Community-Based Protection in Action

Community-based Protection Unit, Division of International Protection
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COMMUNITY-BASED PROTECTION & MENTAL HEALTH& PSYCHOSOCIAL SUPPORT

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PURPOSE

Community-based protection and mental health and psychosocial support (MHPSS) are closely linked and influence each other. The purpose of this document is to help community-based protection actors and MHPSS practitioners understand the implications of their work for one another's field of expertise and how they can together contribute to the wellbeing and protection of people affected by forced displacement.

KEY MESSAGES

- Refugees have assets and resources to support their own mental health and psychosocial well-being and that of their communities.
- Promoting meaningful engagement of refugees, respecting their dignity and autonomy, and providing them with adequate information, can greatly reduce psychological distress.
- Community-based protection activities, such as support groups, community centres and safe spaces are a foundation for effective MHPSS.
- With tailored training and supportive supervision, many MHPSS interventions can be done by refugees who are non-specialists.
- MHPSS should be seen as a multi-layered system; it is important to strengthen the community-based psychosocial supports in order to make best use of existing resources at community level for many MHPSS problems and to facilitate referrals for various social and clinical mental health services.
- Community-based protection work that strengthens community ties and structures can contribute to ensuring that clinical mental health services are accessed by those who need it.
- Community-based MHPSS capitalizes on the strengths of refugees and promotes their resilience, rather than focusing only on deficits (the weaknesses, suffering and pathology).
- Resilient individuals and communities can better contribute to their own protection and that of others.

WHY IS THIS IMPORTANT?

Experiences of forced displacement put significant psychological and social stress on individuals, families and communities. In addition to having to cope with the psychological aftermath of adverse events that happened in their countries of origin, refugees[1] often face important challenges and stressors in transit and in countries of asylum, including physical protection risks, limited access to basic services, restricted opportunities for employment and education, racism and xenophobia, and the lack of hope for the future.

Experiences of loss, pain, disruption and violence increase the vulnerability to developing mental health and psychosocial problems. Often, however, psychological reactions to disruptive situations are common and short-lived.

Within a supportive environment many refugees will be able to cope with difficult experiences, and even build resilience. However, a major barrier to psychological resilience in refugee situations is the breakdown or severe disruption of pre-existing and traditional community structures, such as extended family systems and informal social networks, which often regulate community well-being. This can increase exposure to exploitation and abuse from one's own family and community. In situations of forced displacement some people use coping strategies that may be harmful or unhelpful in the long run to themselves or to others. The use of negative coping mechanisms may be reinforced while people struggle to survive in difficult circumstances with limited social support.

It is critical to realize that, even in situations of acute adversity and suffering, people have assets or resources to support their own mental health and psychosocial well-being and that of their communities. It is essential to consider these capacities as strengths when introducing mental health and psychosocial

support (MHPSS) programmes. Focusing only on deficits – the weaknesses, suffering and pathology – of the affected people may conceal their strengths and erode their ability to support each other. Working with refugee communities and strengthening the capacity of people to support each other is foundational for sustainable and effective MHPSS. Forced displacement is a major disruption in people's lives, but sometimes, paradoxically, can provide new opportunities for people to support themselves and others effectively.

UNHCR'S ROLE IN MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Mitigating immediate and long-term risks and consequences for mental health and psychosocial wellbeing of individuals, families and communities is an integral part of UNHCR's protection mandate. Therefore MHPSS should be regularly integrated into UNHCR's protection and assistance programming and should not be seen in isolation from protection work.

Using this broad and holistic concept of MHPSS necessitates collaborative work between various functional areas, such as health, community-based protection, child protection, SGBV, education and other areas. MHPSS problems in humanitarian contexts can be addressed through activities such as supporting community resilience, promoting mechanisms for social support, and offering specific services to individuals or families with more complex mental health needs. UNHCR distinguishes between an MHPSS approach and MHPSS interventions.

[1]This document refers to refugees. However, the content provided herein could equally apply to internally displaced persons or other persons of concern to UNHCR.

DEFINITION OF MHPSS

Any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder[1] (IASC, 2007).

MHPSS APPROACH

Adopting an MHPSS approach means providing a humanitarian response in ways that are beneficial to the mental health and psychosocial wellbeing of refugees. This is relevant for all actors involved in the protection of and assistance to refugees.

