

Strengthening Child and Adolescent Mental Health Services and Systems in Humanitarian Settings

The Potential of Implementation Science



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KEYWORDS

- Mental health • Psychosocial support • Systems strengthening
- Implementation science

KEY POINTS

- Evidence for the effectiveness of mental health and psychosocial support for children and adolescents in humanitarian settings does not organically translate into practice.
- Implementation science offers mechanisms with which we can better scale-out and scale-up evidence-based interventions while maintaining quality and contextual relevance.
- Examples from Rwanda and Lebanon demonstrate the potential for implementation science to move beyond randomized controlled trials to real world impact.

INTRODUCTION

Worldwide, 1 in 4 people live in conflict-affected places, and over half of the world's conflict-affected population is children.¹ Children residing in settings of armed conflict are at risk of adverse mental health and developmental outcomes due to direct exposure to potentially traumatic events, but also indirect exposure through a wide range of daily stressors, including disrupted family environments, interpersonal loss, destruction of routines and structure, fragmented communities, and uncertainty about the

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Abbreviations	
IASC	Inter-Agency Standing Committee
MHPSS	mental health and psychosocial support
PDSA	plan-do-study-act

future.^{2–4} Armed conflict exacerbates every public health issue and has been termed the greatest public health concern for children globally.⁵

The global prevalence of diagnosable mental disorders is 1 in 10 in children and adolescents, making up around one-fifth of all disease-related disability worldwide.⁶ Within war-affected populations, prevalence rates of mental disorders are 2 to 3 times higher than the global average.⁷ Higher rates tend to be observed in children with more direct or prolonged exposure. For example, in Ukraine, youth in a war-affected region were 4 times more likely to show elevated traumatic stress reactions than those in peaceful regions.⁸ In Palestine, prevalence rates of mental disorders in children have been estimated around 35% and have risen to 75% during the second *intifada* (uprising).⁹ Though high, these numbers do not reflect subclinical distress, nor indigenous constructs of distress that may be missed by standard screening tools.¹⁰

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

The complex picture of risk and protective factors shaping mental health among children and adolescents in humanitarian settings is critical to inform mental health and psychosocial support (MHPSS) interventions. Drawing on the diathesis-stress model¹¹ and social ecological theory,¹² addressing risk factors and strengthening protective ones can help shield children from the harms of war, displacement, and political insecurity. MHPSS is defined as any intervention that aims to protect or promote psychosocial well-being or prevent or treat mental health conditions.¹³ Given extremely limited human resources to provide such support, particularly during humanitarian emergencies, the Inter-Agency Standing Committee (IASC)¹³ developed guidance centered around an intervention pyramid that includes focused specialist and nonspecialist community-based interventions (Fig. 1). It is grounded in a

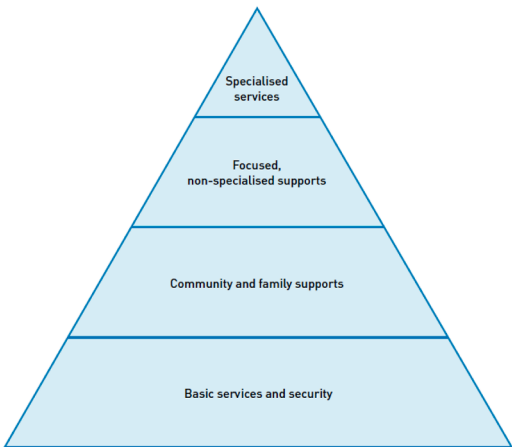


Fig. 1. Mental health and psychosocial support in emergencies intervention pyramid (IASC, 2007). (Source Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.)

task-sharing model, widely endorsed by MHPSS providers, in which interventions can be delivered by trained and supervised nonspecialist mental health providers. This can improve the feasibility of implementation, as long as strong systems for training and supervision are enacted and systems for referrals are defined.

