ORIGINAL RESEARCH

Transitioning Mental Health & Psychosocial Support: From Short-Term Emergency to Sustainable Post-Disaster Development. Humanitarian Action Summit 2011

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Abbreviations:
IASC = Interagency Standing Committee
ICRC = International Committee of the Red Cross
ICVA = International Council of Voluntary Agencies
IFRC = International Federation of Red Cross and Red Crescent Societies
MHPSS = Mental Health and Psychosocial Support
NGO = non-government organization
OCHA = (United Nations) Office for the Coordination of Humanitarian Affairs
SCHR = Steering Committee for Humanitarian Response
WFP = World Food Program
WG = Working Group
WHO = World Health Organization
UNFPA = United Nations Population Fund
UNHCR = United Nations High Commissioner on Refugees
UNICEF = United Nations International Children and Education Fund
WHO = World Health Organization

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Abstract

Introduction: The Working Group (WG) on Mental Health and Psychosocial Support participated in its second Humanitarian Action Summit in 2011. This year, the WG chose to focus on a new goal: reviewing practice related to transitioning mental health and psychosocial support programs from the emergency phase to long-term development. The Working Group's findings draw on a review of relevant literature as well as case examples.

Objectives: The objective of the Working Group was to identify factors that promote or hinder the long term sustainability of emergency mental health and psychosocial interventions in crisis and conflict, and to provide recommendations for transitioning such programs from relief to development.

Methods: The Working Group (WG) conducted a review of relevant literature and collected case examples based on experiences and observations of working group members in implementing mental and psychosocial programming in the field. The WG focused on reviewing literature on mental health and psychosocial programs and interventions that were established in conflict, disaster, protracted crisis settings, or transition from acute phase to development phase. The WG utilized case examples from programs in Lebanon, the Gaza Strip, Sierra Leone, Aceh (Indonesia), Sri Lanka, and New Orleans (United States).

Results: The WG identified five key thematic areas that should be addressed in order to successfully transition lasting and effective mental health and psychosocial programs from emergency settings to the development phase. The five areas identified were as follows: Government and Policy, Human Resources and Training, Programming and Services, Research and Monitoring, and Finance.

Conclusions: The group identified several recommendations for each thematic area, which were generated from key lessons learned by working group members through implementing mental health and psychosocial support programs in a variety of settings, some successfully sustained and some that were not.

Background

Working Group Mandate and Goals

From its inception in 2008 part of the Harvard Humanitarian Initiative Humanitarian Action Summit, the mandate of the Working Group (WG) on Mental Health and Psychosocial Support has been to[1]: identify new and persistent field or policy-level challenges to humanitarian response; provide specific work products to advance policy and best practices; provide opportunities to present original work; and improve collaboration between operational and multilateral agencies, research institutions, and donor agencies. With this mandate in mind, the Working Group established several goals: (1) Build on and compliment the Interagency Standing Committee Guidelines on Mental health and Psychosocial Support (MHPSS) in Emergency Settings; (2) Address the gap between emergency MHPSS and the development of sustainable post-disaster/ post-conflict community mental health in the developing world; (3) Address the

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deficiency of evidence-based research on MHPSS interventions during complex emergencies by proposing ethical guidelines for research; (4) Devise concrete methods to address the absence of an evidence base to aid providers of mental health and psychosocial programs in moving forward with rational plans of intervention; (5) Propose guidelines for training mental health and psychosocial emergency practitioners; (6) Utilize future leaders, young academics and practitioners to contribute to innovative strategies for program development, research, and training.

In setting an agenda, the WG built on previous work and recommendations, such as the "IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings."[2] The Interagency Standing Committee (IASC) consists of the heads of UN agencies (OCHA, UNFPA, UNHCR, UNICEF, WFP, WHO), the World Bank, the Red Cross Movement (IFRC and ICRC), and three large NGO consortia covering hundreds of international NGOs (e.g., Interaction, ICVA, and SCHR). The IASC Guidelines, published in 2007, provide a "multisectoral, interagency framework that enables effective coordination, identifies useful practices and flags potentially harmful practices, and clarifies how different approaches to mental health and psychosocial support complement one another."[2] The Working Group sought to produce work that fills in gaps not discussed in detail in the IASC Guidelines regarding mental health and psychosocial interventions.

Membership

Members of the Working Group from 2008-2009 were encouraged to stay active with the 2010-2011 group. New members were drawn from personal recommendations from WG members and active participants from the 2009 Summit. The WG has been committed to maintaining a geographically diverse group consisting of both known and published authors and experienced humanitarian workers, and was equally committed to including representatives from low and middle income countries in group membership. To this end, the WG pooled personal financial resources to cover expenses for one or more low and middle-income WG members who did not otherwise have funding to attend the Summit.

Previous Process

At the 2009 summit, the WG focused on developing ethical guidelines to address the deficiency of evidence-based research on mental health and psychosocial support during complex emergencies (WG Goal 4). Through the comprehensive review of existing literature, the WG identified eight overarching themes for developing ethical guidelines[1]: (1) Identifying the purpose and benefits of research; (2) Ensuring validity of research across cultures; (3) Ensuring researcher neutrality; (4) Ensuring that research mitigates risks to beneficiaries and does no harm; (5) Ensuring confidentiality of information shared; (6) Understanding biases in selection of subjects and research topics; (7) Obtaining and maintaining adequate consent; (8) Exercising caution in dissemination of results.

As of the result of the work at the 2009 summit, the WG took the stance that the absence of relevant research on mental health and psychosocial support in emergency settings is unethical. Conducting research without ensuring appropriate services available to those researched is also unethical – in other words, *"No survey without service, no service without survey."*[1]

Objectives

Rationale and Objectives

The focus for the Working Group's work at the 2011 summit was developed as a hybrid of the WG's Goals two and three: How best to transition MHPSS programs from short-term emergency interventions to sustainable services and programs for the post-conflict/disaster development phase. For various reasons mental health and psychosocial programs do not fit naturally into a purely "relief context." The current global shortage in mental health human resources means that "most mental health services are already understaffed and high-income country medical career and work structures are not geared to support mental health services in humanitarian settings."[3] Additionally, short term relief interventions do not work well for mental health and psychosocial programming. Indeed, it has been pointed out that, the 2-week in-and-out model of short missions by high-income country specialists – possible for surgical interventions—cannot be applied in the area of mental health.[3] First, the recovery period for any patient with a mental health disorder is usually a minimum of six months, and in order to address the likelihood of relapse or provide treatment for those with severe disorders, a longer time period 18 months to 2 years is needed. The objectives of social interventions,[2] whether in transforming community attitudes toward marginalized groups, empowering groups of survivors, or changing educational practices in schools cannot be realized in weeks, or often even months.