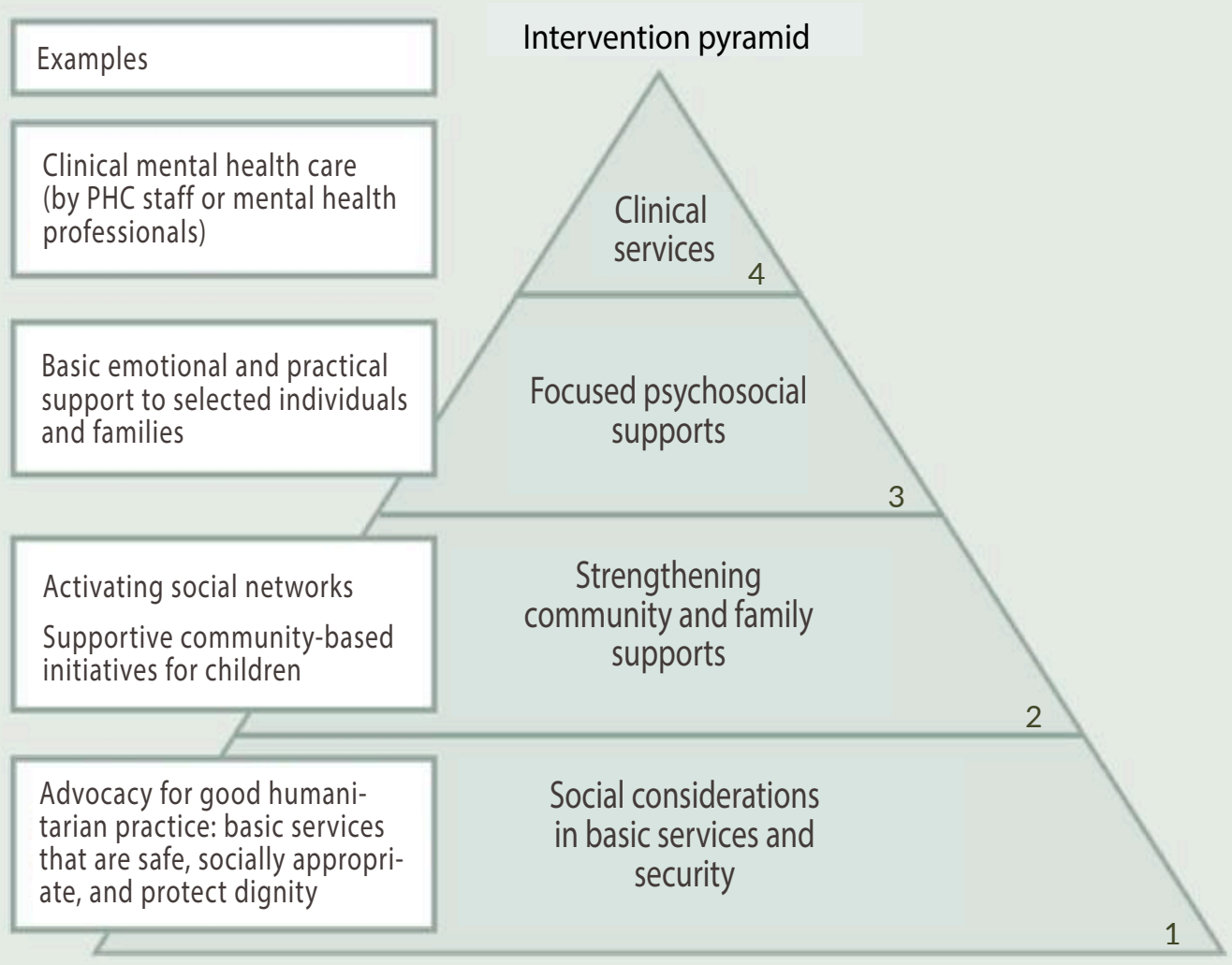
MHPSS INTERVENTION

MHPSS interventions consist of activities with a primary goal of improving the mental health and psychosocial wellbeing of refugees. In practice, MHPSS interventions are usually managed by experts in health, community-based protection, and education. This could include the provision of services by supervised lay helpers.

[1]The term "mental disorder" is more commonly used in the medical sector, while "psychosocial disability" is the preferred term for use in community-based work.

The scope of mental health and psychosocial services and support can be seen in the pyramid of multi-layered services and supports as developed by the Inter-Agency Standing Committee Guidelines on MHPSS in Emergency Settings (See figure 1).