Recent reviews of research gaps identified key priorities which includes scaling evidence-based MHPSS with quality and sustainment. This gap limits the use of evidence-based MHPSS in common practice, where actors on the ground need to know what and *how* to deliver MHPSS at every level of the IASC pyramid, across the social ecology of the affected child, and across different humanitarian sectors. An implementation science and systems strengthening approach will be critical in the years ahead to help the field deliver evidence-based MHPSS interventions at scale—with quality—while strengthening sustainable health and social services systems in war-affected settings.^{4,14,15}

IMPLEMENTATION SCIENCE IN MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Implementation science is the *scientific study of methods to promote the systematic uptake of research findings and other evidence-based practice into routine practice*.¹⁵ It arose from a recognition that evidence generated from research was not routinely integrated into practice, and evidence-informed practice changes were occurring at a glacial pace. A review on research from the US National Institutes of Health found that it took an average of 17 years to translate just 14% of health research into common practice.¹⁶ Implementation science is intended to address services gaps, and support the use of evidence-based interventions at a broader scale, along with strategies to ensure sustainment and quality. It can accelerate the use of evidence-based practices in accessible, sustainable, and high-quality care for those who can most benefit, improving the theory-practice gap and reducing health inequities.¹⁷ Research, especially when blending both effectiveness and implementation questions, can help to identify uptake barriers and facilitators at individual, practitioner, service, and system levels, as well as develop, apply, and test strategies to overcome barriers and improve uptake and scale.^{18,19}

In recent years, implementation science leaders have espoused the use of hybrid designs to better overcome time lags that plague the translation of evidence to common practices in health care.¹⁷ Three common hybrid designs have been put forth; (1) hybrid type I designs which involve testing the effects of an intervention while observing and gathering information on the implementation process; (2) hybrid type II designs which involve testing of both intervention effects and implementation strategies; and (3) hybrid type III designs which mainly focus on the testing of an implementation strategy while observing and gathering information on the intervention's impact on relevant outcomes.

While the evidence base for the effectiveness of MHPSS in low- and middle-income countries and conflict-affected settings is steadily growing,²⁰ evidence for *how* to implement at scale while maintaining quality, is limited. A systematic review identified only 14 studies that included explicit testing of implementation strategies,²¹ reflecting a tendency to use type I designs and prioritize effectiveness testing over scalability.²² Despite some more recent type II trials (eg, in Rwanda²³ and Lebanon²⁴), a massive evidence-to-practice gap in MHPSS services in humanitarian settings remains.

Pathways to scale for evidence-based MHPSS interventions for war-affected children, youth, and families include *scaling-up* and *scaling-out*. Scaling-up refers to the expansion of service delivery to serve more people in the same population or setting, while scaling-out refers to the adaption of an existing evidence-based intervention to

new population or setting, as well as mechanisms to imbed interventions into health systems, policy, regulation, or politics.¹⁹ Existing evidence on scaling-attempts for MHPSS in humanitarian and conflict-affected settings are largely focused on scaling-up and not scaling-out.²¹ To have greater impact, scaling-up *and* scaling-out are needed to optimize accessibility, reach, and sustainability of care across settings and populations.

There are multiple existing frameworks to support implementation science efforts including Exploration, Preparation, Implementation, Sustainment (EPIS);²⁵ Reach, Effectiveness, Adoption, Implementation, and Maintenance (REAIM);²⁶ Consolidated Framework for Implementation Research (CFIR);²⁷ Promoting Action on Research Implementation in Health Services (PARIHS),²⁸ and the roadmap to impact.²⁹ The EPIS framework has guided several hybrid type II studies in postconflict settings.^{30,31} Use of an established implementation science framework can help researchers and practitioners analyze and document the implementation ecology, its features and opportunities, as well as potential strengths and pitfalls at each level, compiling existing knowledge to help identify different pathways to scale.