Survivors of traumatic events, particularly children and adolescents, may need to revisit treatment at different times in their development. For example, survivors of childhood sexual abuse might need to renegotiate traumatic reminders and symptoms that may occur as they become sexually active and begin to make decisions about intimate relationships as a young adult. In this manner, responses to traumatic events and subsequent treatment must be seen as a process that unfolds over time at a different course and rate depending on a number of individual, cultural and contextual factors. Second, most of the work by expatriates is on-the-job training of local staff. Such training is labor intensive, time intensive, and does not contribute to sustainable clinical supervision structures.[3] MHPSS programmes therefore need a longer term approach from the outset. However funding streams usually differentiate between short and long term interventions, creating an artificial division between MHPSS programs in the emergency context, and those that focus on long-term development of services.[2]

Methods, Processes, Themes

In developing content for the 2011 Summit, the WG both reviewed relevant literature and developed case examples based on the experiences and observations of working group members in implementing mental and psychosocial programming in the field. Group members reviewed literature related to mental health in complex emergencies and humanitarian settings and the transition of mental health from the acute phase to the development phase in DRC, Liberia, Sierra Leone, and Haiti (search terms included: mental health, complex emergencies, humanitarian settings, transition, acute phase to development phase, in DRC, Liberia, Sierra Leone and/or Haiti). Articles were accessed online via PubMed and Google Scholar. Literature on existing school-based mental health interventions was also reviewed for applicability in transitioning to development (search terms included: children, war, conflict, emergency, refugee,

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developing country, mental health, school, education, school-based intervention, sustainable). Due to time constraints, these were not systematic reviews. Additionally, working group members took examples and experiences from their own fieldwork to develop case studies that considered the work in the context of long term development and sustainability. The WG also considered sustainability of training emergency workers (psychological first aid) and research. Case examples developed for the Summit examined mental health education and training, clinical mental health services, and community-based psychosocial programs in Lebanon, the Gaza Strip, Sierra Leone, Aceh (Indonesia), Sri Lanka, and New Orleans (United States). Unpublished working papers and notes compiled by WG members that were also taken into consideration included examples from Uganda, Haiti, and Kosovo as well. To facilitate collaboration from a variety of geographic locations, the WG communicated through an email listserv and bi-monthly conference call. Additionally, the WG utilized Basecamp, an online forum for sharing messages, submitting documents and written work product, and coordinating group work.

Findings and Recommendations

Key Terms

Definition of Mental Health and Psychosocial Support: The IASC guidelines define MHPSS interventions as, "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. Although the terms *mental health* and *psychosocial support* are closely related and overlap, for many aid workers they reflect different, yet complementary, approaches. Aid agencies outside the health sector tend to speak of *supporting psychosocial well-being*. Health sector agencies tend to speak of mental health, yet historically have also used the terms *psychosocial rehabilitation* and *psychosocial treatment* to describe non-biological interventions for people with mental disorders. Exact definitions of these terms vary between and within aid organisations, disciplines and countries."[2]

The Concept of a "Disaster": In 2009, the WG adapted the UN Office for the Coordination of Humanitarian Affairs (OCHA) definition of a *complex emergency*: a situation characterized by extensive violence and loss of life, massive displacement of people, widespread damage to societies and economies, the need for large-scale, multi-faceted humanitarian assistance, as well as obstructions to such assistance by political and military constraints including security risks for the relief workers themselves.[4] Disasters are not events in themselves but produced by the interaction between the events and the system's ability to cope. Humanitarian workers are most often asked to intervene in places where capacity is insufficient. As such, the WG suggests that the relevant question to ask at the outset of a disaster is "what is the deficit?" Specifically, after taking into consideration local strengths and available resources, what is the local deficit in material resources, skills and knowledge, and political will that inhibits residents' ability to cope with the effects of the disaster through both formal and informal systems, and how can humanitarian workers help those affected address it (K. Allden, MD, and L. Jones, OBE, MRCPsych, 2011 Humanitarian Action Summit presentation, March 2011)? Similarly, any assessment of potential sustainability for mental health services must also ask "what are the extant resources?" and how can external actors shore up rather than supplant these local systems of care.

Keys to Lasting and Effective MHPSS Services

Discussion of topics identified in the literature as relating to transition from the emergency phase to development, and further explored through the WG's numerous case examples, focused on five key themes that should be addressed in order to ensure effective and lasting mental health and psychosocial services. These five themes were: Government and Policy, Human Resources and Training/Supervision, Programming and Services, Research and Monitoring, and Financing of Programs (Chart 1).

While the discussion during the WG's sessions aimed to identify actions that would promote adequate long-term sustainability of programs, the WG initially opened discussion with a list of sometimes-common practice that may inhibit positive long-term benefits of mental health and psychosocial programs.[2]

Do NOTs

- Do not come in with pre-designed, culturally uninformed agendas and programs;
- Do not ignore existing government and non- government actors and systems;
- Do not ignore local capacity and experience;
- Do not parachute in with short-term interventions;
- Do not create stand-alone programs that drain staff and resources from existing services and cannot be integrated and sustained.

Taking into consideration the need for transitioning MHPSS programs from the emergency phase to development, and the challenges present in doing so, the Working Group highlighted the following recommendations, organized by thematic area:

Government and Policy

1) Is there an existing strategy, framework, or policy in place?

Prior to the development of new MHPSS services, it is essential to determine whether strategies, frameworks, or policies already exist in the affected country. For example, Sri Lanka had an existing template for an MHPSS policy, in the form of draft provincial mental health plans and practices by local psychiatrists, but which had not been capitalized on due to a lack of resources and political will at a policy level. The influx of funds and overwhelming stakeholder support for an urgent MHPSS response to the 2004 tsunami provided an opportunity for the aid community (e.g., WHO, NGOs, etc.) to partner with national government and formalize a mental health policy strongly influenced by existing frameworks (A. Galappatti, MSc, unpublished WG report, 2011; A. Galappatti, MSc, 2011 Humanitarian Action Summit presentation, March 2011). In the Occupied Palestinian Territory, there is a long history of joint efforts by the Ministry of Health (MoH), World Health Organization (WHO), and other stakeholders working to strengthen mental health policy. In 2004, the WHO, the MoH, and others in Gaza developed 5 year implementation objectives of the "Plan on the Organisation of Mental Health Services in the Occupied Palestinian Territories." The updated 2010 plan is currently being drafted and agreed on by both parties in power in Gaza and the West Bank (Hammas vs. Fatah). Gaza has recently established a new Directorate of mental health at the Ministry level (2004 Palestinian Mental

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Health Plan; cited in I. Weissbecker, PhD, MPH, unpublished WG report, 2011).

If there is no pre-existing policy, the role of humanitarian actors is to help create one (K. Johnson, MD, MPH, unpublished WG report, 2011; J. Nakku, MBChB, M.MED(Psychiatry), unpublished WG report, 2011).[3,5–9] A policy group or committee consisting of members from the government, NGOs, and CBOs who have been working in MHPSS during the acute phase can be formed to create, design, and develop policy based on their experience and expertise (K. Johnson, MD, MPH, unpublished WG report, 2011).[10] National and regional service provision leaders (e.g., in mental health and education) and relevant academic departments (e.g., psychiatry, psychology, and the broader social sciences) can also be engaged in the process of policy development (K. Allden, MD, unpublished WG field summary, 2010). Their involvement will lend prestige to MHPSS programs and foster enthusiasm, advocacy, promotion efforts, and a sense of local ownership. Recent efforts by the International Medical Corps in Lebanon have resulted in a partnership between the WHO and the MoH in drafting MHPSS policy for Lebanon, which had no pre-existing strategy (Z. Hijazi, I. Weissbecker, PhD, MPH, and R. Chammay, MD, PhD, unpublished report, 2010).