FIGURE 1. THE IASC PYRAMID (ADAPTED WITH PERMISSION)



WHAT IS COMMUNITY-BASED PROTECTION?

Community-based protection (CBP) facilitates the empowerment of communities to obtain their rights safely and with dignity. Through community-based protection (CBP), crisis-affected communities and the humanitarian actors who assist them can identify a community's most serious protection risks, explore their causes and effects, and jointly decide how to prevent and respond to them. CBP is a continuous process that engages communities as analysts, evaluators and implementers in their own protection. As such, it can and should be integrated into humanitarian response programmes across sectors and in all humanitarian contexts. This leads to better protection impacts and improves the lives of people of concern.

LINKAGES BETWEEN MHPSS & COMMUNITY-BASED PROTECTION

Whether intended or not, protection risks and the related protection interventions to address them have a strong influence on the mental health and well-being of people of concern. Such influences could positively or negatively influence a person's well-being, depending on how protect risks and interventions are addressed. As such, CBP and MHPSS significantly influence each other; and cannot be provided in isolation. Protection actors should therefore be trained on MHPSS and the relevant actions of the IASC Guidelines in MHPSS in Humanitarian Emergencies.[i] Community-based protection programmes contribute significantly to improving and maintaining the mental health and psychosocial well-being of refugees: who are meaningfully engaged in protection responses instead of being passive recipients of assistance, are likely to be more hopeful, cope better, and be more effective in rebuilding their own lives and support others effectively. A community-based protection approach forms the basis of good MHPSS programming.

The reverse is also true: People who are overwhelmed by grief and sadness, trapped by thoughts of past experiences and present stressors, or affected by severe mental health problems may need additional support and outreach to re-establish a sense of belonging in community and to be able to engage as partners in community-based initiatives.

The links between CBP and MHPSS are most obvious and substantial in layer 2 of the MHPSS pyramid: interventions to strengthen community and family support. Within refugee operations, most of the interventions here are implemented through community-based protection. However, community engagement is also critical at other levels of the MHPSS pyramid. MHPSS programmes within UNHCR should therefore be rooted in strong community-based protection work and promote community engagement at all stages and levels of programming.

Community-based protection interventions can contribute to improved mental health and psychosocial well-being of refugees in many ways. Here are examples of a range of interventions where UNHCR and partners have supported refugees and their communities to take a leading role in improving their mental health and psychosocial wellbeing:

LAYER 1: SOCIAL CONSIDERATIONS IN THE PROVISION OF BASIC SERVICES AND SECURITY

The daily living conditions of people in displacement have a significant impact on their psychosocial wellbeing. Insecurity, poverty, unemployment, poor housing, and insufficient food, water and medical care, all have profound effects on the wellbeing of people.

A lack of basic services and security or inadequate and discriminatory delivery of such services can lead to significant anxiety, stress and frustration among refugees and can fuel tensions between them.

WHO WOULD YOU RATHER BE?

Excluded from decision making processes that affect your life.	Freedom to participate in decision making processes that affect your life.
Being in a subordinate position when receiving food rations or relief items.	Receiving cash to purchase food and relief items of your own choosing.
Being forced to use undignified or unsafe communal toilets and bathing facilities.	Having access to safe, sanitary toilets and bathing facilities.
Sharing cramped shelters with no privacy.	Living in private, comfortable shelters.
Lacking information about rights and what will happen next.	Accessing information about your rights, news, and upcoming changes.
Perceived favouritism towards particular groups.	Equal treatment of all groups, regardless of status or background.

These examples all show that the ways in which basic services and security are addressed can support or undermine psychosocial wellbeing and mental health. Applying an 'MHPSS approach' to basic services and security requires working in participatory ways, respecting dignity and autonomy of the people of concern, and providing people with adequate information. This can greatly reduce psychological distress in humanitarian settings and give refugees a sense of agency.

Advocacy may be required to ensure that basic services and security are equally accessible for people with specific needs, including people with psychosocial disabilities,[2] and survivors of sexual and gender based violence.

INCLUSION AND PARTICIPATION

Communities often know best what their needs are, and the barriers they encounter in trying to meet those needs, may need support to overcome these barriers. They are also aware of the coping capacities the community already has, and what kind of external support would be required to build on these capacities. Meaningful participation of communities leads to better humanitarian programming and strengthens protection, while also promoting dignity and a sense of ownership or empowerment.

