon, Jordan, Iraq and Egypt. Respondents in all six locations expressed concerns about the level of Mental Health & Psychosocial Support (MHPSS) needs in children they came into contact with through their programmes and a concern that gaps may exist in appropriate provision to meet these needs.

2. Methodology

The mapping was carried out through conducting a desk review and country programme visit to Egyptand Jordan and a desk review together with skype calls/e mail exchangeand completion of standard questionnaires with Save the Children (SC) staff, partners and other Key Informants in Iraq,Lebanon and Turkey/Syria.Each of the country programme visits involved spending time with Save the Children staff, visiting locations where psychosocial programmes are in progress, conducting participatory group work with affected children, parents/carers and community members and interviews and meetings with other key informants working in the sector.

Limitations

Field work and in particular focus group discussions were very limited due to time and resources available and therefore only able to provide a snapshot of the views of community members including children. The lack of statistical information and disaggregated data relating to Syrian refugee children meant it was not possible to meet some of the deliverables.

There are also many children whose needs are not known, who are invisible and receive no help or support. Some of these children may be the most severely affected; children living in Syria where ongoing conflict prohibits access to them, others living in scattered populations for example in Lebanon or remote locations in Iraq and those children who are kept at home and not supported to access services or prevented from doing so. Amongst these are disabled children or those with other special needs and children, girls in particular, whom parents do not believe should be mixing with boys or members of different communities.

3. Impact of the Syria crisis on children

The conflict which began in Syria in 2011 has wrought a devastating impact on the country and the lives of all Syrians and with no end in sight the situation for Syrian children and their families is only likely to get worse. There are 3,106,455 registered Syrian refugees[1] and 7.6 million internally displaced people[2] in Syria as a result of over three years of conflict; approximately half of these are children.

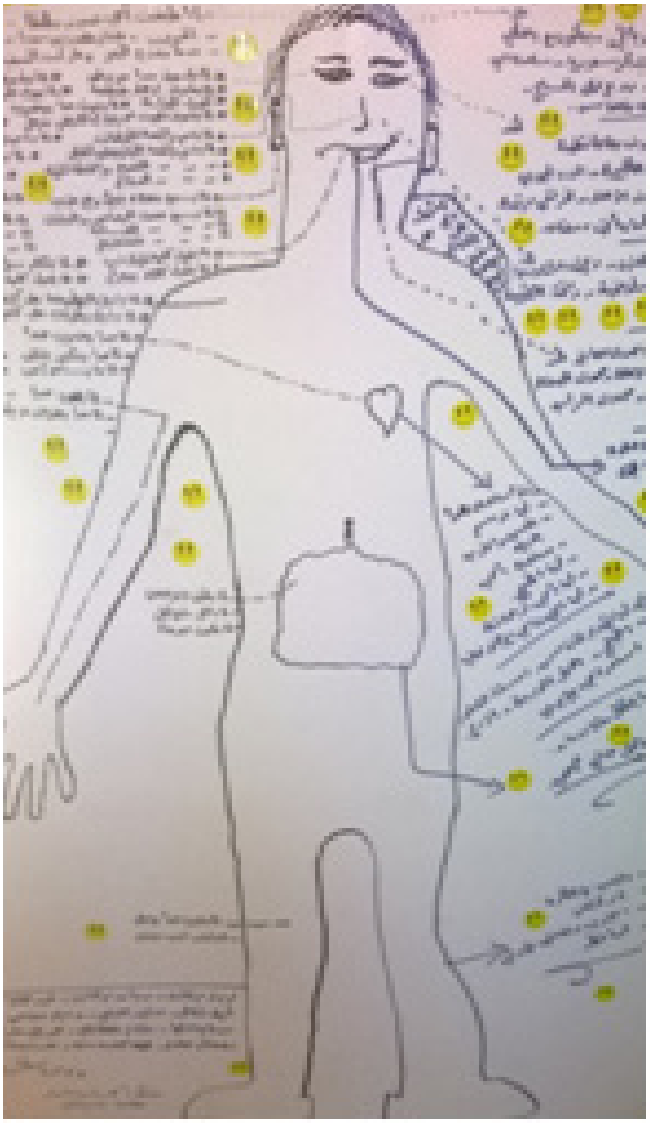
1 http://data.unhcr.org/syrianrefugees/regional.php 07 Dec 2014

2 http://www.unocha.org/syria

The effect on children of violence, loss, displacement and violation of so many of their rights is unimaginable. "After three years of conflict and turmoil, Syria is now one of the most dangerous places on earth to be a child" concludes a 2014 Unicef report[3] which states that

- 5.5 million Syrian children are in need of humanitarian assistance – that is 56% of all Syrian children(inside Syria and amongst displaced and refugee population);
- One in 10 children – over 1.2 million – have fled the country to become refugees in neighbouring countries. Some of these countries already host large numbers of refugees or Internally Displaced Persons (IDP's) and face immense social and economic pressure;
- By the end of January 2014, 37,498 Syrian children had been born as refugees;
- Nearly 3 million Syrian children are out of school – that is 40% of all children of school age;
- 323,000 children under 5 live in besieged or hard to access areas;
- 8,000+ children arrived at Syria's borders without their parents.