Program designers must ensure that new programs or policies do not harm or undermine existing structures in a way that inhibits sustainability or quality of services. Sri Lanka provides a cautionary example, where a gender based violence (GBV) initiatives by NGOs, international agencies, and central government have, in effect, dismantled effective local models in order to replace them with often untested "standardized" programs (A. Galappatti, MSc, unpublished WG report, 2011). "The subjecting of local services to external project-logic and reporting practices also undermined the coherence of the local services. External support to a GBV support desk in a hospital in Sri Lanka meant that temporary support staff were brought under management of an external agency and classified as their employees, which undermined prospects of these staff being absorbed into hospital structure" (A. Galappatti, MSc, unpublished WG report, 2011). An international agency demonstrated a more integrative approach when it conducted a rigorous, independent and confidential stakeholder analysis before designing program for support to mental health in two provinces (A. Galappatti, MSc, unpublished WG report, 2011).

Disaster or crisis intervention offers the international humanitarian community a unique opportunity to create new services, or reorganize and reform pre-existing ones, so that short-term support may be transitioned into sustainable MHPSS programs.[3] Ideally, MHPSS policy should be incorporated into the broader health policy and implemented at all levels of health care, so that MHPSS services are co-located and integrated with medical and social services delivery.[10–11] Special attention should be paid to the development of community MHPSS programs as an alternative to large psychiatric hospital settings, with the goal of providing services that are less intimidating, less stigmatizing, and more accessible to the population as a whole. Policy development should give special consideration to cross-cutting issues (e.g., GBV, HIV) and vulnerable populations (e.g., children, former combatants; Z. Hijazi, unpublished WG report, 2011). Where available, policy should be informed by recently collected, population-based research data.

2) How, and to what extent, should government be involved?
It is important to consider where and to what extent government buy-in is desirable. A key advantage of government involvement is the potential prioritization and availability of funding and infrastructure required to sustain and develop integrated MHPSS services and programs over the long term, and ultimately, make programs self-sustaining within the country without complete dependence on the international community. Inclusion of MHPSS in national mental health programs and allocation of funds promotes MHPSS services as a public health priority.[12] Government can develop large-scale community health strategies to link formal an informal providers to harmonize health promotion at the community level. One example is the Ugandan government's Village Health Team (VHT) strategy, where multipurpose non health-trained community members volunteer to monitor health programs/initiatives at the village level. The VHT are largely informal within the health sector, but some districts have opted to include them on pay roles so they can continue working at the grassroots level.[13] Active engagement of local Ministries of Health (MoH) can be crucial to gaining necessary support and long-term commitment to sustain programs, as has been the experience of WG members in numerous settings (e.g., Aceh, Cambodia, Haiti, Lebanon, Sierra Leone, Uganda, West Bank/Gaza; K. Allden, MD, unpublished WG field summary, 2010; J. Asare, MD, MRCPsych, and L. Jones, OBE, MRCPsych, unpublished report, 2010; A. Galappatti, MSc, 2011 Humanitarian Action Summit presentation, March 2011; Z. Hijazi, 2011 Humanitarian Action Summit presentation, March 2011; Z. Hijazi, I. Weissbecker, PhD, MPH, and R. Chammay, MD, PhD, unpublished report, 2010; J. Nakku, MBChB, M.MED(Psychiatry), unpublished WG report, 2011; I. Weissbecker, PhD, MPH, unpublished WG report, 2011;).[2,6–9,11,14] WG member's experience with International Medical Corps in post-tsunami Aceh illustrated that the Indonesian Ministry of Health's immediate commitment to training psychiatric nurses and general practitioners at the local level greatly contributed to successfully sustaining MHPSS services long.[7] In another example from Ethiopia: one national psychiatrist relocated to a peripheral mental health hospital in order to build up local services and to continue capacity building for refugee health staff as part of his duties. This provided an excellent model of how a national government services could be developed in combination with providing mental health services to refugee communities within its borders (L. Jones, OBE, MRCPsych, unpublished WG report, 2011).

While our discussions acknowledged government involvement and buy-in as central to sustainability in general, it was also simply noted that (a) this should be carefully considered in situations where there are issues of poor governance or political sensitivity related to the provision of services, and also that (b) government involvement was not always a sufficient condition. Government involvement may also mean relinquishing control of decision-making about how services will be delivered and resources will be allocated. Government structures and services are heterogeneous, internally complex, and individual elements do not always work in concert with one another. If key individuals officials or institutions are ineffective, corrupt, or do not support the enhancement of MHPSS services, efforts to involve government in the program development process could be detrimental. It is essential to consider the multiple stakeholder dynamics and their potential impact on service delivery. Even where a national policy framework

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exists, governmental decisions with respect to the allocation of state resources can seriously impact program implementation, and where governance is weak, policies may be disregarded by stakeholders (A. Galappatti, MSc, unpublished WG report, 2011). The political climate in Gaza restricts many NGOs from contact with or support of local government, forcing NGOs to operate in constant "relief" mode to circumvent local authorities, thus inhibiting genuine development (I. Weissbecker, PhD, MPH, unpublished WG report, 2011). In countries recovering from civil war and internal strife, where different parties are still not reconciled, program independence may be necessary in order to provide services that are neutral or depoliticized (A. Galappatti, MSc, 2011 Humanitarian Action Summit presentation, March 2011).

3) How do we sustain buy-in from the government?

It is important to consider how government involvement in the provision and development of MHPSS services, once acquired, can be sustained over the long-term. Collaboration with government in the development of MHPSS services and policy is often crucial to ensure sustainability, but requires critical and strategic engagement. Strong relationships between external actors and local stakeholders are necessary; but these relationships often take time, determination, and testing to develop (Z. Hijazi, unpublished WG report, 2011; Z. Hijazi, 2011 Humanitarian Action Summit presentation, March 2011). Attention must be paid to power differentials, and possible conflicts of interest must be recognized and proactively engaged, in order to prevent a breakdown of cooperation. The visionary and leadership capacity of those on either side of the relationship is crucial to this process (A. Galappatti, MSc, 2011 Humanitarian Action Summit presentation, March 2011). Where funding is available, programs will not survive without leadership and a commitment to serve intended beneficiaries (K. Allden, MD, unpublished WG field summary, 2010).[3,6–9]

Shifts in political will, even in developed countries, can at times force services to cease. For example, a hospital centered-refugee mental health program in Boston targeting southeast Asian refugees was forced to close when the clinic's service contract was altered to focus on community support – as the political will to serve refugees shifted, government funds were transferred elsewhere and the clinic was not able to survive on public insurance billing alone, and thus closed (K. Allden, MD, unpublished WG field summary, 2010). Agreements to sustain services may be formalized to ensure that program and policy implementation is institutionalized and sustainable over time, even in the face of changing government structure or shifts in political will. An effective advocacy role can both create as well as institutionalize constructive political will, such as when the MoH in Lebanon signed a memorandum of understanding with the national Order of Physicians to sustain agreement with respect to newly developed MHPSS policy (Z. Hijazi, 2011 Humanitarian Action Summit presentation, March 2011; Z. Hijazi, I. Weissbecker, PhD, MPH, and R. Chammay, MD, PhD, unpublished report, 2010). Efforts should also be made to develop the capacity of government to manage programs and services.