In line with UNHCR's Age, Gender and Diversity (AGD) Policy, women, men, boys and girls of all backgrounds should be able to participate in decisions that affect their well-being and have their views taken into account in programme design and implementation. This will ensure that services reach those with the most pressing needs in an inclusive, contextually appropriate and non-discriminatory manner.

Participatory assessments and other structured or ad hoc interactions with refugees promote refugee participation. Refugees can also be engaged as community workers or volunteers, to support other refugees by providing them information on available services and how to access them. Such refugee community workers can also be involved in identifying refugees who are marginalized, isolated, or have specific needs, and subsequently refer or accompany them to these services and advocate to service providers for more inclusive and accessible services.

"UNHCR and partners need to ensure that refugees and other persons of concern…are involved in all stages of design and implementation of the MHPSS activities."

Operational Guidance: Mental Health & Psychosocial Support Programming for Refugee Operations, UNHCR

INFORMATION

Lack of access to accurate information on basic services and about the security situation (presence of checkpoints, landmines or unexploded ordinances) is a significant source of stress for refugees. Clear and accessible information contributes greatly to refugees' mental health and psychosocial wellbeing. Refugees can help UNHCR to identify the most accessible and culturally appropriate means of communication, as well as ensuring that information is disseminated widely in the community, including for some persons with disabilities (such as those with limited mobility, hearing, visual and intellectual impairments) or marginalized groups.

CASE STUDY: PROVIDING TAILORED INFORMATION TO REFUGEES IN LEBANON

In Lebanon, UNHCR uses multiple approaches to ensure information reaches the widest number of refugees in a participatory manner:

- An inter-agency website for refugees with information about programmes and services (www.refugees-lebanon.org) which was designed with inputs from refugee outreach volunteers (ROVs)
- A communication tree, making use of their country-wide network of ROVs, to communicate accurate information and help dispel unfounded rumours that cause stress and tension among refugees.
- Community centres where refugees can access information, as well as a wide range of services
- Home visits by ROVs to disseminate information to refugees who may be unable to access information through other channels.

[2]The term "mental disorder" is more commonly used in the medical sector, while "psychosocial disability" is the preferred term for use in community-based work.

SECURITY

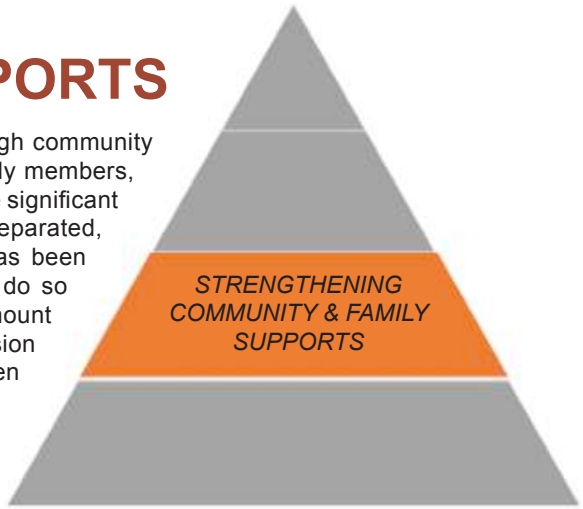
Security threats, whether real or perceived, are a common source of stress in situations of forced displacement. Providing accurate information about the security situation is key to minimizing stress and assisting refugees to make informed choices. Refugees can also use self-protection measures to mitigate security threats. For example, community watch groups, primarily operating in camp settings, can reduce the risks of security incidents and provide their fellow refugees with a sense of security and give the refugee community a sense of agency.

EXAMPLE: REFUGEE COMMUNITY WATCH GROUPS IN UGANDA

In Uganda, UNHCR supports the formation and training of community watch groups, who work in close coordination with local police and serve as volunteers within the refugee community. Because refugee settlements stretch over large areas, each watch group member receives a bicycle, enabling more outreach and quick response to SGBV and other violence. Proactive participation of the refugee community in protecting themselves from SGBV enhances community-based protection and promotes the mental health and psychosocial well-being of refugees.

