mental health and psychosocial support framework
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About UNRWA

UNRWA is a United Nations agency established by the General Assembly in 1949 and mandated to provide assistance and protection to some 5 million registered Palestine refugees. Its mission is to help Palestine refugees in Jordan, Lebanon, Syria, West Bank and the Gaza Strip achieve their full human development potential, pending a just and lasting solution to their plight. UNRWA services encompass education, health care, relief and social services, camp infrastructure and improvement, protection and microfinance. UNRWA is funded almost entirely by voluntary contributions.

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Cover Photo: Children in the Bedouin community of Abu Falaf/Kurshan in the West Bank. © 2016 UNRWA Photo by Dirk-Jan Visser
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<td>Community Mental Health Programme</td>
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<td>DP</td>
<td>Department of Planning</td>
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<td>EiE</td>
<td>Education in Emergencies</td>
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<td>ERCD</td>
<td>External Relations and Communications Department</td>
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<td>GBV</td>
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<td>mhGAP</td>
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<td>Medium Term Strategy</td>
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<td>RSS</td>
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<td>UNRWA</td>
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1. introduction

1. The UNRWA Medium Term Strategy (MTS) 2016-2021 recognizes the need to address mental health and psychosocial issues (see Annex 1). The prevalence of adverse mental health and psychosocial issues are of increasing concern to Palestine refugees. In many UNRWA fields of operations, children and adults are exposed to violence, conflict and displacement. This is further complicated by a variety of external factors, including poverty, unemployment, food insecurity, oppression and exclusion. If not addressed, psychosocial distress can lead to mental illness, unhealthy and dangerous behaviour, substance abuse, low academic achievement and increased school dropout rates, in addition to exacerbating the prevalence of non-communicable diseases.

2. The current and projected burdens of mental health and psychosocial issues in the Palestine refugee population are of significant concern, not only for public health, but for economic development and social welfare. Mental health and psychosocial well-being are fundamental to the collective and individual ability to think, interact, earn a living and enjoy life. They directly underpin the core human and social values of independence of thought and action, happiness, friendship and solidarity. For children, psychosocial distress and difficulties can undermine their education and learning, impacting both their immediate development but also their future lives. This Mental Health and Psychosocial Support (MHPSS) Framework sets out the Agency’s approach to meeting these challenges faced by Palestine refugees in accordance with the Agency’s MTS.

MHPSS within the Context of UNRWA

3. Research indicates that rates of behavioural, emotional and physiological symptoms of distress are as high as 35 to 40 per cent among Palestine refugees, particularly for children residing in camps and in areas witnessing a high degree of violence and conflict.¹ Research by the World Health Organization (WHO) has shown that upwards of 30 per cent of visitors to primary health care centres globally have a diagnosable mental health condition; in the context of UNRWA, this would translate to over 700,000 patients. WHO estimates that 70 per cent of these patients can be managed within a primary health care facility.²

4. At the same time, it has become imperative that UNRWA develop a more consistent approach to maintaining the well-being of front-line staff addressing mental health and psychosocial issues. The humanitarian work that UNRWA undertakes can be physically, emotionally and psychologically demanding. Moreover, assistance is increasingly being provided under insecure and life-threatening conditions, with the 2014 conflict in Gaza and the ongoing conflict in Syria being two examples.

5. A range of preventive and treatment interventions that offer safe, effective and affordable support to individuals with mental health and psychosocial issues exist.³ Key interventions to promote, protect and restore mental health include: awareness and education about mental health and illness; psychoeducation to facilitate positive coping mechanisms and lifestyles; access to basic counselling support and other interventions; and enhanced legal, social and financial protection for persons, families or communities adversely affected by mental disorders.⁴

6. To date, the Agency’s programme departments have been responding to MHPSS needs in different ways. The Agency has a number of different processes, structures and systems across the five fields of operations. By way of example: (1) Gaza Field Office has a programme dedicated to community mental health; (2) the number of school counsellors differs significantly between field offices; and (3) the number of community mental health counsellors in the relief and social services (RSS) and health programmes differs significantly (see Annex 2). These differences highlight the need for a more coherent and consistent approach to MHPSS interventions across the Agency so that they are provided in a predictable and consistent manner according to the same standards.

7. A number of discrepancies between and within field offices and programmes will in part be resolved with the implementation of Agency-wide programmatic reforms. For example, the UNRWA Education Reform includes the Inclusive Education Policy and a Conceptual Framework on Psychosocial Support for UNRWA Schools. Together with supporting tools, these constitute the Agency’s standard for an inclusive education approach that will support the psychosocial well-being and build the resilience of all children in UNRWA schools. This approach is in line with the core principle of MHPSS, namely the emphasis on integrating appropriate MHPSS interventions into existing services, rather than building new stand-alone services that may not be sustainable.

8. In UNRWA, the development of a more coherent and consistent approach to MHPSS interventions can be further enhanced by ensuring MHPSS is aligned with ongoing efforts to strengthen the mainstreaming of protection across the Agency as defined in the MTS, including both its regular and emergency operations. This is also consistent with the MHPSS principle that recognizes the human rights of all affected persons and the importance of protecting individuals and groups at heightened risk of protection threats. Done correctly, and with an understanding of both the challenges and opportunities (see Annex 3), the Agency can move towards a common model that is based on established
MHPSS principles, identified competencies and trainings, and evidence-informed interventions.

9. A first step in achieving this objective is the establishment of an MHPSS Framework for UNRWA. Like many of the Agency’s other policy and guidance documents, the MHPSS Framework recognizes that the core UNRWA programmes are among the Agency’s greatest strengths: quality, inclusive and equitable programme delivery in safe and protective environments by trained and supported staff. In education, this means that the psychosocial needs of all children are responded to and their psychosocial well-being and resilience promoted through inclusive education practices. In health, the training of physicians and nurses means that patients with mental and psychosocial issues are identified and supported, providing a more holistic approach to health care. Camp improvement programmes, effective livelihood interventions and strong civil society partnerships also make a contribution to positive mental health and psychosocial well-being.

10. Most UNRWA field offices have already developed mental health and psychosocial activities that can be built upon. This includes, but is not limited to, the development of life skills for children, individual and group counselling and guidance, and public awareness and adult education on positive coping mechanisms. There are, however, many individual MHPSS cases in which a more active and tailored response is required. In this regard, UNRWA aims to establish a system that will build the capacity of key staff to respond to individual MHPSS cases either directly – through focused, non-specialized interventions or coordinated internal referrals – and/or through external referrals when required to external partners providing specialized services.

Objectives of the MHPSS Framework

11. The main objective of the MHPSS Framework is to facilitate greater coherence, consistency and quality of UNRWA MHPSS interventions and their impact across the Agency in order to protect and improve the mental health and psychosocial well-being of Palestine refugees.