The report also states that child casualty rates are the highest recorded in any recent conflict and notes that a UN estimate of at least 10,000 children having been killed is likely to be an underestimate since death and injury rates are so difficult to measure.



The statistics demonstrate the scale of the tragedy but cannot convey the magnitude of human suffering for each individual child. Participatory work with refugee children during this mapping provided a glimpse into the ways in which the experiences of refugee children have shaped their thoughts and feelings. Children aged 8-13 taking part in a body mapping exercise as part of the MHPSS mapping included "the death of relatives, limbs of the dead people, bombing and the smell of chemical gases amongst the things that made them sad and the news of having a relative released from prison, people killed for the cause of religion and land (Martyr "Al Shaheed"), the thought of returning to Syria and thesmell of the soil in Syria amongst things that made them happy."

3 Under Siege, The devastating impact on children of three years of conflict in Syria, Unicef 2014

Despite all the terrible hardships, suffering and loss, the resilience of children is what stands out. Given all that Syrian children have endured, it is remarkable that on the whole they continue to get on with their lives, making the most of opportunities to study, socialise and play and look

forward to the future with hope. And in a region where mental health and psychosocial issues have carried a significant stigma amongst the general population, it was said many times that people are now much more willing to acknowledge these kinds of problems and seek and accept the help that is needed.

Participatory group work also revealed the comfort children draw from their family, their friends, from going to the mosque and attending school and happy memories of home.

4. Mental health and psychosocial concerns for Syrian children

As well as being exposed to physical harm and injury the experiences of Syrian children include displacement, exposure to violence and destruction, witnessing the killing of family members, family separation, deprivation of food and water and displacement. Many children are unable to go to school or pursue normal activities of daily life. Furthermore, children in Syria may be subject to arrest, detention torture and sexual abuse. This sadly also true for many other children in the region experiencing violent conflict.

Even when the immediate dangers of conflict are not present, children's experiences are compounded by the consequences of the conflict creating or contributing to child protection issues with potentially serious impacts on their mental health and psychosocial wellbeing. Loss of home, economic difficulties, inadequate living conditions and community tensions, family separation and break up of families, SGBV especially domestic violence, child/early marriage, child labour, limited/poor education and vocational opportunities and uncertainty about the future are all significant factors. For example, focus group discussions with older children revealed their preoccupation with the living conditions of day to day life; the physical dangers present and the unpleasant and restrictive camp environment were a major cause of psychosocial distress.

Children have been affected directly and indirectly by the conflict – some parents and caregivers are so anxious and overprotective as a result of their experiences that they prevent their children from leaving home to go to school or socialise. Safety and security are not only a concern inside Syria but also for many refugees living in both host communities and camps; tensions can exist between different ethnic groups living side by side in camps and SGBV was frequently mentioned as a risk in all settings.Despite co-existence programmes many refugees face extreme hostility from members of the host communities and have difficulty integrating.

Another consequence of the conflict is economic hardship which has led to an increase in child labour[4] - for example in Jordan an estimated 25% of children support their family through labour and more and more children will be forced into work as the conflict becomes ever more protracted, pushing the economy further into decline. Economic hardship is also blamed for the increase in child/early marriage although many portray this as way of protecting girls who might otherwise be at risk of abuse.

The findings of this mapping exercise show that Syrian children and their families experience a wide range of mental health and psychosocial problems. Commonly noted amongst children are the following: Symptoms of post-traumatic stress were found extensively;though no cases with a clinical diagnosis of Post-Traumatic Stress Disorder (PTSD) were identified as there is generally little capacity or availability for professional determination, symptoms included hyperactivity, hyper arousal, fear, anxiety especially separation anxiety and nightmares and young children with unusual crying or screaming. Other symptoms or problems that were widely reported include somatic symptoms such as speech disorders and problems with hearing or vision, negative thoughts and feelings of inferiority,phobias, depression,self -harm, suicidal thoughts and behaviour, anger and aggression (especially for boys), anti-social behaviour, bullying, isolation e.g. through being kept at home for their own protection or from becoming withdrawn and children running away from hope-lessness. Amongst adolescents in particular there were frequent reports of feeling a loss of identity and hope lessness about the future. Nocturnal Enuresis was widely reported in all settings and was mentioned by all key informants – for example the Moroccan Hospital at Za'atari camp in Jordan deal with around 20 cases per month and although more frequently a problem for younger children,adolescents are also affected. Daytime urinary incontinence was also a problem.

Traumatic events are kept alive for children through the conversations of adults around them and continually being exposed to stories of conflict, death, destruction and flight; witnessing the anguish of adults can only add to their distress.Depression and symptoms of post-traumatic stress amongst mothers were frequently referred to by key informants and children. This has a significant bearing on the mood of the children and on the capacity of their mothers to care for them effectively and sympathetically.

4 The Institute for Family Health (IFH), Jordan

A number of informants mentioned the deteriorating behaviour of adolescent boys, many of whom are obliged to work to supplement the family income and as a consequence do not attend school. Behaviours mentioned include aggression and getting into fights, using alcohol/ drugs using bad language and becoming very challenging and in some cases abusive towards their parents and siblings. It is generally difficult to engage these boys in psychosocial activities, which may not be particularly appealing to teenagers and they are frequently said to be disruptive, angry or frustrated if they do attend activities.