LAYER 2: STRENGTHENING COMMUNITY AND FAMILY SUPPORTS

Most people maintain their mental health and psychosocial well-being through community and family support. People in distress, including refugees, often turn to family members, friends, or neighbours for help and support. In many refugee settings there are significant disruptions of community and family networks: Family members are separated, neighbours do not know one another, trust among community members has been shattered, people who would normally support each other are not able to do so because they are in grief and pain themselves. It is, therefore, of paramount importance to help refugees to support each other and to foster social cohesion in refugee populations. Cultural and contextual specificities have to be taken into account, which requires a thorough understanding of communities, including leadership structures and relationship dynamics between various groups and individuals. Within UNHCR, activities related to Layer 2 are usually coordinated by community-based protection staff and partners.



ACTIVITIES TO STRENGTHEN COMMUNITY AND FAMILY SUPPORT

- Supporting the re-establishment and/or development of refugee community structures which are representative of the population from an age, gender and diversity perspective
- Establishing community centres and self-help groups
- Fostering social support for people with specific needs, including people with psychosocial or intellectual disabilities
- Promoting the inclusion of people with psychosocial or intellectual disabilities in activities for livelihoods
- Supporting initiatives by the refugee communities to improve the wellbeing of persons of concern and to fight exclusion and marginalization of people with specific needs
- Promoting peaceful coexistence with host communities.

STRENGTHENING THE SOCIAL FABRIC IN REFUGEE COMMUNITIES

Supportive community and family ties have an enormous impact on mental health and psychosocial well-being. It is therefore important to strengthen those ties among refugees, as well as to promote mutually supportive relationships between refugees and people in host communities. This can consist of supporting communities to:

1. Establish, re-vitalize community groups and activities (such as those for children, youth ,women or parents).

2. Set up common spaces where refugees can interact and engage in joint activities (such as spaces for children and youth, community centres, and community-based schools).

Opening these groups and spaces to people from different refugee and host communities also promotes peaceful coexistence and reduces tensions. Explicit efforts to include marginalized groups and persons with specific needs (including persons with disabilities, persons of diverse sexual orientations and gender identities, and older persons) helps in diminishing the distress, loneliness, isolation and/or discrimination that they face. These types of interventions are at the core of UNHCR's goal to promote meaningful engagement of refugees in their own protection.

Although refugees organized in community groups or committees can play an important part in contributing to the mental health and psychosocial well-being of their communities, UNHCR and partners should be cautious about setting up separate community groups focusing exclusively on people with specific MHPSS problems. This may unnecessarily set people apart and further their stigmatization and marginalization. In many situations, if contextually appropriate, people with MHPSS problems can be included in the work of existing community structures (such as child protection committees, community health workers, parents/teacher associations, and camp manager committees) and their members provided with awareness training about MHPSS and including individuals with MHPSS problems.

PSYCHOLOGICAL FIRST AID (PFA)

One example of an activity that can be done by a wide range of persons involved in the humanitarian response is psychological first aid (PFA). PFA describes a humane, supportive response to people in severe emotional distress who may need support, for example after being recently exposed to a potentially traumatic event (such as SGBV or other violence). The aim of PFA is to help people to help themselves to regain control of their situation. Psychological first aid is not professional counseling, and therefore does not require professionals. Training refugees in PFA can strengthen community self-protection by building capacity of refugees to support themselves and others to cope with adverse events. It can also strengthen communication skills when offering support to others, including equipping parents with new ways to communicate with their children and or/partners, through a more empathic and listening approach.

EXAMPLE: A RESPITE CENTRE FOR CHILDREN WITH DISABILITIES IN MALAWI

In Dzaleka Camp, Malawi, parents of children with disabilities came together to establish a respite centre for children with disabilities. This was in response to the limited opportunities that children with disabilities have to access education, which also serves to limit their interaction with other children of the same age. Due to a lack of other options, children with disabilities were also left alone at home while their parents went out to work or carry out tasks outside the home, which created protection risks. The respite centre is managed by a community management committee, made of parents of children with disabilities. Parents also work in the centre as volunteers, and have received training from a local organization. The centre provides social and recreation activities as well as basic rehabilitation and life skills. It is also intended to serve as a transition to formal education, with some children moving from the centre to the local primary school, with support from the resource centre located in the school. Respite centre staff and volunteers also conduct home visits to children with disabilities to identify needs and provide information and referral. Parents of children with disabilities are now able to work to provide for other basic needs of their families, thus contributing to their own and their families' well-being.

The example above illustrates the links between different levels of MHPSS interventions, as well as the connections between CBP and MHPSS.