Human Resources and Training

1) Leverage existing human resources and understand management structures

Services and programs involving the creation of new cadres of staff that did not previously exist in the community are often unsustainable once emergency funding has been withdrawn (L. Jones, OBE, MRCPsych, unpublished WG report, 2011).[2] Such services may collapse over time, leaving staff trained during the emergency phase without positions. It is important to consider pre-existing human resources and MHPSS service structures to identify expertise and service providers that can be sourced locally so that staff members can be trained to function better in their existing roles.[3,6–9] Training local staff who are already working in existing public services can be beneficial, as the knowledge they obtain is likely to remain within the system even if personnel change location (A. Galappatti, MSc, 2011 Humanitarian Action Summit presentation, March 2011; Z. Hijazi, 2011 Humanitarian Action Summit presentation, March 2011; J. Nakku, MBChB, M.MED(Psychiatry), unpublished WG report, 2011). Primary health care providers, such as nurses, community health officers, midwives, public health officers, and doctors, can often be sourced locally and targeted for training[15] in the identification, management and referral of individuals experiencing mental health problems. Such integration of mental health into general health care is also recommended by the WHO and by IASC guidelines.[2] One working group member works with a refugee established and operated hospital and clinic on the Myanmar border in Thailand, where ex-pat program staff train local mental health workers and medical staff, and advise on program development (K. Allden, MD, unpublished WG field summary, 2010). In Lebanon, WG members from International Medical Corps have worked to address needs of Iraqi refugees and the vulnerable host population by training primary health care providers in mental health intervention and referral (Z. Hijazi, I. Weissbecker, PhD, MPH, and R. Chammay, MD, PhD, unpublished report, 2010). This type of integration of MHPSS services into primary health care can optimize limited resources and thus promote sustainability (K. Allden, MD, unpublished WG field summary, 2010; Z. Hijazi, 2011 Humanitarian Action Summit presentation, March 2011; Z. Hijazi, I. Weissbecker, PhD, MPH, and R. Chammay, MD, PhD, unpublished report, 2010).[12,16]

Special attention must be paid to the recruitment of potential MHPSS trainees in locations where the capacity of existing resources is overextended. Ideally, training should be implemented after sufficient staff is in place. This can be challenging, as many resource-poor countries have a dearth of skilled professionals (K. Allden, MD, unpublished WG field summary, 2010). Although extending the capacity of existing professionals to provide MHPSS services can be an effective way to expand services temporarily, several potential challenges should be taken into consideration. Such additional services run the risk of simply increasing the workload of already over-extended service providers. This is especially the case if management structures are not supportive of such changes by adjusting processes and resources to fit those new demands.

It is also essential to identify providers who are genuinely interested in acquiring MHPSS skills. This can be challenging, particularly in countries where mental health practitioners can be almost as stigmatized as their patients (e.g., Sierra Leone; I. Weissbecker, PhD, MPH, 2011 Humanitarian Action Summit presentation, March 2011). It is also important to determine whether potential trainees are able to make time for training, and are not overburdened with other work or training programs. Often, it is advantageous to seek trainees with previous MHPSS training or experience (e.g., Haitian doctors who were trained in

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Cuba). However, it is important to note that previous training can serve as a deterrent if previous experiences (e.g., in psychiatric asylum-based settings) have been off-putting (Mental Health & Psychosocial Support Working Group discussion, 2011 Humanitarian Action Summit presentation, March 2011).

2) Facilitate long-term mentoring and apprenticeship

Short-term skills training programs may be of limited use for some interventions that consolidate people's existing skills (e.g., psychological first aid for post-crisis distress; K. Allden, MD, unpublished WG field summary, 2010; K. Johnson, MD, MPH, 2011 Humanitarian Action Summit presentation, March 2011; L. Kadis, MD, unpublished WG report, 2011), but should be avoided for more complex interventions (e.g., addressing the needs of SGBV survivors or individuals with psychiatric disorders).[3,6–9] Recovery periods for complex conditions are much longer and the risk of relapse is elevated. Patients initiated on treatment during the emergency period should be followed up for a minimum of one year. Training practitioners in the specialized interventions required to treat and manage such patients requires clinical supervision and extended follow-up. Consequently, an apprenticeship model is more appropriate and effective than short-term skills training.[3] MHPSS training for complex interventions should consist of programs in which trainees are mentored and supervised by experienced practitioners over extended periods of time[11] (ideally, 18 to 24 months). Longer program duration also allows for the acquisition of data that can be used to provide evidence supporting program effectiveness and justifying service needs to governments and donors (P. Bolton, MBBS, MPH, 2011 Humanitarian Action Summit presentation, March 2011).

3) Develop leadership and ensure professional support

In addition to training key service providers, the identification and training of leaders is crucial to the effectiveness and sustainability of MHPSS programs.[17] Leadership requires vision, dedication, and enthusiasm; it is not just a role, but an activity that individuals can be trained to perform.[17] It is also important to focus on ongoing professional support involving open communication and peer supervision to encourage the continued evolution of providers' skills. Sound leadership and the ongoing support of professionals and providers can help ensure that the quality and effectiveness of programs are sustained along with the programs themselves. Beyond merely focusing on the sustainability of a service, it is crucial to ensure that the quality of that service is also maintained over time. Without addressing quality of service, staff skills will not continue to develop.

4) Accreditation may be essential

Accreditation may help foster the development of more effective skills, encourage government and donor support and, consequently, enhance the sustainability of quality services. For example, the accreditation of MHPSS courses by the order of physicians in Lebanon was essential in acquiring government support (Z. Hijazi, 2011 Humanitarian Action Summit presentation, March 2011; Z. Hijazi, I. Weissbecker, PhD, MPH, and R. Chammay, MD, PhD, unpublished report, 2010). In some cases, lack of accreditation can have severe negative consequences, such as in Sri Lanka where competent counselors based at a hospital for eight years risked losing their jobs to new less capable novices because the two year training they had received had not been accredited (A. Galappatti, MSc, unpublished WG report, 2011). Where possible, the development of accredited certificate and diploma courses that are accessible to front-line workers in affected communities is strongly encouraged (K. Allden, MD, unpublished WG field summary, 2010). The establishment of medical school departments of psychiatry and university departments of psychology, nursing, and social work is also central to the development of accreditation programs. Training can be incorporated into the local and national education and training programs of the country by drawing on and expanding existing syllabi when such materials and structures exist. A strong base of clinical professionals with academic resources can train, community MHPSS workers. This task shifting means that services can be extended deeper into the community at the village level.