Depression is said to be more common than aggression in girls, although girls are also less visible through being kept at home due to fears of insecurity or because they are compelled to carry out domestic labour and as a consequence can be very isolated.

Mental health and intellectual and developmental disabilities such as psychosis, Autism and Downs syndrome were usually pre-existing disorders which in many cases were exacerbated by the conflict and its consequences including lack of treatment or support. Also noted were physical disabilities; cerebral palsy in particular appears to be a significant problem in all settings.

Where symptoms of psychosocial distress were identified which impacted on children's day to day lives, for example preventing them from fully engaging in education, these were overcome in the majority of cases through responses such as group therapy or individual support, without the need for more specialised or level 4 support. However, it should be noted that most of the findings relate to settings where the Syrian population have been living as refugees for around two years and so any acute problems are likely to have subsided in most cases. The picture is likely to be different amongst newly arrived refugees and children living in Syria. In the case of the latter in particular, children may experience more extreme symptoms and are less likely to be able to access support; an assessment undertaken by the Child Protection Working Group in 2013[5] found that deterioration in the psychosocial wellbeing of children was reported by 98% of respondents. For some children, especially those living in places where the conflict has been the most intense, the unrelenting distress, exposure to violence and human rights abuses, insecurity, lack of access to basic services including education and the changed behaviour of family and community members may have a long term negative effect on their normal social and psychological development.

Education[6]

Education is a major feature of normal everyday life for children and promotes healthy socialisation and development as well as learning. Therefore facilitating school attendance and ensuringquality provision of the required standard i.e. in relation to the curriculum, language, an environment which is conducive to education and addresses the psychological wellbeing of children in order to facilitate their learning and development is integral to MHPSS for children.

5 Syria, Child Protection Assessment, 2013, CPWG

Mental health and psychosocial needs linked to education are prevalent in Syria and all countries of asylum and relate to two aspects – firstly the impact on the almost 3 million Syrian school age children out of school as a result of the conflict and what can be done to mitigate this impact /facilitate school attendance. There are many reasons why Syrian children do not attend school – they are compelled to work or are prevented from attending by parents/carers or the lack of accessible school places, including provision for children with disabilities or special needs, overcrowded classrooms, unfamiliar curricula, language differences, discrimination and abuse in schools or attacks on schools in Syria. The CPWG Child Protection Assessment undertaken in Syria in 2013 notes that "680 schools are used as shelters for IDPs, and 2,963 schools are either partially damaged or completely destroyed."

The second aspect relates to the needs of children who are able to attend school yet struggle to learn or engage fully because of the impact on their psychological wellbeing of their experiences and current living situation. "Displacement, conflict and poor living conditions createhigh levels of anxiety and stress. In a survey undertakenby Save the Children, large proportions of childrenwere identified as displaying signs of psychosocial distress. Nearly one in three children identifiedfeelings of helplessness, 39% regularly had bad dreamsand 42% said they regularly felt sad. In another survey,38% of children at schools supported by Save theChildren were identified as displaying emotional andbehavioural traits suggesting they were unable to copewith the stresses of their environment……and teachers noted morethan half of the children as being easily scared and 40%were frequently unhappy."[7]

5. Mental health and psychosocial response for Syrian children

5.1 National capacity

All the countries included in this mapping lack sufficient national level professional capacity to provide adequate mental health and psychosocial support to Syrian children. A pre-existing regional shortage of mental health professionals, especially child psychiatrists and others such as psychologists and social workers has been placed under extreme pressure as a result of the Syrian conflict.Professionals working in the region may not have the experience or expertise to work with children affected by such levels of trauma whocontinue to live in an unstable environment; for example, concern was expressed in Lebanon that anyone with a BA in psychology could promote themselves as a therapist as there is no certifying body.

Training of psychologists in Jordan is often geared towards educational psychology and whilst clinical psychologists may have a good theoretical understanding, they often lack practical experience in therapeutic interventions. Whilst there are examples of good initiatives to trainnational actors on mental health and psychosocial issues, including through the WHO Mental Health Gap Action Programme (mhGAP), a number of national actors interviewed for this mapping were critical of the lack of strategic and comprehensive capacity building and felt thatthe response by the international community had failed to support the development of sustainable solutions for the region.

6 Please see Futures under threat, The impact of the education crisis on Syria's children, Save the Children 2014 for detailed information
7 Futures under threat, The impact of the education crisis on Syria's children, Save the Children 2014

5.2 Coordination

The way in which MHPSS for Syrian refugee children is coordinated varies from country to country and can involve one, two or even three coordination groups; Child Protection Working Groups (CPWG) or Protection Working Groups (PWG), MHPSS working groups and Health Working Groups, some of which have sub-working groups developing for example case management guidelines or Standard Operating Procedures (SOP's). Jordan's very active MHPSS coordination group has produced a number of important documents through sub-working groups, for example their "Guidelines on MHPSS Projects" which provides useful examples of MHPSS activities for different target groups. In Lebanon, products related to MHPSS have been developed through the CPWG psychosocial task force as well as the case management task force linked to the MHPSS working group under Health.