FROM AN MHPSS PERSPECTIVE

The intervention contributes to the well-being of both the participating children and their families. For the children, interaction with peers is important to reduce isolation and promote cognitive and social development. For the respite centre volunteers, being able to help people from their own community is likely to build their resilience and promote their dignity and self-esteem.

FROM A CBP PERSPECTIVE

It is important that refugees, including marginalized and isolated groups, have themselves identified what the problems were and what kind of support they needed to be able to address this problem. Their views were taken into account in the design of the intervention, which builds on the capacities of refugees, who are then empowered to support their peers. The protection situation of the children has been enhanced as a result of this programme, including through bringing children and families in contact with child protection actors, and through building protective peer networks.

WORKING WITH REFUGEE VOLUNTEERS TO FOSTER REFUGEE WELLBEING

Another community-based protection intervention is to engage individual refugees as volunteers to support other refugees. With adequate training, supervision and support, refugees can successfully provide culturally appropriate support, given their deep knowledge of their communities. Examples include:

- Community-based outreach programmes, particularly in complex out-of-camp settings,
- Engaging refugees as 'peer counselors' or 'community psychosocial workers.'[ii]

The engagement of refugees is also key to building their own self-esteem and dignity, and strengthens their ability to cope with their own problems. A pilot programme in Syria,engaging Iraqi refugees as outreach volunteers, showed positive effects on well-being of the participants. Moreover, the psychosocial wellbeing of the MHPSS outreach volunteers themselves showed also significant improvement.[iii]

"Some of the things I do to help people are very practical. But I think that listening and talking, as one human being with another human being, makes the biggest difference."

-Somalian refugee peer counselor in Ethiopia

THE IMPORTANCE OF CULTURAL AND RELIGIOUS PRACTICES

In crisis situations, spiritual or religious beliefs and practices may help people cope with pain and suffering. They may provide meaning, support collective identity, and give a sense of hope. Being able to pray and engage in other religious practices can be a great comfort and help structure daily existence. The refugee crisis in Europe has, for instance, highlighted the importance of dignified burials--in the presence of a religious authority, for refugees who died at sea, and the major distress that can result where such rituals are not able to be performed.

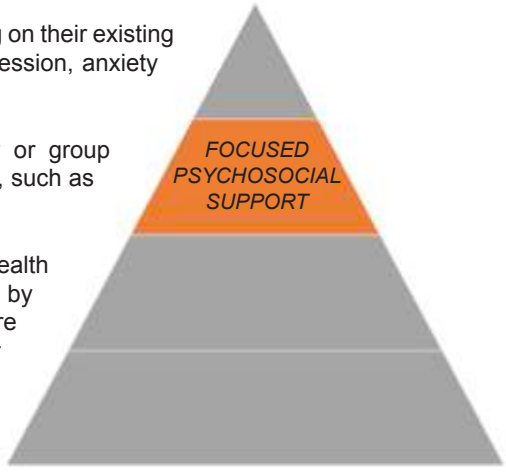
Interventions should take local cultural and religious practices into account and try to build upon positive and non-harmful practices, following a careful evaluation of these practices against human rights standards, by linking with religious and traditional leaders and practitioners. In contexts where community networks and protection mechanisms can be significantly disrupted, it is important to look at the individuals that community members would normally turn to in situations of distress before they were displaced. In many contexts these may be religious and traditional leaders, who may play a central role in building social cohesion and re-establishing community ties.

EXAMPLE: TACKLING SUBSTANCE ABUSE IN COLLABORATION WITH RELIGIOUS LEADERS IN CAMEROON

In Cameroon, UNHCR's main MHPSS NGO partner set up a programme to address substance abuse among refugees. It engaged Muslim clerics, who through their preaching, informed the communities about the dangers posed by drugs, which are banned by Islam. These messages reinforced and complemented the awareness-raising activities by the NGO workers. The NGO also cooperated with traditional healers who are an important source of psychosocial support for refugees. The NGO consulted and trained traditional healers. Informal referral pathways were set up, so that healers could refer to the NGO in case a client did not benefit from their services.

LAYER 3: FOCUSED PSYCHOSOCIAL SUPPORT

Some people cannot overcome their psychosocial and mental health issues by relying on their existing support networks. For example, people who suffer from more severe forms of depression, anxiety and grief, or people who have complex social problems, may need external support.



People in these kinds of situations may benefit from focused individual, family or group interventions, which can be delivered by well-trained and supervised non-specialists, such as community workers, social workers, or refugee volunteers.