5) Train everyone at every level and develop sustainable supervision structures

It is essential that training take place at every level of the system. Training should be delivered to both service providers and management. Recent implementation of updated MHPSS programs in Lebanon involved the training of gatekeepers and mid-level staff in addition to general practitioners to ensure that patients could access these services at any point of contact. Orientation of heads of clinic before, during, and after training also ensured that management supported the trainings and facilitated implementation of services (Z. Hijazi, 2011 Humanitarian Action Summit presentation, March 2011; Z. Hijazi, I. Weissbecker, PhD, MPH, and R. Chammay, MD, PhD, unpublished report, 2010). Another WG member's experience at Kakuma refugee camp in Kenya utilized active mobile outreach by community mental health workers into the camps to identify mental health patients, who were then treated by Kenyan psychiatric nurses that had been trained by NGO workers (K. Allden, MD, unpublished WG field summary, 2010).

Formal, long-term training of a core number of MHPSS "helpers" should be designed on a national scale (K. Allden, MD, unpublished WG field summary, 2010).[15] Clinical psychologists or psychiatrists can supervise these MHPSS helpers, who may be trained within an action-research approach during the emergency period. For example, primary health care workers and community health workers can be trained by clinical professionals who have expertise in the evaluation, diagnosis, treatment, and long-term management of psychiatric disorders.[15] Core skills to be taught would include psychoeducation, identification and referral, provision of interpersonal support, problem solving, and treatment compliance enhancement.[12]

Programming and Services

1) Sustainability in development requires addressing the whole system

For MHPSS services to be sustainable over the long term, it is crucial to think beyond programs and consider the system as a whole. Individual programs should be designed with respect to the implementation and development of an overall strategy that is holistic, integrative, and comprehensive.[3,11] For example, when developing services for displaced populations it is essential to consider the long-term movements of individuals (e.g., in terms of displacements, return, repatriation, and resettlement) and how services will be provided to address changing needs and ensure continuity of services for repatriated refugees.[17] Often, there is an emphasis on providing services for camp-based populations, with the result that limited attention is paid to unencamped

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individuals or the general population (e.g., refugees integrated or living within the host population). This can leave needs of vulnerable host populations unaddressed and also makes transition difficult; when camps are dismantled, services are dismantled as well (K. Allden, MD, unpublished WG field summary, 2010).

2) Allow for different entry points for sustainable MHPSS services

Comprehensive, integrative MHPSS programming combines mental health intervention strategies and psychosocial support as part of a holistic service package.[11,18] To fully mobilize resilience and protective factors, it is important that multiple layers of intervention related to mental health and psychosocial support be integrated into broader health programs and delivered together. Mental health services include a number of components, ranging from psychiatric support and psychological interventions (e.g., psychoeducation, skills training) to advocacy work and the creation of peer training/supervision networks and programs (L. Kadis, MD, unpublished WG report, 2011).[11] In addition to targeted mental health promotion, it is crucial for MHPSS programs to also include services that address broader psychosocial problems and can thereby stimulate the inclusion and re-integration of people with mental health issues and facilitate coping at the level of the community. This psychosocial package should be comprised of several components, including practical support (e.g., medical services, food, water and sanitation assistance), community education about prevailing psychosocial problems such as substance abuse (to foster understanding and encourage self-help), community mobilization (e.g., stimulating cultural/religious leaders to re-assume their rolls, assistance with grass root initiatives), and community activities aimed at improving the general atmosphere, stimulating community action, and re-activating local customs and culture.[11] As noted by Silove, "supporting the reconstruction of social institutions that encourage survival and adaptation provides a platform for individuals and their collectives to mobilize their own natural capacities for recovery."[17]

3) Consultation from various community stakeholders is essential

Comprehensive and sustainable MHPSS programs also require partnership with the affected community and beneficiaries, to foster the development of culturally acceptable services and promote a context in which the targeted community has a voice and can influence or determine the nature of the services provided (K. Allden, MD, unpublished WG field summary, 2010; T. Betancourt, ScD, MA, 2011 Humanitarian Action Summit presentation, March 2011).[17,19–20] For example, International Medical Corps has used participatory methods to help communities in Aceh build quiet houses that provide a space in which to mourn the dead.[21] Community consultation must account for diversity within the community because, in some cases, minority voices may be silent, and services maybe be needed even when beneficiaries do not feel able to ask for them (T. Betancourt, ScD, MA, 2011 Humanitarian Action Summit presentation, March 2011; I. Weissbecker, PhD, MPH, unpublished WG report, 2011).[3] The focus should be on resiliency and coping at the community level, as well as the outcomes of individual persons alone. This approach to program development can help to establish a framework in which MHPSS services support the ongoing recovery of the community as a whole. In planning MHPSS programs, it is particularly important to work in coordination with successful, established community services, avoiding duplication and using or expanding existing capacity where feasible. Interventions should be broad and flexible, designed to accommodate appropriate traditional healing practices, respond to a range of needs, and adapt to changing needs over time (A. Galappatti, MSc, unpublished WG report, 2011).[20] A smooth transition can be fostered through the formation of public-nonprofit partnerships (e.g., between NGOs, CBOs, academic institutions, etc). Partnering with relevant ministries (e.g., health, education, social welfare) and government services can ease the integration of new MHPSS programs with existing health and social welfare systems and help to ensure that resources to support programs will be maintained once the crisis intervention phase has ended.

4) Plan for long-term sustainability from the outset, even with short-term interventions

In situations where MHPSS services are to be temporary or time limited, it is essential that a phase-out plan be in place from the beginning and considered in the design of the program itself. For example, if staff or volunteers are to be provided with incentives, it is preferable that these incentives be slowly decreased over time rather than abruptly cut off at a predetermined endpoint (A. Galappatti, MSc, unpublished WG report; Z. Hijazi, unpublished WG report, 2011). MHPSS program designers should also determine what resources would be required to sustain services in the community without funding or organizational support from external agencies. Short-term projects that involve high numbers of staff or relatively highly paid staff are unlikely to be sustained, unlike those which use numbers and pay scales that are commensurate with local ability to pay (A. Galappatti, MSc, unpublished WG report, 2011; J. Nakku, MBChB, M.MED(Psychiatry), unpublished WG report, 2011). In Chad, International Medical Corps continues to run a "relief operation" after five years because key providers in the refugee camps remain on NGO salaries (L. Jones, OBE, MRCPsych, unpublished WG report, 2011). Where sustainability is feasible, it is essential to allow time for a transition period and to involve local providers in the planning and implementation of MHPSS programs to facilitate the transfer of ownership.