In addition, MHPSS needs to be mainstreamed into broader sectoral responses such as Education and Livelihoods. There are understandable challenges for an organisation such as Save the Children in balancing the need to fully participate in coordination groups (to promote the specific needs of children, learn and share experiences, contribute to products generated by coordination groups and maintain visibility) and the demands on time this entails.This also further illustrates the challenges in collecting data on mental health and psychosocial support for Syrian children without a centralised case management or health information system.

8 Refugee numbers refer to registered Syrian refugees and are correct at time country reports were written

5.3 Overview of response

The table below provides a very brief overview of the situation and MHPSS – please see individual country reports for detailed information on responses at country level.

Egypt	• 138,086 Syrian refugees ; 43% of whom are under 18 years old • 78,327 in Greater Cairo • All refugees are in urban neighbourhoods • No 4W's • Limited response/few actors i.e. approximately 6 international organisations and a small number of national organisations • No case management/referral system
Jordan	• 609,376 Syrian refugees; 52% of whom are under 18 years old • Refugees are in host communities and in 5 refugee camps • 4W's completed • Comprehensive MHPSS response; approximately 36 organisations working across all levels, majority level 3 • National case management & referral system & SOPs
Kurdish Region of Iraq	• 228,484 Syrian refugees; 46.8% of whom are under 18 years old • Refugees are in host communities and in camps in Erbil, Dohuk and Sulaymaniyah • 5W's matrix and service mapping for each governorate • Approximately 22 organisations across all levels (for refugees & IDPs) • Limited reach at level 4 • Case management SOPs almost finalised; no national case management or referral system
Lebanon	• 1,124,942 Syrian refugees; 53% of whom are under 18 years old • Refugees are in host communities or in some cases in existing camps • 4W's completed • Comprehensive MHPSS; approximately 40 organisations working across all levels both national and international; majority level 3 intervention (as funded by UNHCR) and level 2 (by UNICEF) with an increased focus on level 3 (by UNICEF). Both fund Level 1 • Case Management SOPs are being finalized; these are long-term SOPs which are being revised together with the national system and Case Management Practical Guidance has been developed to support case management in the emergency response and endorsed by MOSA. Local level referrals are updated regularly through coordination
Syria/Turkey	• Syria: 6.45 million IDPs, approximately 50% of whom are under 18 years old • Syria: No 4W's; INGOs mainly work through local actors level 1, 2, 3 and very limited capacity at level 4. No national case management/referral system • Turkey: 896,702 Syrian refugees; 53% of whom are under 18 years old • Turkey: Rudimentary 4W's of MHPSS with 15 organisations working across all levels. No national case management or referral system

A key objective of this mapping was to assess whether children have MHPSS needs which are not being met – particularly in relation to specialised mental health and psychosocial support, i.e. levels 3 and 4 of the Interagency Standing Committee (IASC) intervention pyramid. For the most part, this view was not expressed by Save the Children staff or others interviewedat least in relation to refugee children with the exception of children with "special needs" (see below). Limited access and information relating to mental health and psychosocial needs of children inside Syria make it much more difficult to verify the level of need but it is safe to assume that in many areas, especially those that are inaccessible, there are extreme needs which are not being met. (See also Limitations above)

Despite this generally encouraging picture, it is often difficult for the relatively small numbers of children requiring specialist support to access this. For example, in Egypt, Government services are of quite a high standard but it would take most refugees one or two hours to reach a clinic from where they live; even if transport was paid for it would not be reasonable for people to do this to access regular support. In other settings there are insufficient referral services or the reach of services is very limited,for a range of child protection problems including specialised MHPSS – this was a problem in parts of KR-I, Lebanon, Turkey and most critically in northern Syria.

The parameters of this review, together with insufficient baseline and monitoring information and a lack of statisticaldata do not allow for a full analysis of whether the responsein place is appropriate to meet the needs and is effectiveincluding in terms of cost. In other words, even where there is comprehensive mapping of the response in place, we do not have complete information on how many children are seen and/or referred according to the level of intervention. However, a number of observations can be drawn from the mapping process and these form recommendations for each country programme and inform section 6 below: summary of gaps and areas to be strengthened.

Quality MHPSS is costly but can be justified if it can be seen to make a difference. Even where systems are in place to measure change in mental health and psychosocial wellbeing it can be hard to know whether improvements are attributable to the interventions or just to a normal process of recovery. Programmes need to be accountable for their expenditure by ensuring more rigorous measurements are in place andfinding creative ways to scale up their response without undermining quality.

Children with special needs/disabilities

These terms were used to refer to children with mental health and intellectual and developmental disabilities such as Autism and Downs syndrome as well as physical disabilities, for example cerebral palsy. Children in all of these categories may have significant psychosocial and/or mental health needs placing increased stress on parents/carers already struggling to cope, yet they are often ignored when service provision is planned.

Whilst many MHPSS programmes – including those run by Save the Children, made efforts to include children with physical disabilities or other special needs in their PSS responses, this was not always possible due to the lack of resources, specialist knowledge and difficulties in ensuring the environment was safe in relation to their needs. Save the Children in KR-I, working closely with Handicap International (HI) are striving to overcome these challenges through a pilot programme to

raise awareness of and ensure the protection and inclusion of children with disabilities and special needs and this may be an approach that could be replicated in other countries in the region.