It is a myth that quality psychosocial interventions can only be done by mental health professionals. It is equally a myth that all psychosocial interventions can be done by trained lay workers. It is therefore important that when refugees with limited training are involved in delivering MHPSS interventions, they have a clear understanding of their strengths and their limitations, and are able to consult with and refer to more highly qualified MHPSS workers. Perhaps the most important elements in successful work with refugees as psychosocial workers is ongoing training and on the job as well as peer supervision. See the example from Cairo, page 14.

In addition, refugees involved in MHPSS work must also have support to deal with their own psychosocial wellbeing. Refugee volunteers/workers deal with similar hardships to their peers. Hearing about other people's problems and trying to solve them often causes additional distress. Mechanisms should therefore be in place for care and support for the refugee volunteers/workers themselves.

"It is a myth that quality psychosocial interventions can only be done by mental health professionals."

EXAMPLE: USING THE POWER OF GROUP SUPPORT IN RWANDA

Interpersonal dynamics in small groups can be powerful in addressing loss, grief, fear, loneliness and trauma among people who are socially marginalized and/or are overwhelmed with negative emotions and thoughts. In post-conflict and refugee settings the social fabric is often damaged, with high levels of mistrust many lives being marked by atrocities and losses of the past. In these contexts, group-based approaches can foster healing by addressing the interconnection of individual and social wellbeing. 'Community-based sociotherapy' is an example of a group-based approach implemented in a post-conflict society. It has been developed in Rwanda and since 2015 it is also used with Congolese refugees in Rwanda.

Groups meet weekly for 15 weeks in three-hour sessions facilitated by two 'sociotherapists' who are community members themselves. The approach aims to establish a safe group environment where participants can share experiences and are encouraged to take care of each other. The focus is on strengthening social links between group members which supports participants in building their self-confidence and capacity to solve their problems, deal with distress and engage in community activities. The dynamic in the group provides opportunities for participants to learn from one another. Gradually they regain the vitality and trust to introduce positive changes in their personal, family and community lives.

Groups usually consist of people with different ages, genders and backgrounds – but it is also possible to create more homogeneous groups. Since 2005, the programme has engaged thousands of people and evaluations indicate that the intervention improved the mental health and social wellbeing of participants.

TRAINING REFUGEES TO PROVIDE SCALABLE PSYCHOLOGICAL INTERVENTIONS

Refugees with common mental disorders, such as depression, anxiety, or post-traumatic stress disorder can be effectively helped with psychological methods. In humanitarian settings, the need for psychological treatments is far greater than what can be provided with the limited number of mental health specialists that are available.

The World Health Organisation, in collaboration with a range of global mental health researchers and partners including UNHCR, is therefore developing and testing a series of psychological treatments that can be delivered by non-specialists, including refugees, if they are well trained and supervised.[3]

Trainees should include both women and men, particularly if the group has strong gender divisions. These methods share certain features: they are brief (5-8 sessions); they have been adapted for low resources settings and various cultural contexts; and have been presented in brief, practical manuals.

[3]These include a number of research trials in relation to psychological methods such as Problem Management Plus (http://www.who.int/mental_health/emergencies/problem_management_plus/en/), interpersonal therapy and cognitive behavioural therapy and other techniques and packages.

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EXAMPLE: REFUGEES AS COMMUNITY PSYCHOSOCIAL WORKERS IN CAIRO

One of UNHCR's partners in Egypt works to enable refugees in Cairo to play an active role in providing protection to highly vulnerable refugees in this massive urban context. The programme trains refugee psychosocial workers who come from the community and are recommended by the community. The team is multicultural, multilingual and multidisciplinary with refugees from Africa and the Middle East.

Psychosocial workers need to have completed secondary education, but prior experience in psychosocial work is not required. One class of 25 to 30 students is trained yearly, with an initial 5 weeks classroom and field training period, following by weekly capacity building / learning sessions while they are on the job. Psychosocial workers are closely supervised by a senior refugee team leader and receive regular support and supervision from Egyptian psychiatrists. The team members have weekly case management meetings. Each refugee worker also has a 'buddy' (a senior refugee worker) and are part of a peer support group to share the burden of their work, which can be emotionally challenging.