12. The MHPSS Framework, rather than being a guidance document, is aimed at setting out general principles and concepts that will guide MHPSS programming across the Agency. This will be achieved through further steps to ensure that minimum MHPSS standards and practices are integrated into UNRWA interventions, including its prevention/promotion activities, assessment modalities, and core interventions and referral systems. The development of technical instructions and guidance will be one mechanism to achieve this as a next step to ensure the implementation of the MHPSS Framework.

13. The MHPSS Framework will also help ensure that UNRWA has well-coordinated and technically supported structures in all UNRWA fields of operations, building on the capacities of the education, health and RSS programmes to support the psychosocial well-being of children and adults in times of both relative normalcy and emergency. The MHPSS Framework does not aim to replace or duplicate what is already contained in programmatic strategies that contribute to MHPSS, but rather provide an overarching approach given the cross-cutting nature of MHPSS and the need to ensure alignment with MHPSS standards and practices.
2. definitions, vision and mission

Definition

14. WHO defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” The importance of mental health is also highlighted in the WHO constitution, which states that “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

15. The Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (hereafter the ‘IASC Guidelines’) defines MHPSS as a composite term used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. These closely related terms reflect different yet complementary approaches. Actors outside the health sector tend to speak of supporting psychosocial well-being, while people working within the health sector tend to speak of mental health.

16. ‘Mental health’ and ‘psychosocial well-being’ are complementary terms that will be used collectively throughout the MHPSS Framework under the umbrella of MHPSS, unless used separately for specific reasons.

MHPSS Vision and Mission

17. The Agency’s vision is for the right of every Palestine refugee, adult or child, to achieve the best possible mental health and to protect and promote psychosocial well-being through basic UNRWA services in education, health, RSS, infrastructure and camp improvement (ICIP), and protection.

18. The mission of the MHPSS Framework initiative will be to provide such support by:

- Promoting the psychosocial well-being and building the resilience of all children by providing quality, inclusive and equitable education in a child-centred, safe and stimulating environment, in which the psychosocial needs of all children are identified and addressed;
- Providing primary health-care services that protect and promote the mental health and psychosocial well-being of those served;
- Providing relief and social services that support self-reliance and empowerment;
- Protecting and promoting the rights of refugees against protection threats that frequently have mental health and psychosocial impacts and should be addressed as part of a comprehensive protection response;
- Recognizing that the necessary living environment is important to well-being and promotes positive individual development, as well as community well-being and resilience;
- Working with Palestine refugee communities to ensure participation and reinforce communal strengths and resilience;
- Ensuring UNRWA is able to promote, identify and support the mental health and psychosocial needs of Palestine refugees;
- Building partnerships with other agencies to facilitate the sharing of best practices, knowledge and expertise; and
- Recognizing the need to provide at least a minimum MHPSS response to Palestine refugees during emergencies, conflicts and crises.
3. MHPSS Principles and Concepts

19. MHPSS cuts across the Agency’s programmes and operations, and therefore adoption of Agency-wide principles and concepts is important to ensure consistency and coherence across UNRWA. In this way, UNRWA will be better able to strengthen Agency-wide systems, structures, procedures and staff capacities. This section helps to define the responsibilities of those staff who are accountable for oversight and coordination and the principles that they should respect during their daily work.

MHPSS Principles

20. The MHPSS Framework adopts and builds on the core principles of the IASC Guidelines. These are:

(I). Human rights and dignity: MHPSS programming and interventions should recognize the human rights of Palestine refugees and protect individuals and communities who are at risk of violations of these rights. It should be provided in a manner that respects the dignity of Palestine refugees and maximizes access and fairness in the availability and accessibility of services, taking into account gender, age, disabilities, localities and other relevant factors.

(II). Participation: The MHPSS Framework recognizes the importance of involving Palestine refugees in programming to ensure MHPSS interventions reflect both their needs and strengths. Participation is also seen as being essential in promoting community ownership and resilience.

(III). Do No Harm: As a humanitarian entity, the Agency shall ensure that it does not inadvertently inflict harm on any individual receiving services, either through its own interventions or those of external referral partners. All services should be provided in the best interests of the concerned child or adult and by adequately trained and supervised staff members. Informed consent, confidentiality and participation of beneficiaries are all key to upholding the ‘Do No Harm’ principle. These are also key elements of the Agency’s Protection Policy (2012) and minimum protection standards.

(IV). Build on available resources and capacities: UNRWA recognizes the strengths and capacities of Palestine refugee communities. To facilitate this, UNRWA will seek to work with Palestine refugees to support self-help and resilience.

(V). Resilience: Some MHPSS needs can be effectively addressed by supporting Palestine refugees to build their own resilience – that is their ability to adapt to change, cope with difficult life situations and maintain a positive outlook for the future. The resilience of Palestine refugees can be further built through strengthening protective factors (external factors that support psychosocial well-being) and promoting positive coping mechanisms (behavioural and psychological strategies that help the individual to master, cope with, reduce, or bear stressful and difficult situations). UNRWA is unable to prevent conflict and instability, eliminate protection threats (though some can be mitigated), or remove sources of mental health or psychosocial harm. However, the Agency is in a unique position to provide an enabling environment for the development of protective factors and positive coping mechanisms. UNRWA can help build resilience through strategies that include:

- Directly addressing the sources of distress in the community, through consultation and needs-led programming (such as the lack of hygienic and liveable spaces, unemployment, and gender-based violence);
- Providing inclusive education practices and policies within an environment that promotes the rights and well-being of all children on a day-to-day basis;
- Further developing the knowledge base and protective factors of the community to stressors in their environment, taking into account life-cycle stages;
- Enhancing psychosocial well-being, coping and resiliency through parent education, family and community interventions;
- Focusing on early assessment, prevention and mitigation of protection risks affecting vulnerable groups, including women (with a special emphasis on those who are pregnant or new mothers), children, older persons, persons with disabilities and/or those with chronic medical conditions.

(VI). Integrated support systems: MHPSS activities and interventions will be integrated within core UNRWA programmes, including education, health and RSS, and protection response. Each of these programmes will develop a minimum response through which it can support Palestine refugee children and adults experiencing mental health or psychosocial issues. This will also provide for more sustainable support for Palestine refugees.

(VII). Sustainability: A sustainable approach ensures that UNRWA does not create services (or dependence on services) that are separate to the delivery of regular programming. By integrating MHPSS principles and
practices within its core programmes, UNRWA will ensure a sustainable minimum response in line with IASC standards. To this end, UNRWA will not provide highly specialized psychiatric and other allied health services for the community in the long-term as part of its programmes. Such an approach would be unsustainable given the financial and technical capacity of the Agency. Instead, UNRWA will seek to establish and maintain referral linkages to external partner agencies when these exist to ensure Palestine refugees have access to the MHPSS they require.

21. The mainstreaming of MHPSS into core programmes will reduce the extent to which MHPSS is reliant on finite external project funding. Emphasis will be placed on staff training and capacity-building, which will help ensure the development and implementation of low-cost and efficient MHPSS delivery models.