In addition to insufficient resources and facilities, a lack of understanding of certain physical and mental health disorders, including from some practitioners, along with parental attitudes,contributes to exclusion from schools and other services for many affected children. As a consequence of the above factors, global standards for inclusion were not met in the majority of settings.

In each of the countries included in the mapping there were examples of the *lack of inclusion in education and lack of MHPSS* for these children and their families and almost all key informants cited this as the principal issue when asked about gaps in MHPSS.

5.4 Save the Children Response (see also Annexe 1 for Matrix of SC response)

Save the Children programmes provide MHPSS at levels one and two in all the countries included in the mapping and at level three in Jordan (SCJ), Egypt and in Lebanon and KR-Ithrough case management. Level one and two activities largely fall within level two and comprise recreational activities, activities to improve self-esteem, promote resilience, problem solving and team building, develop life skills,provide informal education, raise awareness and provide information (for children, parents/carers and teachers). Some, but not all of these activities have clearly identified and measurable psychosocial goals. All programmes are also working to a greater or lesser extent to build local child protection capacity through promoting / forming /training child protection committees andtraining partners /other local actors in MHPSS. In the case of Lebanon this is also through Social Development Centres'establishing links with community based organisations and groupsin order to strengthen child protection systems in the community.In Egypt a related health project has been training nursing staff and general practitioners in PSS and response to SGBV.

Level three activities comprise more focused interventions using supportive individual or group therapeutic approaches such as play therapy or Cognitive Behavioural Therapy (CBT) delivered by psychologists sometimes together with social workers. In Egypt this is mainly through groups and occasionally individual work with children and in Jordan (SCJ) both group and individual sessions are held through programmes in education and in communities. Because there is a strong case management component in Jordan such interventions are part of a holistic approach with parallel processes to address child protection concerns where necessary whilst the lack of services and case management structures in Egypt makes this optimal approach difficult.

Programmes in all countries recognised the importance of working with parents/carer givers, especially mothers, in order to promote psychosocial wellbeing in children and as a minimum includedpsycho-education sessions and health information (sometimes in partnership with other organisations). Most programmes also provided more structured support and advice on parenting including positive parenting classes. Egypt and Jordan (SCJ) offered group and in the case of Jordan individual therapy aimed at supporting the parents (normally mothers) directly with the objective of enabling them to better support their child/ren.

Focused approaches with older children/youth are a key component of PSS response in Jordan (SCI) through their Multi Activity Centres for 13-24 year olds and Drop in Centres for working children and also in Lebanon through their largeparticipatory projects with adolescents which uses life skills as a common denominator and also add on English classes, computer classes, community projects and sexual and reproductive health, financial literacy and recreation activities. In KR-I, Youth Friendly Spaces (YFS) for 12-18 year olds are organised separately to Child Friendly Spaces (CFS) for younger children. On the whole however programmes failed to target and engage adolescents sufficiently and this age group was the least likely to receive psychosocial support. The reasons for this include lack of flexibility in times at which activities were available (i.e. to facilitate attendance of working young people) or failure to include activities which appeal to that agegroup and in many cases young people were prevented from attending either because they were obliged to work or because their families did not encourage or allow them to attend.

Children under 5 were able to benefit from Early Childhood Care & Development (ECCD) activities in Lebanon and KR-I andattendkindergartens in Jordan (SCI). It is not clear how much these activities had well-defined psychosocial goals but even without this, providing opportunities for this age group to play, which also allows their mothers to have a break from caring for them is likely to be beneficial to their wellbeing.

The most widely used model for delivery of MHPSS for children has been via activities implemented in child friendly spaceseither within camps for refugees or displaced persons or in locations within host communities.The following terms are sometimes used interchangeably: **Child Friendly Spaces**(CFS) Child and Youth Friendly Spaces (CYFS) Youth Friendly Spaces (YFS) or Child and Family Centres (CFC) The precise model used varies across country programmes but the following conclusions can be drawn from the findings:

- Activities should be structured and have clear PSS goals rather than be just recreational. To know whether or not psychosocial outcomes are reached it is essential to have baseline measurements and regular monitoring in place;
- CFS may be better framed as Child and Family Centres as a way of promoting the inclusion of parents/carers as integral to providing MHPSS for children. This will also help in providing a broader and more holistic approach, more likely to allow an entry point for work with males;
- PSS involving work with parents, especially mothers, and parents and children together is very important inpromoting children's psychosocial wellbeing;
- Interventions should go beyond the relatively small numbers who can attend a "space"; outreach is essential in order to increase numbers of beneficiaries, include the most vulnerable and become more embedded in communities. In some settings there is a need for mobile services to reach scattered and remote populations.

MHPSS has also been integrated into **schools or educational settings** in a variety of ways including the following: training teachers and school counsellors to respond appropriately to children with psychosocial needs, for example with PFA training, raising awareness of the ways in which children's experiences can affect learning and what can be done to help, providing direct therapeutic support through psychologists and social workers based in schools and through case management including referral to specialised services for children who require additional support, such as mental health care or services for survivors of gender based violence. The model used by SCJ in the schools in Za'atari camp has a strong case management component and provides a comprehensive service which also has excellent links with community members and structures. Through this engagement school attendance can be promoted and any obstacles to attendance addressed. Given the importance of education to children living in these difficult circumstances this is a model that could be replicated elsewhere.