CHALLENGES TO MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SCALING

There are multiple structural and systemic barriers facing MHPSS service strengthening in war-affected settings. These include the devastation of infrastructure, lack of skilled and motivated personnel leading to high staff turnover, poor supervision and long-term technical support of nonspecialist and specialist staff leading to burnout and poor quality services, and poor referral mechanisms, as well as major competing priorities for tight resources in other areas of health, and a failure to bridge the humanitarian-peacebuilding-development nexus.^{14,21,32–35} These are often compounded by an overall lack of mental health policy and leadership at the national level, resulting in little political will to distribute financial resources, worsened by active political instability and insecurity.³⁶ Ongoing occupation, attacks on health care facilities and staff, and the control of humanitarian aid, such as in Gaza, make efforts to provide any contextually meaningful mental health support at scale deliberately futile.³⁷

On the demand side, limited mental health literacy, practical barriers (such as transport, childcare, and time), and stigma, all contribute to reduced help-seeking.³⁸ In contexts of collective trauma linked to decades of war, occupation, and political instability, other contributing factors include a mismatch between individual clinic-based specialist care and collective need. For example, in Lebanon, the primary reason for not seeking mental health services is the perception that everyone is experiencing the same thing and that difficulties will get better on their own.³⁹ While in Gaza, the violation of justice, freedom, and human rights are inextricably linked to mental health and care provision.⁴⁰ In current practice, the mismatch between service assumptions, including the pathologization of reactions to oppression, occupation and settler colonialism, and the need for contextually relevant care that responds to collective need, is a core barrier.⁴¹

Scale-up pathways for contextually relevant mental health interventions are challenging—but not impossible. Troup and colleagues²¹ identified core scale-up strategies in humanitarian settings. These include integrating mental health services into primary health care and community-based services using Train-the-Trainer models and task sharing, sustainable supervision models and referral mechanisms. On the demand side, community mobilization and sensitization can be used to improve mental health awareness at the community level, as well as embedding community detection mechanisms at the organizational level, and strengthening wider social ecological environments through working with families and communities, and advocating at the

national and international level. Strong examples of such sensitization and awareness can be witnessed in Ukraine where the first Lady, Olena Zelenska, has launched a mental health campaign called *How Are You?* and led an effort to increase access to mental health services during Ukraine's ongoing war.⁴² Scale-out strategies can include collaboration with government ministries to integrate government approved guidelines into national policy. For example, after the Tsunami in Sri Lanka, a mental health policy was developed by the Ministry of Health with the support of local key actors, the WHO and the International Medical Corps to integrate mental health care into accessible primary care settings.⁴³

In using an implementation science framework in the preparation phase, human resources for MHPSS in humanitarian settings might include the selection of trainees based on motivation, experience, and integration within communities, contextually and culturally relevant interventions and training, and refresher trainings and ongoing collaborations with technical experts.³⁰ Further preparation steps might include proactive community detection and manualizing protocols for MHPSS evidence-based interventions, as well as integrating them into existing systems—from primary care to schools and social protection programs—to address multiple levels of the care continuum.^{23,44}

CASE EXAMPLE 1: SUGIRA MURYANGO (STRONG FAMILY) PROGRAM IN RWANDA

An example of moving beyond randomized control trials to implementation science approaches to scaling can be seen in the efforts to scale the Sugira Muryango (SM/ Strong Family) program in postgenocide Rwanda. The SM intervention is a strengths-based home visiting intervention designed in postgenocide Rwanda to promote early childhood development and prevent violence by engaging both male and female caregivers in nurturing care relationships with their young children ages 0 to 3. The intervention has been tested in several trials^{45,46} and has demonstrated significant effects on improving anxiety and depression in male and female caregivers, while also reducing violence in the home by building skills in parental self-regulation, problem-solving, and conflict resolution along with standard content on play/stimulation, nutrition, and hygiene. The theory of change is shown in Fig. 2. To identify and reach