**Multilayered Approach**

22. UNRWA recognizes the continuum of mental health and psychosocial difficulties; people are affected in different ways and require different support. The IASC Guidelines recognizes four layers of complementary MHPSS support (Figure 1). These are intended to provide a holistic approach to the provision of MHPSS to a population. As such, the MHPSS Framework is also based on a multilayered system of services that integrates MHPSS principles and practices into programmes in order that Palestine refugees: (1) receive basic services in a dignified and respectful manner, one which reinforces their sense of dignity and well-being; (2) are provided with opportunities to learn and strengthen positive coping mechanisms, be these as individuals, parents or community members; (3) have access to individual or group non-specialized services should they experience significant distress or coping difficulties; and (4) have access to specialized services should they experience more acute mental health difficulties.

23. UNRWA places significant importance on prevention and promotion activities, with the objective of enhancing the ability of individual Palestine refugees, families and communities to resist and positively cope with stressors of all kinds. However, UNRWA also recognizes that some refugees will require more structured support. Where possible, UNRWA will seek to provide focused, non-specialized support by trained and supervised staff. This may include basic counselling and support to protection cases, including cases of violence, abuse, neglect and exploitation, such as gender-based violence (GBV) and child protection concerns. UNRWA will also seek to ensure that Palestine refugees have access to specialized services should their needs exceed the capacities of UNRWA services, this being through referrals whenever possible to external partners.
Basic services and security: UNRWA will deliver its relief and social services, shelter assistance, health care and basic education in a way that promotes and enhances psychosocial well-being and resilience, protects the rights of refugees, strengthens local sources of support, and engages community networks. In this respect, considerable work has already been accomplished by the education programme, notably through the implementation of systematic inclusive education, which aims to ensure that the well-being of all children in UNRWA schools is promoted and their diverse needs are met, whether these be learning, health or psychosocial needs, and that those children with additional or extensive needs, including psychosocial needs, are identified and supported. The health programme has similarly sought to ensure that physicians, nurses and other health care staff are able to identify and support individuals with mental health needs, through the WHO Mental Health Gap Action Programme (mhGAP) and stepped-care model. The health programme’s MHPSS Technical Instructions set out its approach in this regard.

UNRWA will also continue to ensure that its services are delivered in a dignified and supportive manner. To this end, programme initiatives provided by the Agency should be established in participatory, safe and socially appropriate ways. When appropriate and relevant, UNRWA can train its front-line staff in Psychological First Aid to ensure that they are equipped to provide basic psychosocial support to individuals and families who have been exposed to highly distressing events.

Community and family support: The second layer of the MHPSS structure is aimed at assisting children or adults who are otherwise able to maintain their mental health and psychosocial well-being if they receive help in accessing key community and family support. In a number of UNRWA fields of operations, the refugee experience is often characterized by displacement or the threat of disruption to family and community networks, fear, and a lack of safety. Rather than focusing exclusively on individual counselling, the psychosocial well-being of these refugees can be reinforced by strengthening community and social support structures and self-help mechanisms. This can include information on self-help, psychoeducation sessions on positive coping methods, supportive parenting programmes and the activation of social networks, such as through women’s groups and youth clubs.

Focused, non-specialized support: The third layer of intervention represents the support necessary for a smaller number of children and adults who additionally require a more focused individual, family or group response. These interventions are typically provided by trained and supervised staff, such as counsellors or social workers. In schools, for example, this may include individual or group counselling for children who have been exposed to violence or protection threats. This may also take the form of specifically designed ‘groups’ to assist children who may be experiencing sleep problems or other intrusive symptoms. In health clinics, patients suffering from non-communicable diseases can foreseeably be supported through targeted groups that reinforce positive coping and health lifestyles. Focused, non-specialized support may also take the form of a combination of legal and psychosocial counselling for survivors of GBV and child protection cases.

Specialized services: Specialized services are intended for a small percentage of the population that may suffer from mental health difficulties and/or difficulties in their basic daily functioning. While UNRWA is not in a position to directly provide specialized services – such as psychiatric assessments and care, including most forms of psychotherapy – all efforts should be made to ensure that these persons have access to appropriate services whenever possible. To this end, while trained UNRWA staff may provide support to MHPSS cases that require mild to moderate support through focused non-specialized interventions, more severe cases will be referred for external psychological or psychiatric support by partners.
Prevention/Promotion, Assessment, Intervention and Referral (PAIR) Model

24. In addition to being guided by international guidelines, UNRWA will use a four-stage model that outlines the process by which services should be developed and provided to meet the MHPSS needs of individuals, families and communities. The PAIR model unpacked is: (1) Prevention/Promotion: Provision of activities that promote the overall well-being of individuals, families and communities and help foster adapted coping mechanisms and resilience; (2) Assessment: Ensuring that the psychosocial needs of individuals and families can be identified and understood through a tiered assessment system; (3) Interventions and evaluation: To develop a range of interventions in keeping with the IASC MHPSS pyramid to address the psychosocial needs of individuals, families and communities; and (4) Referral: Referral on to other professionals or agencies internally and/or externally to ensure that holistic needs are met, including access to specialized mental health services and protection services not provided by UNRWA.

25. The PAIR model is consistent with, and allows for, the application of international guidelines and practices (including the IASC Guidelines and the mhGAP approach). A more detailed description of the PAIR model as applied in UNRWA is provided in Annex 4.

Staff Safety, Well-Being and Self-Care

26. UNRWA recognizes the importance of staff safety, well-being and self-care. In order to provide safe, effective services that support psychosocial well-being and help prevent mental distress of Palestine refugees, staff need to have an enabling environment and access to sufficient support within the Agency.

27. In all field offices, UNRWA staff have been exposed to incidents of violence, which is a safety and security of staff issue under the responsibility of the Department of Security and Risk Management. Many staff are required to provide services in conflict zones, often at direct risk to themselves. In response, UNRWA is committed to establishing and maintaining basic self-care practices for its staff. This is not only essential for the well-being of the staff themselves; it is also essential for the ability of staff to deliver services and to be able to provide MHPSS to Palestine refugees through their work.

28. The importance of ensuring that the psychosocial needs of staff are met has been recognized in some field and programme initiatives. For example, within the education programme, the needs of staff have been emphasised in its document ‘Psychosocial Support for UNRWA Schools: A Conceptual Framework’. At the field level, the Gaza Community Mental Health Programme (CMHP) has elaborated a multidimensional commitment to staff care.

It will be important to ensure that these practices are systematized throughout the Agency.

29. Within UNRWA, the responsibility for promoting an Agency-wide culture of staff well-being falls within the remit of the Human Resources Department. As such, the MHPSS Framework is of significance to human resource and administrative departments who should be working to enhance the development of policies and strategies that strengthen support to all UNRWA staff.