In considering the long-term sustainability of MHPSS programs, it is important to recognize that interventions developed for emergency settings have relevance in a non-emergency context, just as non-emergency interventions and services are relevant to emergency situations. Where possible, MHPSS services that are initiated in response to an emergency situation should be integrated into existing community-based programs to increase their post-emergency survival potential. The integration of MHPSS into community services such as educational and public health programs reduces stigmatization and eases patient access. Particularly effective approaches include the linking of MHPSS services with community-based health programs (e.g., nutritional, HIV/AIDS, health education, sexual violence, reproductive health, safe motherhood and tuberculosis program activities) and the integration of trauma healing activities into basic education for children in post-conflict settings.[11,19,22–23]

5) Do not forget to address neglected and vulnerable groups

It is important that MHPSS programs foreground the care of identified neglected and vulnerable groups whose extreme experiences require a holistic care plan including a precise

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clinical understanding and adapted, culturally acceptable strategies of intervention in post-conflict situations (K. Johnson, MD, MPH, unpublished WG report, 2011; J. Nakku, MBChB, M.MED(Psychiatry), unpublished WG report, 2011).[20] Mental illness is not always perceived as a majority need, and it often remains hidden and silent due to stigmatization. In some cases, neglected mental health needs become apparent only in the evaluation of other problem areas (e.g., a need for substance abuse intervention may be identified in the evaluation of maternal health). Neglected and vulnerable groups in particular need of intervention would include survivors of sexual GBV (including male victims and observers), individuals with developmental delay, individuals with intellectual and physical disabilities, individuals with substance abuse problems, individuals with head injury damage and traumatic brain injury, former combatants, children, and the elderly (Z. Hijazi, unpublished WG report, 2011; J. Nakku, MBChB, M.MED(Psychiatry), unpublished WG report, 2011).[18,20,22–27] As the minority voices of these vulnerable group members may be silent, it is crucial to design and to provide MHPSS services for them even in the absence of requests for assistance, such as the creation of Child Friendly Spaces (CFS) for psychosocial intervention through local community engagement that can later be turned over to the community during development (Z. Hijazi, unpublished WG report, 2011).

Research, Monitoring, and Evaluation

Consistent with our consensus finding at the 2009 summit, the 2011 Working Group recognized the utmost importance of research as well as continued monitoring and evaluation in the provision of mental health and psychosocial programming while transitioning from emergency relief to long-term development.

1) It is necessary to combine service delivery and research

The WG has taken the stance that assessment, monitoring and evaluation must be included in programming, and interventions or programs should be based on systematic research.[11,28] In the context of MHPSS interventions, monitoring and evaluation efforts on the part of NGOs in and of themselves constitute research, and as such are governed by and remain accountable to ethical constrains for research. Similarly, it is unethical to accept grants for research without also locking in service provision because researchers cannot simply depend on service providers to follow through with their research. This view is consistent with the past consensus statement of this Working Group in 2009, and the group's motto "*no survey without service, no service without survey.*"[1] Working Group members affiliated with International Medical Corps (IMC) have had past experiences where IMC funded primary research to evaluate their programs. Program evaluation was specifically identified as a gap in existing research for mental health and psychosocial services (K. Johnson, MD, MPH, unpublished WG report, 2011).[1]

The group recognizes that there are inherent challenges to research, monitoring, and evaluation for mental health programs in the aftermath of conflict and in the initial stages of development, as documentation and systematic measurement can prove difficult.[6,11] There are always security risks to staff members; post-conflict settings almost always have a severely diminished pool of qualified human resources available for assisting with instrument design and data collection; and mobile populations in emergency settings provide researchers with an inherent difficulty in attempting to obtain "measures of potential mediating variables such as social support, coping style, and pre-morbid mental and physical health status."[22] Western-based evaluation models might be inadequate to accurately determine program effectiveness, and may not be culturally valid or ethically sound within the given context.[3,11,29–31] Lastly, the existing research base also lacks evidence-based data on vulnerable groups with extensive mental health needs in both crisis and in development. For example, few studies have assessed the mental health or psychosocial needs of refugee or internally displaced children who are not exiled, particularly in regions outside Europe.[10]

To address these challenges, the WG recommends that researchers and services providers document as much data as possible in order to help shed light on baseline needs (L. Jones, OBE, MRCPsych, unpublished WG report, 2011).[3,6–9] Evidence of the effectiveness of psychosocial interventions, for example, need strengthening, and developing clear indicators for psychosocial interventions goes hand in hand with being able to demonstrate the effectiveness of such interventions.[12,32] Cross cultural assessments of psychological problems and needs, cross-cultural validation of stress-related disorders, and cross-cultural assessments of the relevance of assistance offered must be further studied, with appropriate program evaluation, to determine which interventions are appropriate in a given setting (K. Johnson, MD, MPH, unpublished WG report, 2011).[15,18,20,23] Currently, there are relatively few formal studies of community-based approaches to psychosocial support in resource-poor settings or longitudinal research examining long-term outcomes.[20]

Ideally, good research, monitoring, and evaluation can inform constructive improvements in programming with long-term impact on beneficiaries. One working group member from the International Medical Corps shared her experiences in Lebanon, where formative evaluations and experiences informed a positive change in the training of local mental health care providers. Specifically, evaluations indicated that mental health at the primary health care (PHC) level needed to be provided through an all-inclusive trained team of medical professionals and social workers working together to provide optimal mental health care (Z. Hijazi, 2011 Humanitarian Action Summit presentation, March 2011; Z. Hijazi, I. Weissbecker, PhD, MPH, and R. Chammay, MD, PhD, unpublished report, 2010). In response, International Medical Corps adopted an approach to tailor training to all levels of PHC staff – general practitioners, mid-level staff, social workers, and doctors from different specialties. IMC also made plans to pilot the integration of case management teams attached to PHC clinics in select PHCs, to help ensure that care provision is comprehensive and that clients are connected to needed services (Z. Hijazi, 2011 Humanitarian Action Summit presentation, March 2011). A key finding in the Lebanon case example was significant need for long term follow up, support and supervision of trained PHC workers after the conclusion of training. As a response, IMC has organized refresher trainings for one year following the training. There is also a need for strengthening communication and consultation among PHC staff and mental health specialists (Z. Hijazi, I. Weissbecker, PhD, MPH, and R. Chammay, MD, PhD, unpublished report, 2010). In Bosnia-Herzegovina, program evaluation indicated that PCP knowledge and skills in managing common mental disorders improved markedly after training. Independent

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evaluation demonstrated the importance of a bottom-up approach to development of projects, the value of situation and needs assessments, the importance of encouraging health staff to participate as stakeholders in the process, and the need for stakeholders to see the project as a national one, with its own character to improve prospects for sustainability.[14]

2) Funding for continuing monitoring and evaluation is essential

Improving research, monitoring, and evaluation efforts as related to programming is accomplished by seeking sufficient, earmarked funds to support monitoring and evaluation efforts. This means that funding for continuing monitoring and evaluation must be factored into program costs from the outset. One working group member suggested that, when submitting a proposal for program funding, include specific allocation of funds for monitoring and evaluation, and include a separate justification of funds for research. It is important to note that monitoring and evaluation is a process, not an event, which starts with a formative evaluation. Working group members' experiences in Lebanon are a good example of this.