Where relevant, all MHPSS programmes are delivered or available to the local population and any other refugees as well as Syrian refugees and Egypt has a strong co-existence programme. This is essential in order to promote community cohesion, address hostile attitudes towards refugees and also to ensure all vulnerable children and their families are supported, particularly in settings such as Lebanon, which has suffered from decades of conflict and turmoil with a huge impact on the local population.

KR-Ithrough case management. Level one and two activities largely fall within level two and comprise recreational activities, activities to improve self-esteem, promote resilience, problem solving and team building, develop life skills,provide informal education, raise awareness and provide information (for children, parents/carers and teachers). Some, but not all of these activities have clearly identified and measurable psychosocial goals. All programmes are also working to a greater or lesser extent to build local child protection capacity through promoting/forming /training child protection committees andtraining partners /other local actors in MHPSS. In the case of Lebanon this is also through Social Development Centres'establishing links with community based organisations and groupsin order to strengthen child protection systems in the community.In Egypt a related health project has been training nursing staff and general practitioners in PSS and response to SGBV.

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6. Summary of gaps / aspects to be strengthened

The focus of the following section is on Save the Children programmes:

"Technical" aspects

i. Monitoring, Evaluation, Accountability and Learning (MEAL) is patchy across the programmes with a lack of baseline measurements, inconsistencies and a lack of rigour in monitoring and insufficientdocumentation and evidence relating to programme outcomes. The lack of SC generic tools was widely noted i.e. tools that are not related to specific programming interventions.

ii. Case management is not a component of MHPSS in all settings. Case management is an important aspect of the response, even in circumstances where there are few referral agencies and is part of strengthening child protection systems.

iii. Screening of children is important to ensure they are able to receive the level of support they need. This is likely to be more effective through the use of agreed, standardised tools/procedures together with training and ongoing support to those using the tools.

iv. The lack of disaggregated data on children and MHPSS i.e. how many children are referred for/ receiving which level of MHPSS support is a significant gap. The availability of this information will also help us to better understand what the real needs are and whether programme responses are meeting these needs.

v. MHPSS materials; with a wide range of Save the Children and other programming materials there can be confusion over the best use of materials. A structure to provide guidance and to ensure quality assurance of materials used in the field would be helpful in improving the quality of response.

Programmes (content and approach)

i. Level 1 and 2 activities should be reviewed to ensure they are optimal: key issues are to promote the delivery of basic services in ways which enhance PSS wellbeing, ensure complaints mechanisms are child friendly andreach greater numbers including the most vulnerable through outreach and mobile services, greater involvement of volunteers/community members and flexible hours. Programmes should aim to increase the resilience of beneficiaries, support community cohesion and strengthen community based and national child protection structures where possible and PSS activities should be structured and goal-oriented.Reference can be made to the Minimum Standards for Child Protection in Humanitarian Action, CPWG, 2012, Standard 10 Psychosocial Distress and Mental Disorders.

ii. Links between MHPSS and education should be strengthened where necessary.

iii. Child participationand empowering children through actively involving them in finding their own solutions should, wherever possible be a fundamental component of PSS work. This was most evident in the work of SCJ and in the Lebanon adolescent programmes.

iv. Engaging youth, particularly boys in psychosocial responses is challenging and some programmes are having more success than others, for example the drop in centres in Jordan (SCI), and community projects in Lebanon. It is important to explore ways to involve boys and also men in MHPSS interventions in order to meet their individual mental health and psychosocial needs and to prevent and strengthen responses to SGBV including domestic violence. Save the Children in Lebanon through a national partner are piloting some innovative work with men in Lebanon.

v. Approaches which involve working with parents/parents and children together should be more consistently implemented. A clear finding was the close interconnection between the emotional wellbeing of children and their parents, particularly mother's wellbeing, yet the PSS response does not routinely address both the need to provide individual support to the parent/carer and support their parenting capacity.

vi. The excellent advanced MHPSS (level 3) responses by SC Member in Jordan and SCI in Egypt should be consolidated by strengthening MEAL, documenting processes and generating materials as a way oflearning and strengthening responses in other settings.

vii. National capacity to provide quality child psychiatric services (involving multidisciplinary teams of psychiatrists, psychologists, social workers and psychiatric nurses)for all Syrian refugee children (and national children) is very weak across the region and opportunities should be taken to develop and strengthen these services where necessary and possible.

viii. The development of a strategy to ensure MHPSS to children with special needs/disabilities is a priority for all country programmes in order to meet global standards for inclusion and equality

Professional development

i. Establishment of a regional peer group would facilitate mutual support and professional development for senior staff and promote shared experiences and learning across the region including programme exchanges. A peer group could operate virtually (drop box with shared resources, e mail/skype group) and through quarterly physical meetings at a rotating country office in the region involving training, sharing experiences and learning, site visits, case studies etc.

ii. All country programmes provide training for their staff in a range of topics but due to staff turnover this needs to be repeated and include an element of coaching. The following topics were specifically requested for additional training: managing aggression, activities for youth and approaches/models to work with parents and children together.Training opportunities should also be sought for senior staff.

iii. The following aspects should be strengthened in order to prevent burnout and maintain professional standards: support and mentoring for psychosocial workers, supervision for psychologists and others working individually with children and staff wellbeing and self-care.