Capacity Development

30. While recognizing that staff have capacity built through programmes, specific capacity-building and training will be required in order that the principles and practices of the MHPSS Framework are consistently implemented across all fields of operations. This training should be based on practices that are congruent with the MHPSS Framework and be facilitative to the core MHPSS interventions embedded within programmes. While it is noted that trainings will need to be integrated into existing programme approaches and tailored to the requirements of different staff roles and competencies, they should be complemented by adequate supervision. The following elements can be considered among the basic requirements for MHPSS capacity development:

- Basic and advanced identification, detection and assessment skills;
- Community and parent-education skills (for example, stress management, helping children cope with stress, etc.);
- Psychological First Aid (PFA);
- Ethics and professional behaviour (for example, ‘Do No Harm’, confidentiality, etc.);
- Protection, child protection, disability inclusion and GBV;
- Focused, non-specialized interventions, such as basic counselling (individual and group);
- Case management and internal and external referrals; and
- Staff well-being and self-care.

31. This training should take into account the work carried out to date by programmes, such as the Education Reform with its overall support and professional development tools to support teachers and school principals. It should also build on resources that have already been developed within fields, which might be readily compiled to serve as a foundation for future trainings. As an initial step, the Agency will undertake a comprehensive exercise to: (1) identify common programming and training requirements; (2) compile and review existing training materials relating to MHPSS competencies and better
practices; and (3) should new training materials be required, identify possible sources of support. This mapping exercise should also take into consideration how protection and other cross-cutting issues can be integrated into relevant trainings.

32. Training support provided by the Agency will be based on a collaboratively developed training plan. Core elements of the training plan may: (1) include toolkits and methodologies based on MHPSS standards and best global practices (internationally validated training modules) made available for front-line staff; and (2) adopt a Training of Trainers (ToT) approach, utilizing the capacity of UNRWA staff. All training must be practical and useful to front-line staff. MHPSS trainings must also be implemented in accordance with a realistic timeline so as to not overburden staff, while also allowing for proper supervision and support.

33. The issue of staff training is one of the key areas where the Agency will seek strategic partnerships with other organizations and where project support will also be sought from donors.

### MHPSS in Emergencies

34. Given the recent conflicts and emergencies that have characterized a number of UNRWA fields of operations, the Agency will aim to develop a specific approach to addressing MHPSS in emergencies. This approach will be integrated in the UNRWA Emergency Management Framework that is currently being developed and be consistent with the Agency’s regular MHPSS programming, but will scale up to meet the psychosocial needs of Palestine refugees in emergencies, particularly of those with additional or extensive psychosocial needs. Implementation of this MHPSS component of the UNRWA Emergency Management Framework will require extensive collaboration between the UNRWA programmes, as no one programme will likely have the capacity to provide an adequate MHPSS response in times of emergency.

35. The UNRWA emergency response on MHPSS will remain consistent with the IASC Guidelines. To this end, UNRWA will maintain a focus on prevention/promotion, to reinforce positive coping mechanisms while also working to strengthen social and community support. This will be complemented with focused, non-specialized interventions for children and adults who have experienced greater levels of distress. For example, increased attention may be given to children and parents, with particular focus on helping them to re-establish a sense of routine and stability. Similarly, psychoeducation sessions may assume a greater focus on understanding acute (rather than general or chronic) stress, with particular emphasis on positive coping mechanisms and stress management. However, UNRWA will not seek to develop or implement specialized interventions that are not in line with its general MHPSS programming principles.

36. In line with the Agency’s ‘Do No Harm’ approach and international standards, UNRWA will ensure that its interventions are evidence-based and reflect global best practices. Should the emergency require additional MHPSS support, the responding UNRWA staff will receive the requisite training and supervision. The Agency may also engage with partners on the ground who have the capacity to deliver appropriate training.

37. As part of the implementation of the MHPSS Framework, the Agency and fields will ensure that consideration is given to MHPSS principles and practices and that basic guidelines are embedded within preparedness and response plans for emergencies where they do not already exist. Annex 5 presents an example of further areas for consideration.

### Strategic Partnerships

38. UNRWA will seek partnerships on both an operational and technical level with organizations that can enhance the MHPSS Framework vision and implementation. These partnerships are considered critical in not only enhancing the quality of UNRWA MHPSS interventions, but also in extending the availability of MHPSS to Palestine refugees.

39. The Agency, based upon the outline for MHPSS elaborated above, will seek to develop partnerships with the following aims: (1) strengthening the capacity of staff to carry out MHPSS interventions, both in terms of prevention and promotion but also for focused and non-specialized interventions; (2) produce research on the mental and psychosocial well-being of Palestine refugees, including those affected by conflict and occupation; (3) develop and maintain referral pathways with quality external specialized service providers; and (4) develop referral linkages for services to help promote staff self-care and well-being.

### Coordination

40. This section sets out coordination requirements that will facilitate the implementation of the MHPSS Framework. This includes the need for coordination: (1) between Headquarters (HQ) and each of the five field offices; and (2) between the programmes at both HQ and within the fields. Giving the cross-cutting and cross-programmatic nature of MHPSS, the coordination structures on MHPSS are critical. An overview and description of the key roles and responsibilities within the coordination structures is outlined in Annex 6.

41. The first coordination requirement, in ensuring the implementation of the MHPSS Framework across the Agency, is coordination between HQ and the five field offices and having a clear technical lead for this at HQ. This function will sit within the Protection Division.

42. An Advisory Committee will be established to ensure coordination of the implementation of the MHPSS,
including planning, technical support and programming across relevant departments and field offices. The Advisory Committee will be comprised of relevant programme department directors (or designates with appropriate technical competencies) who are involved in MHPSS initiatives. Its goal will be to ensure that MHPSS principles and interventions are developed and integrated within the core programmes of education, health, and relief and social services. As the HQ technical lead, the Protection Division will coordinate and support the functioning of this Advisory Committee.

43. At the strategic level, the Advisory Committee, in liaison with the field offices, will ensure agreement on critical issues affecting the Agency’s approach to MHPSS. The foremost among this is the agreement on the implementation of the MHPSS Framework itself. It is envisioned that the Advisory Committee will consult with fields on issues such as MHPSS staff competencies, training priorities and core common interventions. This is with the understanding that there are programme and field specificities that will need to be taken into account. For example, fields of operations differ in terms of context (ranging from stability in Jordan to the occupation in the occupied Palestinian territory and the ongoing conflict in Syria). Fields also differ in terms of available project funds, numbers of counsellors and other MHPSS-related staff, and training capacities. However, this should not prevent agreement of key MHPSS principles and better practices that are common across the Agency.