To remain responsive, service providers must adapt the program to community needs, and this ongoing development and evolution of the intervention can only be effectively done when informed by monitoring and evaluation efforts, with input and feedback from beneficiaries and community stakeholders (K. Allden, MD, unpublished WG field summary, 2010; A. Galappatti, MSc, unpublished WG report, 2011; J. Nakku, MBChB, M.MED(Psychiatry), unpublished WG report, 2011). In some cases, the research itself can reciprocally support programs. One working group member shared a past experience in the Democratic Republic of the Congo, where an assessment conducted by her team led to funding for services. It may be the case that, at times, funding for research to evaluate programming is not available simply because research for funding is simply not sought or specified by those seeking funds. At the 2011 summit, one donor representative in the discussion group noted that proposals she reads often lack a section related to monitoring or evaluation, and that donors often look for even the most basic statements of justification for monitoring and evaluation. Such statements need not be lengthy or intricately detailed, but they must somehow be present in the proposal.

3) One of the best measures of impact for a majority of MHPSS interventions is restoration of functioning at the individual or community level.

For individuals in clinical settings, mental health providers generally use a measure of individual social function to evaluate the impact of a particular intervention. However, in a development field setting, where mental health and psychosocial providers are working with larger numbers of affected individuals, looking for a measure of community well-being, measures of community functioning (such as measures of viable social networks) might be more appropriate to determine impact (K. Johnson, MD, MPH, unpublished WG report, 2011; K. Leary, PhD, unpublished WG report, 2011). For many survivors of large-scale emergencies, repairing the social fabric of the community is key to "facilitating natural recovery from acute stress reactions."[17] In general, large-scale mental health issues "affect the ability of societies to generate 'positive social capital' defined as 'active community participation for collective action.'"[14] When mental health prevents large numbers of individuals from participating in community activities, the community as a whole loses since a high prevalence of mental disorders among its members weakens its ability to form relations of trust, cooperation and mobilization for collective action.[14] In the Broadmoor neighbourhood of New Orleans, MHPSS services in post-Katrina phase were the result of neighbourhood-based grassroots mobilization to address post-disaster psychological needs the community as a whole and the members who continued to live there. Success depended heavily on key partnership between local churches, hospitals, and independent school-based MHPSS programs (K. Leary, PhD, unpublished WG report, 2011).

Similarly, research efforts could better support the transition of emergency programming to development by focusing more on social consequences of mental disturbance, which may also help to identify subgroups most as risk of adverse outcomes if denied emergency treatment (K. Johnson, MD, MPH, unpublished WG report, 2011). Group members found that the evidence-base on the effectiveness of school-based mental health interventions is growing. Intervention research examining school-based settings has been conducted in countries such as Nepal, Indonesia, Bosnia-Herzegovina, Burundi, Sri Lanka, Sudan, Israel and Palestine, Armenia, and Lebanon (T. Betancourt, ScD, MA, 2011 Humanitarian Action Summit presentation, March 2011).[33–36] These interventions spanned a range of approaches and aims (including prevention, treatment, and maintenance), with most reporting favorable outcomes. For example, a randomized controlled trial of a school-based psychotherapeutic group intervention implemented by local school counselors for war-exposed adolescents in Bosnia targeted symptoms of PTSD, depression and maladaptive grief.[33] The intervention was culturally situated and strongly emphasized community resources and resilience. Results demonstrated the effectiveness, feasibility, and sustainability of a multi-tiered intervention package that included broad school-based psychoeducation as well as training of local educational staff in order to address human resources shortages for mental health care. A recent review and meta-analysis of school-based interventions for PTSD and comorbid symptoms (e.g., depression, anxiety) supported the effectiveness of school-based programs using local staff, concluding that "neighborhood schools may be an ideal location for providing intervention" while highlighting the importance of training and ongoing supervision.[36]

However, working group members also discovered a paucity of research on the sustainability of interventions in these settings. Interventions were usually implemented over a relatively short time span of weeks or months, and studies differed widely with respect to the frequency and length of sessions, as well as the level of training and supervision provided to those administering. In one case, providers were instructed to administer interventions after training periods as short as one day. In that particular case [in Lebanon]there were no positive effects from the intervention one year after implementation.[37] Effects are typically measured shortly after implementation, although a handful of studies have done follow-up evaluations 4 to 12 months later. The lack of longitudinal research hinders our ability to understand what is needed to maintain initial effects (T. Betancourt, ScD, MA, 2011 Humanitarian Action Summit presentation, March 2011).[36]

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4) Success is determined by the sustainability, acceptability, access, and impact of the given intervention.
The success of an MHPSS program depends upon a number of interrelated factors. Simply measuring its short-term impact (for example, through measuring the immediate improvement in patient outcomes) or whether it was sustained long-term is insufficient. A sustained service that is neither fully accessible nor acceptable to the local population is of little use. For instance, a drop-in centre for women affected by GBV to "hangout" in post-tsunami Sri Lanka went largely unused due to its remote location and the culturally unfamiliar framing of this intervention (A. Galappatti, MSc, unpublished WG field experience, 2011). Information concerning factors such as ease of access and local acceptability must be tracked from the outset of an intervention because without data, the argument for support by government or funders is less compelling, and common practices will not improve between disasters (P. Bolton, MBBS, MPH, 2011 Humanitarian Action Summit presentation, March 2011). Involving researchers from the affected country may also facilitate obtaining data that will both improve treatment/intervention outcomes, and prove to potential funders that the program is worth funding (K. Allden, MD, unpublished WG field summary, 2010).

In cases where services are intended to persist into the development phase from the outset, service providers should continue to monitor both effectiveness and feasibility as part of program activities. In development, the situation on the ground will (hopefully) change, and thus services will have to change as well. To adapt effectively, programs should continue to feed data into iterative changes and monitor their effect, which will require input from (1) the population (via rapid qualitative methods and/or meetings), (2) the government (via meetings), and (3) service providers or other interested parties (via meetings; P. Bolton, MBBS, MPH, 2011 Humanitarian Action Summit presentation, March 2011). Interventions should also take into account the findings from relevant literature, where it exists. The difficulty in measuring impact for MHPSS interventions makes continued data-collection essential. As mentioned earlier, data support arguments of program effectiveness to government, funders, and the community. Ultimately, mental health interventions should either save lives, make beneficiaries more functional, or improve quality of life (P. Bolton, MBBS, MPH, 2011 Humanitarian Action Summit presentation, March 2011). Lastly, both researchers and service providers must keep in mind that research can actually become aggravating or exhausting to intended beneficiaries where it requires lots of time of its participants (particularly if inconvenient), where it is not perceived as helpful or relevant to the lives of beneficiaries, or where it is perceived as impolite. Therefore, research activities should be designed to be brief and done when convenient to the subject, clearly relevant/helpful to the current situation of participants, and sensitive to local standards of politeness (P. Bolton, MBBS, MPH, 2011 Humanitarian Action Summit presentation, March 2011; A. Galappatti, MSc, 2011 Humanitarian Action Summit presentation, March 2011).[1]