Partnership/linkages and advocacy

i. Responses for youth 18+ years for whom there is no formal education and 16+ years who do not wish to continue with education are inadequate and opportunities should be taken to advocate for provision of programmes to fill this gap such as sports coaching and higher education.

ii. Save the Children should aim for representation and engagement with national level MHPSS coordination and working groups and ensure links with global level MHPSS initiatives.

7. Examples of promising practice

The following are very brief summaries of innovative approaches to some of the challenges in providing MHPSS to children.

Co-existence programme – Egypt

This programme was introduced to the Child Friendly Spaces run by Save the Children in Greater Cairo. These centres are open to Syrian refugees and the local Egyptian population and the co-existence programmes were introduced as a way of building relationships, overcoming resistance to having joint activities and reducing resentment and hostility between Syrian refugees and Egyptian children and adults. The first step is to train the facilitators in the values of coexistence and inclusion, stereotypes and conflict resolution and how to create a safe and inclusive space for a diverse group. Activities are then held with children over five days in each space; these include working together in small groups to "build our city" using a process of voting and negotiation to agree on how the city would look and what services etc. would be included and arts, crafts, storytelling and using various forms of communication. Cultural diversity is highlighted and celebrated and children prepare and participate in a closing ceremony.

In a similar process a three days camp was held with 70 Egyptian, Syrian and Sudanese adolescents to work on values of team building, diversity and intercultural dialogue.

Children taking part in a co-existence programme in Egypt

MHPSS through education–SCJ Jordan

The education programme involves working inside schools to raise awareness of mental health and psychosocial issues and increase the capacity of teaching staff to support children, as well as providing direct support to children through their psychologists and social workers. A key aspect is to promote and encourage school attendance through understanding why this might be a problem for some students and addressing any obstacles.School attendance is promoted in a variety of ways including through the Imam's who deliver positive messages about school via the mosques and through the use of a Facebook page.

The following structure is used to implement programmes in schools:

- A help desk with psychologists, social workers, a case manager and information assistant. Children can self-refer or be referred for direct psychosocial support or referral on to other services i.e. for protection concerns. Through engagement with the psychologist or social workers, children are encouraged to take an active role in finding solutions.
- A registration office with links to the relevant government ministry, where attendance can be tracked and problems addressed through working with teachers, referring children to the help desk and working in communities through community mobilisers and youth coordinators.

As well as being reactive, the programmes implement a strategic programme response to emerging issues; for example awareness raising and reproductive health sessions were held to address a reported rise in sexual activity between young people.

Drop in Centres (DIC) – SCI Jordan

This pilot programme was developed to respond to the increasing problem of child labour and aims to find ways to engage with working children who are unable to take part in other activitiesfor children and young people because they have to work.Young people can attend the centres on their own terms whenever they wish, perhaps coming for a sleep or a snack and are initially offered informal support and the opportunity to participate in unstructured or semi structured activities. As they become more comfortable attending the centre they are encouraged to take part in more structured activities such as making goods from recycled materials or informal education (basic literacy and numeracy).An initial screening of all young people is carried out by IMC who also provide more specialised MHPSS if this is required. Rather than income generating activities, the young people can be helped to find ways to minimise expenditure, for example through growing vegetables and school attendance is encouraged. The DIC teams always try to engage and work with parents, raising awareness of the risks to working children and the benefits of attending school.

Goods made from recycled materials at DIC in Za'atari camp, Jordan

Outreach and mobile CFS – Lebanon

Reaching out to Syrian refugees in a variety of settings, including to communities scattered over large areas of land, is a challenge to which Save the Children have responded in a number of different ways, for example:

- Child Friendly Spaces are used as a base from which to conduct outreach activities in a variety of settings including informal settlements and collective shelters;
- Programmes implemented through social development centres (SDC's) in communities which have been identified as being the most vulnerable, include a component of mobile activities in an initial one year pilot programme.The programmes also aim to create links with community based organisations and groups in order to strengthen child protection systems in the community through capacity development;
- A CFS in the UNHCR registration centre provides a safe space, making the waiting period less stressful for children and their parents and allows information to be provided on a range of topics including PSS. Vulnerable children can also be identified and referred on to specialist services if necessary;
- Another form of outreach is through the "new arrivals" programme. When shelter or other sectoral teamsconduct visits with new arrivals, the child protection focal person accompanies the team during the household assessment visit. This allows information to be given to families such as how to register with UNHCR, register births and how to access services such as CFS, education etc. In addition, if a specific need is identified this might require the CP team member to facilitate access to services (PSS, education etc.) or make a referral to the service provider and/or the case management agency. Follow up visits are made by the CP focal person at the time of the sectoralfollow-up visits to ensure the necessary response is in place.

Engaging men – Lebanon

A recent, so far one-off small scale initiative has been successful in reaching men through providing activities such as woodwork as a way to engage and create opportunities for discussion. PSS staff joined the men as they worked, informally chatting about issues of general concern related to children such as difficulties in accessing education. After a few sessions it was found that the men became engaged in discussion and agreed to the suggestion of meeting once in a while to discuss these issues. Whilst it is too early to judge the success of this approach pilot programmes are now taking place in other locations to replicate this.