44. The Departments of Education, Health and RSS and the Protection Division at Headquarters are effectively placed to support the integration of MHPSS principles and practices within their respective programmes at the field level. In education, for example, MHPSS principles are strongly reflected within its overall approach, policies and non-explicitly in the inclusive Education Policy, as well as within the Education in Emergencies (EiE) initiative. In health, a pilot involving a stepped-care model of MHPSS utilizing the WHO mhGAP approach has been implemented in Gaza, which is intended to ensure the integration of specific psychological and social considerations into health programming.

45. In relation to the above, it is understood that HQ programme departments will work closely with their respective field counterparts to develop required interventions, standard operating procedures (SOPs), training requirements, etc., based on the principles outlined within the MHPSS Framework. To achieve this, the programme departments will need to establish a technical (MHPSS) focal point with such know-how. On a practical basis, it is this technical focal point who will provide technical and organizational support to each programme (vertically) at the field level. This will be overseen by the Advisory Committee, who will work to ensure cohesion of efforts and compliance with the agreed-upon principles outlined within the MHPSS Framework. This mechanism, which is consistent with UNRWA practices, will also ensure consistency both across and within fields (noting that the established practices will need to have been agreed upon both at HQ and between fields prior to being developed and implemented).

46. To facilitate this process, HQ will require additional support to coordinate and facilitate MHPSS coordination across the Agency. This will be undertaken by an MHPSS Coordinator in the Protection Division at HQ with a strong background and expertise in MHPSS to support the different programmes and coordinate a common approach as per the MHPSS Framework. In addition to coordination, it is envisioned that this post will be critical in supporting the formulation and development of MHPSS policies, guidelines and good practice documents jointly identified by HQ programme departments and field offices. This post will also work closely with and support the Advisory Committee to develop relevant guidance, collate reporting across fields, and facilitate fundraising for/with programmes as required.

47. At the field-office level, the Field Director holds overall responsibility and accountability for ensuring that the MHPSS Framework is implemented. The Field Director shall appoint a field MHPSS Coordinator who would be best vested in the Deputy Director (Programmes) who, in most cases, can rely on the Field Programme Support Office or another office to follow up on ensuring the elements of the MHPSS Framework are in place and should ensure linkages with the HQ MHPSS Coordinator.

48. MHPSS Coordinators at the field-office level have the responsibility for ensuring that field-level programme staff establish the necessary linkages, harmonization and referral pathways with protection case management and referral systems. While the implementation of the MHPSS Framework will be driven by the programmes themselves, this should be based on policies and practices collaboratively developed with HQ to maintain coherence across the Agency. Relevant issues include, but are not necessarily limited to, ensuring the inclusion of protection principles and practices, facilitating internal referrals between programmes, establishing (when possible) external referral networks to be accessed by all programmes, representation at MHPSS working groups and clusters, and coordinating field policy and reporting.

49. It is also recognized that the implementation of the MHPSS Framework will not be limited to integrating principles and practices into the core programmes. UNRWA field offices currently have a number of ongoing projects and initiatives that support the mental health and psychosocial well-being of Palestine refugees. It is also recognized that fields differ in their capacity to integrate MHPSS interventions and practices. For example, whereas Gaza currently has over 350 staff within the CMHP and the West Bank has almost 140 counsellors across the three programmes, the
numbers are significantly lower in Lebanon, Jordan and Syria.

50. The MHPSS Framework is not intended to undermine field office projects or initiatives. Rather, it is intended to: (1) ensure that fields have the maximum impact through their alignment with the MHPSS Framework; (2) ensure that all Palestine refugees have access to a minimum level of MHPSS, regardless of their field of residence; (3) set out common principles and concepts that will guide the development of MHPSS interventions; (4) align UNRWA mental health and psychosocial programming to global MHPSS guidelines and standards; (5) identify common priorities that require development of guidance and good practice interventions; and (6) avoid duplication or inconsistency in future MHPSS initiatives.

Resourcing

51. The implementation of the MHPSS Framework will use existing funds, where possible. To this end, the Agency will seek to ensure a minimum response – as defined by the IASC Guidelines – in supporting the mental health and psychosocial well-being of Palestine refugees. To achieve this, UNRWA will seek to implement the MHPSS Framework through its core programmes. This does not mean that UNRWA will not seek project or emergency funds to address the mental health and psychosocial needs of Palestine refugees, especially in areas of conflict and severe living conditions. However, funding should be used to put an integrated and sustained approach in place.

52. The UNRWA Programme Budget is primarily funded by United Nations Member States and other donors voluntarily on an annual basis. The Budget funds the Agency’s core activities (including recurrent staff and non-staff costs). Project funding and Emergency Appeals, on the other hand, constitute the Agency’s non-core costs. This includes, for example, response activities, such as building facilities and reform-related activities. UNRWA is aware of the possible inherent, long-term financial risks associated with certain projects and, to this end, has a project prioritization process that views the sustainability and impact on recurring costs in the Programme Budget as one of the key factors in deciding which projects the Agency should embark on. In the context of MHPSS, project funding will be vital for the initial establishment of MHPSS systems, structures and procedures and for capacity-building of front-line staff, but all the while maintaining a vision of sustainability.

53. Project funding comprises voluntary earmarked contributions for specific, time-bound activities, with a view to improving services without increasing recurrent core costs. This includes, for example, response activities, such as building facilities and reform-related activities. UNRWA Emergency Appeals raise earmarked and un-earmarked funds from voluntary contributions in response to humanitarian crises created by external factors. This assistance is often available for as long as the external conditions prevail, although amounts generally decrease over time. This funding portal will provide funding for the full cost of focused MHPSS-prevention activities that are deemed necessary following a crisis. UNRWA Emergency Appeals may also be used for the direct costs of responding to increased MHPSS needs resulting from a humanitarian crisis.

54. In implementing the MHPSS Framework, attention will be given to utilizing available funding to develop practices, guidelines and trainings that can be shared and implemented between fields. This will not only avoid duplication of efforts, but will ensure greater consistency in the application and implementation of MHPSS programming across the fields. As such, the MHPSS Framework also seeks to ensure commitment between departments and fields to identify and work towards common MHPSS programming priorities, regardless of funding streams and field of implementation.