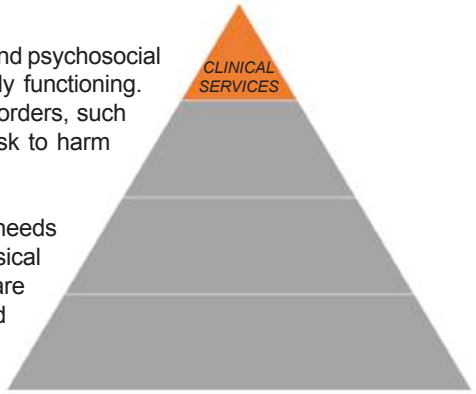
Psychosocial workers assist all refugees regardless of their problems. Their activities include home visits, problem identification and assessment, counseling, problem solving, case management; information sharing, housing support, mental health care, community integration and referral to more specialised services.

They are on call 24 hours a day to manage emergencies related to protection issues and mental health. There are also many emergencies related to general health problems. Many refugees have difficulties in accessing appropriate health care because they are frightened by the complicated health system and do not speak the local language. A health team consisting of refugee and Egyptian doctors and nurses work with the psychosocial workers to actively assist refugees with emergency medical needs to access health care. The health team advocates for medical care while the psychosocial worker helps refugees to understand the public health system.

The refugee psychosocial workers enjoy a high level of legitimacy and trust in their communities. This is a major source of pride for them and an important factor in their ability to rebuild their own lives and facilitate their resilience to deal with issues they are facing as refugees in Egypt.

LAYER 4: CLINICAL SERVICES

A relatively small percentage of any population will have severe symptoms of mental health and psychosocial problems, and/ or an intolerable level of suffering, and have great difficulties in basic daily functioning. This group includes people with severe mental disorders, including pre-existing mental disorders, such as psychosis, drug abuse, severe depression, disabling PTSD, and people who are at risk to harm themselves or others.



People with serious mental health conditions are a particularly vulnerable group that needs protection, including protection of their rights to evidence-based treatment, as well as physical and social protection. These people can often be helped through basic mental health care interventions delivered by mental health specialists--However, they are also often assisted by trained doctors, nurses, clinical officers in primary care, if they are well supervised and supported by a visiting/supervising mental health professional.

Although the overwhelming majority of refugees do not need clinical mental health services, those with severe symptoms, and/or an intolerable level of suffering, who have great difficulties in basic daily functioning will require professional help and it is important that such services are available. Community-based protection work can have a positive effect on the provision of clinical MHPSS services. Most important is to ensure linkages between clinical services and refugee communities. This can be done by engaging community structures for timely referral, accompaniment of people to facilitate their access to services, and adequate follow up.

Clinical mental health services can greatly benefit from community-based protection approaches. For example, insights from regular consultations with refugees and involving refugees in the design of services will enable mental health professionals to better understand MHPSS issues among refugees. For example, insights from consultations with refugees help mental health professionals to better understand MHPSS among refugees, such as how communities define and perceive mental health problems and how they deal with these issues, before and during displacement.

Involving refugees in the design of services enables mental health professionals to provide culturally and contextually relevant and accessible services to those who need them. It is also important that information for communities about available clinical services is also culturally and contextually relevant and that it makes sense to people, and addresses what is at stake for refugees. Good information can challenge myths, promote acceptance and reduce stigma towards people with mental health conditions and the specialized services provided.

Community-based protection work that strengthens community ties and structures can therefore facilitate access to clinical mental health services by those who need it. Strong community ties can also help people with severe MHPSS conditions to re-integrate within the community and support them while they are receiving treatment.

CONCLUSION

As outlined in this document, community-based protection and MHPSS are closely connected. As shown throughout this text, neither can be done well without the other. UNHCR staff and partners are encouraged to systematically look for opportunities to work in a manner that simultaneously improves community-based protection and MHPSS. Doing so, will ultimately lead to better protection of refugees and contribute to their wellbeing.

RECOMMENDED READINGS

- **Inter-Agency Standing Committee (2007). Guidelines on Mental Health and Psychosocial Support in Emergency Settings**:http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf
- **Inter-Agency Standing Committee (2010). Mental Health & Psychosocial Support in Humanitarian Emergencies: What Should Protection Programme Managers Know?** https://www.unicef.org/protection/what_humanitarian_health_actors_should_know.pdf
- **UNHCR (2013). Operational Guidance for Mental Health and Psychosocial Support Programming in Refugee Operations**: http://www.unhcr.org/525f94479.pdf
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