Inclusion and protection of children with disabilities and special needs – KR-I

Save the Children always try to maintain an awareness of challenges in this area and strive to ensure inclusion through a number of initiatives. In order to promote and support the inclusion of children with disabilities and special needs in their MHPSS, SC are piloting a programme in Dohuk, KR-I, working closely with Handicap International (HI). This involves an initial training in minimum standards in protecting children with disabilities, using specially developed training materials and the development of an action plan in order to ensure the inclusion and protection of these children, including through adapting activities for individual children. The programme also looks at wider issues in relation to children with disabilities – for example in relation to WASH.

8. Recommendations for strengthening MHPSS at regional level

MHPSS is a critical component of a humanitarian response and whilst this mapping did not include an evaluation of programmes, many of the interventions can be seen to impact in a positive way on the lives of children and their families. Although the mapping did not identify the need for any significant changes in approach, it can be seen from section 6 that a number of actions could be taken to strengthen programmes and fill the gaps that exist.

The aim of the following recommendations therefore is to identify what can be done at regional level to promote the sector,build on the current response and harness existing potential in order to strengthen and expand the reach of programmes and support the professional development of staff working in the sector.

- **Recruit a full time regional MHPSS specialist.** Based at the regional level, this position will be key in supporting country programmes in the development of a strategy to strengthen programmes and fill gaps as outlined in section 6.

- **Strengthen Monitoring, Evaluation, Accountability and Learning (MEAL)** through identifying/ developing appropriate tools and providing support to country programmes in their implementation

- **Identify/develop standardised technical tools and programme frameworks**e.g. for screening and data collection and support their implementation across the region

- **Document promising practices, pilot programmes and establish system for sharing**

- **Establish & coordinate regional MHPSS learning centre/peer group** with the aim of supporting professional development and sharing learning across countries

- **Provide relevant training opportunities** for both field and senior staff, as well as for partner organizations.

- **Strengthen participation in national, regional and global networks in order to identify advocacy opportunities and increase visibility**

List of Annexes

- Annexe 1 Matrix of SC response – MHPSS Mapping
- Annexe 2 Country Report Iraq (available upon request from the CO)
- Annexe 3 Country Report Lebanon (available upon request from the CO)
- Annexe 4 Country Report Turkey/Syria (available upon request from the CO)
- Annexe 5 Country Visit Report Egypt (available upon request from the CO)
- Annexe 6 Country Visit Report Jordan (available upon request from the CO)

Compiled list of Acronyms	
ACF	Action against Hunger
ACTED	Agency for Technical Cooperation and Development
ADHD	Attention Deficit Hyperactivity Disorder
AFAD	Disaster and Emergency Management Presidency
BSFT	Brief Strategic Structural Family therapy
CBO	Community Based Organisation
CBT	Cognitive Behavioural Therapy
CFS	Child Friendly Space
CYFS	Child and Youth Friendly Spaces
CFC	Child and Family Centres
CP	Child Protection
CPC	Child Protection Committee
CPIE	Child Protection in Emergencies
CPIMS	Child Protection Information Management System
CPWG	Child Protection Working Group
CPU	Child Protection Unit
DRC	Danish Refugee Council
ECCD	Early Childhood Care and Development
HI	Handicap International
IASC	Interagency Standing Committee
IDP's	Internally Displaced Persons
IDMC	Internal Displacement Monitoring Centre
IFH	Institute for Family Health
IMC	International Medical Corps
INGO	International Non Governmental Organisation
IOM	International Organisation for Migration
IPT	Interpersonal Therapy
IRC	International Rescue Committee
KAP	Knowledge, Attitudes and Practices
KR-I	Kurdistan Region of Iraq
KRG	Kurdistan Regional Government
MDM	Medecins du Monde

Compiled list of Acronyms	
M & E	Monitoring & Evaluation
MEAL	Monitoring, Evaluation, Accountability and Learning
mhGAP	WHO Mental Health Gap Action Programme
MI	Mass Information
MHPSS	Mental Health and Psychosocial Support
MoFSP	Ministry of Family and Social Policies
MOSA	Ministry of Social Affairs
MRSF	Medical Relief for Syrians
MSF	Medicins sans Frontiere
MSNA	Multi-Sector Needs Assessment
MST	Multi-Systemic Therapy
NCFA	National Council for Family Affairs
NGO	Non Governmental Organisation
PAO	Public Aid Organisation
PFA	Psychological First Aid
PSS	Psychosocial Support
PSTIC	Psycho-social services and training institute in Cairo
PTSD	Post-Traumatic Stress Disorder
RRP	Regional Response Plan (UNHCR)
SBF	Syrian Bright Futures
SC	Save the Children
SCI	Save the Children International
SCJ	Save the Children member Jordan
SDC	Social Development Centre
SGBV	Sexual and Gender Based Violence
SOP	Standard Operating Procedures
TDH	Terre des Hommes
TRCS	Turkish Red Crescent Society
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
UNOCHA	UN Office for the Coordination of Humanitarian Affairs
WHO	World Health Organisation
4 W's	Who is Where, When, doing What

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We help them achieve their potential.

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