4. conclusion

56. Palestine refugees are facing increasing mental health and psychosocial issues because of a variety of factors. As a result MHPSS is becoming a critical service provided by UNRWA with all field offices and programmes involved. Building on the experiences to date this (first-ever) MHPSS Framework for UNRWA aims to bring a more coherent and consistent approach to MHPSS interventions across the Agency as defined in the MTS and in accordance with international standards in this area. Through the implementation of this MHPSS Framework, UNRWA will further strengthen its response to protect and improve the mental health and psychosocial well-being of Palestine refugees.
### Strategic Outcomes and Relevance to MHPSS

<table>
<thead>
<tr>
<th>Strategic Outcomes</th>
<th>Relevance to MHPSS</th>
</tr>
</thead>
</table>
| **Strategic Outcome 1:** Refugees' rights under international law are protected and promoted. | • Ensure human rights are an integral part of the design, implementation, monitoring and evaluation of mental health and psychosocial programmes, especially for people identified to be at risk of protection threats. Protection and human rights training/awareness-raising will be included in psychosocial programmes.  
  • Promote inclusive and non-discriminatory service delivery; avoid unnecessary institutionalization of people with mental disorders; and respect freedom of thought, conscience and religion in mental health and psychosocial care.  
  • Include a focus on human rights and protection in the training of all front-line staff.  
  • Establish mechanisms for the monitoring and reporting of protection cases of violence, abuse, neglect and exploitation.  
  • Establish timely, effective and confidential referral systems across fields to address protection issues identified by MHPSS personnel and vice versa.  
  • Help recipients of mental health and psychosocial support to understand their rights and entitlements.  
  • Ensure respect at all times for the right of survivors to confidentiality and to informed consent, including the right to refuse treatment.  
  • Protect survivors of human rights violations from the risk of stigmatization by including them in broader programming. |
| **Strategic Outcome 2:** Refugees' health is protected and the disease burden is reduced. | • Strengthening clients' social and relational competencies in addition to their understanding of mental and psychosocial well-being.  
  • Strengthening clients’ capacities to understand mental and psychosocial well-being and the associated determinants.  
  • Assessing psychosocial and mental health needs, intervening where possible and referring to other service providers when necessary.  
  • Aligning MHPSS promotion and prevention, assessment, response and referral through the health, education and RSS programmes, in addition to protection. |
| **Strategic Outcome 3:** School-aged children complete quality, equitable and inclusive basic education. | • Overall education and development of the school system as a whole to promote psychosocial well-being and support.  
  • Ensuring an enabling school environment to support children's overall education and social development.  
  • Enhance the role of the school counsellor in providing psychosocial support.  
  • Building the capacity of the school system to prevent, assess, respond and, where possible, refer children that require highly specialized treatment. |
| **Strategic Outcome 4:** Refugee capabilities strengthened for increased livelihood opportunities. | • Strengthening the social and relational competencies of vulnerable families in addition to their understanding of mental and psychosocial well-being.  
  • Reducing the barrier of poor mental health and psychosocial well-being to accessing increased livelihood opportunities.  
  • Developing and enhancing the role of social workers to provide not only relief, but social services that empower the marginalised.  
  • Building the capacity of the RSS programme to prevent, assess and respond, where possible, refer individuals that require highly specialized treatment. |
| **Strategic Outcome 5:** Refugees are able to meet their basic needs of nutrition, shelter and environmental health. | • Strengthening the resilience of families by reducing environmental health drivers of poor mental and psychosocial well-being.  
  • Providing the enabling environment for the health, education and RSS programmes to deliver focused and specialized support.  
  • Supporting individuals/families in their social and relational competencies. |
annex 2: snapshot of mhpss-dedicated staff across fields and programmes

<table>
<thead>
<tr>
<th></th>
<th>Education</th>
<th>RSS</th>
<th>Health</th>
<th>CMHP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Programme</strong></td>
<td><strong>Budget</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Funding Source</strong></td>
<td><strong>GFO</strong></td>
<td><strong>WBFO</strong></td>
<td><strong>JFO</strong></td>
<td><strong>LFO</strong></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Budget</strong></td>
<td>18 school counsellors</td>
<td>78 school counsellors</td>
<td>18 school counsellors</td>
<td>7 school counsellors</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Potential increase by a further 31 using 5 non-teaching periods</td>
<td>Potential increase by a further 11 using 5 non-teaching periods</td>
</tr>
<tr>
<td><strong>Projects</strong></td>
<td>3 mental health supervisors*</td>
<td>3 RSS supervisors</td>
<td>4 school counsellors</td>
<td>18 school counsellors</td>
</tr>
<tr>
<td></td>
<td>7 assistant mental health supervisors*</td>
<td>30 CMHP counsellors working in community-based organizations</td>
<td></td>
<td>3 additional teacher/counsellors for Palestinian refugees from Syria (PRS) and Palestine refugees in Lebanon (PRU) (Project: GIZ)</td>
</tr>
<tr>
<td></td>
<td>207 school counsellors*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>* (Project funded - CMHP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RSS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Programme</strong></td>
<td><strong>Budget</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Budget</strong></td>
<td>3 supervisors</td>
<td>30 CMHP counsellors working in community-based organizations</td>
<td>14 mobile psychosocial support (PSS) counsellors (supervised by Health/RSS)</td>
<td>24 PSS counsellors in health centres*</td>
</tr>
<tr>
<td><strong>Projects</strong></td>
<td>24 PSS counsellors in health centres*</td>
<td></td>
<td></td>
<td>1 CMHP programme manager Support staff:</td>
</tr>
<tr>
<td></td>
<td>2 Assistant MH supervisors*</td>
<td></td>
<td></td>
<td>1 technical adviser</td>
</tr>
<tr>
<td></td>
<td>5 legal counsellors*</td>
<td></td>
<td></td>
<td>2 family and child protection case managers</td>
</tr>
<tr>
<td></td>
<td>* (Project funded - CMHP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Programme</strong></td>
<td><strong>Budget</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Budget</strong></td>
<td>3 supervisors</td>
<td>21 PSS counsellors in health clinics</td>
<td>24 PSS counsellors in health centres*</td>
<td>1 head of CMHP</td>
</tr>
<tr>
<td><strong>Projects</strong></td>
<td>2 Assistant MH supervisors*</td>
<td>1 CMHP programme manager Support staff:</td>
<td>1 technical adviser</td>
<td>1 head of CMHP</td>
</tr>
<tr>
<td></td>
<td>5 legal counsellors*</td>
<td>1 technical adviser</td>
<td>2 family and child protection case managers</td>
<td>1 senior MHPSS specialist (Of the counsellors within health and education approx. 181 counsellors are fixed-term and 53 counsellors are limited duration contract)</td>
</tr>
<tr>
<td></td>
<td>* (Project funded - CMHP)</td>
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<td></td>
</tr>
<tr>
<td><strong>CMHP</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Projects</strong></td>
<td>1 head of CMHP</td>
<td>1 CMHP programme manager Support staff:</td>
<td>1 technical adviser</td>
<td>1 head of CMHP</td>
</tr>
<tr>
<td></td>
<td>1 senior MHPSS specialist</td>
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</tr>
</tbody>
</table>

* (Project funded - CMHP)
## Annex 3: MHPSS SWOT - Strengths, Weaknesses, Opportunities and Threats

### Strengths

- Ongoing Gaza Field Office and West Bank Field Office experience in delivering MHPSS
- West Bank Field Office experience programme-funded, with an intersectoral approach
- Lebanon Field Office with recent experience on integrating MHPSS within programmes and significant external project support
- Ongoing health and education reforms complementary to MHPSS development, including UNRWA ‘Psychosocial Support for UNRWA Schools: A Conceptual Framework’ already endorsed and in place
- Donor support to MHPSS Framework development process and interest in investing in Jordan Field Office
- Staff support and motivation to address this area of need
- Good field and regional networks and knowledge of available resources
- Community trust in the Agency’s ability to deliver quality services
- EiE work and its emphasis on psychosocial well-being and support