Finance

1) Consider the costs: "Emergency funding" should be for a minimum of 1–2 years
The constraints on funding, skills, and supports to provide health services in low-income and resource poor settings, especially emergency or conflict settings, often means that MHPSS services often receive low priority in the face of other urgent health needs.[17] Currently short-term interventions are in many cases only funded for 3–6 months (A. Galappatti, MSc, 2011 Humanitarian Action Summit presentation, March 2011).[3] However, in order for a model to be sustainable, there needs to be a commitment to longer-term funding for mental health and health in general (K. Johnson, MD, MPH, unpublished WG report, 2011). The nature of mental health disorders, as well as lessons learned from successful MHPSS interventions; demand that interventions be funded for longer periods of time from the outset. With a few exceptions (e.g., psychological first aid), MHPSS emergency interventions generally require at least 1–2 years of funding to ensure that beneficiaries are served through the length of their recovery time, that staff are trained to understand the full cycle of mental illness, and that genuinely responsive programs are developed, tailored to community needs (L. Jones, OBE, MRCPsych, unpublished WG report, 2011).[3,6–9]

While emergency interventions typically require a minimum funding commitment of 1–2 years, ongoing financial support is crucial to the long-term sustainability of MHPSS programs. Public private partnerships with ministries of health can serve to create longer timelines for investment of funds and human capital, thus pooling resources to achieve sustainability. The experiences of working group members in multiple settings (e.g., Cambodia, Thailand/Myanmar border, Uganda) have illustrated how a mixture of support from government, private, foundation, and NGO funds – especially when committed to longer term funding cycles – can effectively support long-term development of human resources and sustainable services (K. Allden, MD, unpublished WG field summary, 2010). Public private partnerships have also been extremely successful in jump starting and sustaining recovery efforts in the Broadmoor neighborhood in New Orleans post-Katrina (K. Leary, PhD, unpublished WG report, 2011). One WG member helped to set up mental health services in Cambodia through USAID funding, where they trained primary care physicians from all provinces in a year-long course and started a model clinic at a provincial hospital staffed by these physicians and community mental health workers (and later, a psychiatrist). When USAID funding ran out, the MoH had difficulty sustaining the program for several years until a private donor committed to a ten year public private partnership with the MoH. The program has since been able to expand to a neighboring province (K. Allden, MD, unpublished WG field summary, 2010). Advocating for mental health components in national health financing reforms presents another avenue to locking in long-term funding in a sustainable manner.[12,38] Very often, even where there exists government support or collaboration, the absence of a long term donor will mean an absence of community based services after closure of emergency services, as was one working group member's experience with MHPSS programs in Sierra Leone (L. Jones, OBE, MRCPsych, unpublished WG report, 2011).[3,8]

2) Large amounts of short-term money can sometimes do more harm than good
Intervention providers must also stay very conscious of how and where money is received and spent. Massive amounts of money in the very short term can sometimes do more harm than good if it serves to unwittingly undermine existing local structures

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and processes (A. Galappatti, MSc, 2011 Humanitarian Action Summit presentation, March 2011). Even in situations where donors wish to provide funding for MHPSS relief, large amounts of funds could instead work to undermine existing, effective service providers who understand the local context, or could introduce interventions that are not proven to do more good than harm.[32] In the context of Sri Lanka, a country subjected to both protracted internal conflict and large-scale natural disaster with the 2004 tsunami, pre-tsunami funding cycles for interventions averaged over three years for programs. By contrast, post-tsunami funding more often saw much shorter funding cycles, even for only a few months. The tight timeframes often led to an over-supply of costly short-term or superficial interventions (i.e., children's activity festivals), rather than the financing of long-term community mental health services (A. Galappatti, MSc, 2011 Humanitarian Action Summit presentation, March 2011).

A vast influx of money can often lead to a rapid increase in the number of programs in a given area, not only the amount of money brought in by individual programs. In one conflict-affected district of 500,000 residents in Sri Lanka, the number of agencies involved in MHPSS interventions increased from fewer than 20 to over 70 during the first six months after the 2004 tsunami disaster. The dramatic drop in external financing available after the post-tsunami boom, and the subsequent end of the armed conflict in 2009 has resulted in a shrinking of the field to below pre-tsunami levels. The harm in this case was that a dependency on generously funded and externally staffed programs has seriously impaired the capacity of local support structures to sustain required services. It would be beneficial for multiple NGOs entering into an emergency context to be awareness about not only the impact their own funding has, but also the impact their collective funding has on local, long-term sustainability (A. Galappatti, MSc, 2011 Humanitarian Action Summit presentation, March 2011).

3) Innovate mechanisms for reserving or investing money for long-term use

One concern about discouraging the short-term influx of vast amounts of funds to a particular region is driven by the reality that internationally resources are scarce, and the fear that if funds are refused or underutilized when offered, they may not be offered when needed in the future. Currently, the presence or absence of a long term donor prepared to fund initial services and their scale up is essential to the success of or failure to achieve long term and effective sustainability.[3,6–9] This raises the question, "Can we reserve or invest overflow short-term money to be used longer term?" There exists a need for innovative strategies and flexible funding to be presented in coordination with donors. One WG member working Sri Lanka has begun developing the idea of establishing local mental health trusts to sustain programs when the emergency intervention funds dry up. Trusts could potentially involve several options for funding streams: private contributions, pooling of multiple resources, or looking at options for public financing (A. Galappatti, MSc, 2011 Humanitarian Action Summit presentation, March 2011). While such projects have a great deal of potential in helping long-term sustainability of MHPSS programs, there exists the need for continuing donor commitment to development, as well as a need for increasing the number educated donors who understand the impact of their support at the local level.

Conclusion

Based on literature reviews and numerous case examples based on personal experiences, the Working Group compiled a series of recommendations intended to help transition mental health and psychosocial support programs from emergency-phase interventions to long-term development services. Case examples examine included Lebanon, the Gaza Strip, Sierra Leone, Aceh (Indonesia), Sri Lanka, and the Broadmoor neighborhood in New Orleans (United States). The working group categorized recommendations under five major theme areas: Government and Policy, Human Resources and Training, Programming and Services, Research and Monitoring, and Financing. The working group was very conscious to address both mental health and psychosocial interventions. Despite the fact that the conceptual and practical differences exist between the two, the WG believes the two are not mutually exclusive, but can be layered to address beneficiary needs (Chart 2).

The list below draws on and builds upon action sheets 6.2 and 6.4 of the ISAC Guidelines. It serves as a reminder of points to keep in mind from the outset of planning for a community based MHPSS program, in order to foster long term development of accessible, impactful, culturally appropriate, and sustainable MHPSS services. Ask:

1. *Have I assessed existing services including traditional ones to see how they are functioning and what support they need?*
2. *Have I met with local and international NGOS already active in this field to collaborate and coordinate?*
3. *Am I using local staff?*
4. *Have I involved existing authorities and stakeholders?*
5. *Am I integrating into existing service structures?*
6. *In the absence of points #3 and #4 (due to mass destruction and mass casualties– therefore necessitating use of outsiders), am I developing a transition strategy for handover?*
7. *Am I aware of existing national strategies for mental health, if they exist?*
8. *If none exists is the emergency an opportunity to create one?*
9. *Am I documenting everything I do and collecting data to contribute to the creation of baseline needs?*
10. *Can we create an emergency service that could be a model or basis for a long-term sustainable service?*

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