### Weaknesses

- Programme Budget crisis and reform fatigue
- Large proportion of Palestine refugees living in conditions that are not conducive to well-being (conflict, occupation, poor housing, unemployment)
- Insufficient outreach and communication to community on MHPSS and potential stigma issues associated with this area of programming
- Variable MHPSS capacity across fields
- Variable integration of project inputs into programmes
- Unclear roles and responsibilities of staff, in addition to high workload and training fatigue
- Lack of coordination between programmes
- Variable private space for counselling across programmes
- Weak information management and referral capabilities
- Limited capacity to provide highly specialized services with the Agency
- Lack of coordination between fields and HQ Amman

### Opportunities

- Potential partnership with the United Nations Children’s Fund (UNICEF) on MHPSS delivery, research and advocacy
- Increased global focus on MHPSS as part of regular and emergency programming
- Ability to use trained staff to train others within the Agency in a ToT approach
- More innovative ways of engaging with the Palestine refugee community, including their participation in programme design and delivery
- MHPSS Framework development will clearly articulate shared system concept to be developed/aligned across fields

### Threats

- Potential for medicalization in lieu of appropriate guidelines and supervision
- Need for cross-sectorial approach with limited resources
- Overburdening staff and burnout potential
- Lack of sufficient supervision to staff
- Lack of research and understanding of impact of MHPSS
- Perception of MHPSS as peripheral to other basic needs
- Potential increased consumption of psychotropic medications
**annex 4: prevention/promotion, assessment, intervention and referral (pair) model in unrwa**

**Prevention/Promotion:** UNRWA programmes aim to develop the resilience of Palestine refugees to better cope with the difficult circumstances in which they live. First and foremost, this should be achieved through the promotion of life skills and positive coping mechanisms, as well as the prevention of unhealthy or unsafe behaviours that undermine psychosocial well-being. It can also be addressed by strengthening protective factors and reducing and mitigating protection threats such as violence, abuse, neglect and exploitation that give rise to MHPSS needs.

The education programme takes an inclusive, holistic and rights-based approach that emphasizes the psychosocial well-being of all children, with schools providing an environment that positively fosters their social, emotional and intellectual development. The education programme’s holistic and rights-based approach allows children to achieve a sense of empowerment and basic social capacities. By focusing on general prevention/promotion activities, teachers can not only begin to address the mental and psychosocial difficulties of a child, but also reinforce positive coping, life skills and resilience.

The health programme emphasizes the importance of prevention, early detection and education in improving the overall health of Palestine refugees. By including MHPSS within health education, for example, the health programme can identify new students who may require additional support at an early age. With the introduction of the MHPSS stepped-care model and the WHO mhGAP, the health programme is also enhancing the capacity of physicians, nurses, midwives and other staff to identify and support patients experiencing mental health and psychosocial difficulties. Key components of this initiative are community awareness and adult education with the aim of enhancing coping and positive lifestyles.

The RSS programme is currently engaged in a reform process that seeks to provide a renewed approach to social work, linking this more clearly to livelihoods and the provision of psychosocial support. Social workers have direct contact with families, which provides a unique opportunity to detect and support family members experiencing difficulties. Social workers engage with many families who live in poverty and, as a result, often experience adverse effects to their mental and psychosocial well-being. For this reason, social workers are uniquely placed to address MHPSS needs at the family, camp and community levels.

The Agency’s protection work is also a key part of the overall general prevention/promotion approach to MHPSS. Protection threats such as GBV; child protection concerns; and other forms of violence, abuse, neglect and exploitation may be acutely distressing and have long-term MHPSS effects. MHPSS considerations are therefore a key part of both protection case identification and response. Prevention/promotion is also an integral part of the Agency’s approach to address the root causes of protection threats to reduce their occurrence in the first place.

**Assessments:** In the delivery of general prevention/promotion activities, trained and supervised staff may identify persons with more pronounced mental health or psychosocial difficulties. In such cases, a basic assessment may be used to identify persons who may benefit from focused, non-specialized interventions (for example, supportive counselling). A basic assessment is not a diagnostic tool, but rather is intended to identify common signs and causes of psychological and social distress, with the aim of determining severity and an appropriate course of intervention. This initial assessment is also important in identifying children and adults who may require more specialized support or treatment. There are a number of different tools for assessing mental and psychosocial well-being. For instance, the education programme has developed a toolkit used to guide teachers in identifying and responding to diverse needs of students with psychosocial needs.

In some cases, a more detailed or specialized assessment may be warranted. For example, a medical officer may conduct a mental health assessment in order to make a preliminary diagnosis, prescribe medications, or refer to an outside agency for specialized treatment. The use of specialized psychosocial and mental health assessment tools in UNRWA is currently limited. As part of the MHPSS Framework implementation, the use of these tools should be guided by a number of key considerations: (1) identification of appropriate assessments; (2) identification of staff who may conduct these respective assessments; and (3) training and supervision requirements.

**Interventions:** The primary MHPSS intervention to support children and adults requiring additional support will be focused, non-specialized interventions. These interventions are generally used to address more common emotional, behavioural or social difficulties. Examples of focus, non-specialized interventions include individual and group counselling, including groups that target specific difficulties (for example, stress-related problems, sleep difficulties,
ineffective coping among adults). These interventions should be conducted by qualified and trained UNRWA front-line staff, with assistance from internal programme mechanisms for supervision. Referrals (both internal and external) are primarily triggered when extensive needs are not met and coordination and collaboration across programmes is required.

**Referrals:** As part of the MHPSS Framework, UNRWA will enhance its referral mechanisms both internally and externally with other agencies. In terms of internal referrals between programmes, this will ensure that children and adults are provided the fullest range of services available within UNRWA in a timely, coordinated and consistent manner. This may include, as examples, survivors of GBV who require legal or protection support not available within UNRWA, adults with significant mental health concerns that warrant a specialized assessment or children who are identified by teachers as in need of counselling.

An external referral may be required should a child or adult require specialized care that is beyond the scope of UNRWA services. These services may include but not be limited to specialized forms of therapy, psychiatric care, child protection and legal counselling for GBV survivors. Here, it is recognized that availability and access to external organizations will differ between fields. It is also recognized that while it is preferable to align UNRWA protocols with national systems of accreditation and service delivery standards when possible, this will also differ between fields. However, in order to maintain a degree of consistency across fields, the development of referral systems should be based on a number of common principles, with the understanding that these will need to be operationally defined. These include: (1) established SOPs with defined pathways and referral points to ensure coherence from point of assessment to the external referral; (2) identified criteria for vetting external agencies to ensure due diligence and quality of provided services; (3) the maintaining of confidentiality between agencies; and (4) follow-up and continuity of support.

The development of field office referral systems should be systematized through SOPs, considering issues of informed consent, confidentiality, and coordination with the referral source in order to facilitate continuity of care and support as required. Given the potential for overlap between the protection referral system and the referral system proposed under the MHPSS Framework, these mechanisms will be closely aligned and integrated where possible.
### Matrix of Interventions: Mental Health And Psychosocial Support in Emergency Settings (IASC Guidelines, pp. 20-29)

<table>
<thead>
<tr>
<th>Preparedness</th>
<th>Crisis</th>
<th>Response</th>
<th>Intermediate</th>
<th>Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.1 Establish coordination of intersectoral mental health and psychosocial support under one field-based coordination function/approach</td>
<td>2.1 Ensure a safe space through collective shelters in Agency facilities that take into consideration specific needs (such as children, single women, persons with disabilities and the elderly)</td>
<td>3.1 Facilitate conditions for community participation and ownership of emergency response in all sectors</td>
<td>5.1 Return to regular programming with additional focus on chronic consequences, trauma and depression</td>
</tr>
<tr>
<td></td>
<td>1.2 Regular basic assessment of mental health and psychosocial issues</td>
<td>2.2 Rapid needs assessments, including data on number of children, teachers and counsellors within a shelter/area</td>
<td>3.2 Facilitate conditions for general and focused prevention activities</td>
<td>5.2 Catch-up education</td>
</tr>
<tr>
<td></td>
<td>1.3 Application of a protection and human rights framework through mental health and psychosocial support</td>
<td>2.3 Ensure that there is at least one male and female staff member in shelters and health clinics</td>
<td>3.3 Provide evidence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.4 Identify and recruit MHPSS staff in programmes and ensure adequate training, including in emergency response (PFA as a basic standard)</td>
<td>2.4 Ensure that Agency staff offer PFA and other focused prevention approaches to people in acute distress after exposure to extreme stressors</td>
<td>3.4 Facilitate specific support for children and their caregivers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.5 Inclusive education</td>
<td>2.5 Continue education if possible</td>
<td>3.5 Strengthen access to safe and supportive education and recreational activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.6 Train teachers/facilitators/ counsellors on the implementation of structured psychosocial and recreational activities for children in safe spaces.</td>
<td>2.6 Ensure capacity to monitor and respond to protection concerns (such as GBV and child protection) as part of broader emergency response</td>
<td>3.6 Provide primary health care to account for increased general and focused prevention needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.7 Include specific social considerations (safe, dignified, culturally and socially appropriate assistance) in site planning and shelter provision, in a coordinated manner</td>
<td>3.7 Provide educational continuity and increased general and focused prevention activities</td>
<td>4.1 Facilitate community self-help and support and disseminate information about positive coping styles</td>
<td></td>
</tr>
</tbody>
</table>

*Note: GBV refers to gender-based violence.*
**Annex 6: Coordination Roles and Responsibilities**

The table below highlights the different coordination roles at HQ and field levels and their main responsibilities.

<table>
<thead>
<tr>
<th>Location</th>
<th>Title</th>
<th>Overview of function</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HQ</strong></td>
<td>Protection Division</td>
<td>• Responsible for Agency-wide implementation and integration of the MHPSS Framework</td>
</tr>
</tbody>
</table>
|                 | MHPSS Coordinator                               | • Facilitation of and support to Advisory Committee  
• Maintain vertical and horizontal communications  
• Keep programme directors and focal points abreast of Agency-wide developments  
• Formulation and development of MHPSS policies, guidelines and guidance documents  
• Technical advice to the Agency on MHPSS integration and initiatives  
• Advise on monitoring and evaluation of the MHPSS Framework  
• Collate reporting across fields offices on MHPSS  
• Support the Human Resources Department in the design and roll-out staff well-being care initiatives  
• Support fundraising with programmes as required  
• Support research and learning initiatives |
|                 | Programme directors                             | • Responsible for integration of MHPSS Framework within programme  
• Designation of HQ focal points/Advisory Committee member (if not self)                                                                                           |
|                 | HQ programme focal points                       | • Liaise with the field focal points and alternates for their respective programme  
• Keep the relevant HQ and field coordinators and alternates copied on appropriate correspondence to ensure they remain informed  
• Monitor and support MHPSS Framework integration into field operations |
| **Field**       | Field Director                                  | • Responsible for ensuring that the MHPSS Framework is actioned and implemented                                                                 |
|                 | MHPSS Field Coordinator (Deputy Director Programmes or designate) | • Keep the HQ Coordinator (and alternate) abreast of MHPSS initiatives in their field offices  
• Keep field programme focal points and alternates informed of Agency-wide MHPSS issues  
• Ensure coordination, consistency and coherence at the field level between focal points and programmes implementing MHPSS and protection initiatives.  
• Support to the field in developing and facilitating internal and external referrals between programmes  
• Representation on MHPSS working groups and clusters  
• Coordination of field policy and reporting  
• Inform the HQ MHPSS Coordinator and alternate of any changes to the focal points and alternates in their field |
|                 | MHPSS focal points (and alternate)              | • Disseminate MHPSS information and initiatives within programmes  
• Act as focal point within their programmes for MHPSS integration/initiatives  
• Participate in field-level MHPSS/protection coordination initiatives, such as development of internal and external referral networks  
• Keep their respective field coordinator informed of MHPSS-related activities in their programme  
• Keep the HQ Programme Focal Point informed of MHPSS-related activities in their field |
Approaches to Staff Care in International NGOs, Interhealth & People in Aid, 2009
Code of ethics, Training packages (Nurses, midwives, GPs) (Developed by GFO MHPSS mainstreaming process)
IASC, MHPSS Guidelines on planning, assessment and monitoring - Action sheets 2.1 and 2.2 of the IASC MHPSS Guidelines on planning, assessment and M&E cycles
Integrating Mental Health/PSS, Family and Child Protection Services in PHC, Department of Health
Mahoney, J (UNRWA) (2009), Mental health for Palestine Refugees UNRWA Programme Review, UNRWA, November 2009
PHC MH Guidelines (Simplified) – WB, Health Programme, Annex 4
Protection Audits of UNRWA Programmes
1. UNRWA (2009), *Mental Health for Palestine Refugees*, UNRWA Programme Review, p. 9
7. Allied health services: Distinct from nursing, medicine, pharmacy and the core functions of UNRWA primary health clinics. These are usually services that seek to restore and maintain optimal physical, sensory, psychological, cognitive and social functions.
8. Correct as of November 2016
9. Although there are variations between fields, front-line staff within programmes and protection units/Operations Support Office teams are to varying degrees responsible for identifying and supporting cases of GBV, child protection and a range of other protection-related cases.
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