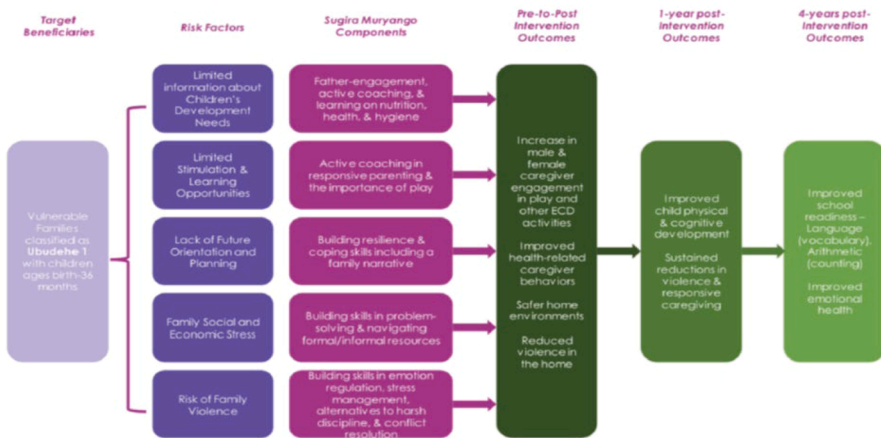


Fig. 2. Theory of change for the Sugira Muryango program. (Source Black, C.J et al., (2025), Scaling up home-visiting to promote early childhood development and prevent violence in Rwanda: a hybrid type-2 effectiveness-implementation trial. *J Child Psychol Psychiatr*, 66: 1484-1499. <https://doi.org/10.1111/jcpp.14160>.)

vulnerable Rwandan households with a child aged 0 to 3 years, the intervention was integrated with the Rwandan government's Vision Umurenge Poverty Reduction Strategy.⁴⁷ In recent years, the SM team has worked closely with the government of Rwanda and the University of Rwanda, testing the PLAY Collaborative strategy to scale the intervention to all households eligible for the social protection program using a Collaborative Team Approach.²³

The PLAY Collaborative strategy is guided by the EPIS implementation science framework and focuses on accompaniment of government partners to eventually fully own and run the program. Individuals with expertise in delivering the intervention comprises an expert Rwandan Seed Team for training and supervision. The PLAY Collaborative also includes cross-site learning efforts across 3 districts and the signing of a common charter committing all partners to quality improvement including use of plan-do-study-act (PDSA) cycles to identify barriers and enhance facilitators to delivery and sustainment of the evidence-based practice. In the Play Collaborative Scale Hybrid Type II study, PDSA cycle problem solving sessions were held at all levels of government from national to district, sector, and clusters of villages. The PLAY Collaborative implementation science research questions were first about the effectiveness of the intervention when delivered by existing community child protection volunteers⁴⁸ as well as understanding issues of burden, incentives, cost, and intervention quality. A digital dashboard tool is currently being co-created with government stakeholders and tested to ensure that data on implementation quality are readily available for government leaders, community-level managers, and Seed Teams. Under the PLAY Collaborative strategy the SM team trained 2608 child protection volunteers (inshuti z'umuryango/IZUs) to deliver SM to more than 20,000 households across 3 Districts. PLAY Collaborative meetings engaged a total of 15,351 GoR officials and local stakeholders (eg village leaders, community health workers, psychologist practitioners) across the implementation ecology. The PLAY Collaborative strategy was designed together to advance GoR strategic goals related to coordination as well as data-driven monitoring and case management across social welfare and child protection systems.

The SM team used EPIS to guide implementation processes, including analysis of recordings and minutes of each PLAY Collaborative meeting, to illuminate implementation barriers by region and share successful solutions to overcoming implementation barriers. This was done with attention to EPIS bridging factors such as partnerships with health and social services agencies, and technology-driven innovations that will be tested in research focusing on the implementation and use of a digital dashboard.²³

CASE EXAMPLE 2: THE SAWA AQWA (STRONGER TOGETHER) FAMILY INTERVENTION IN LEBANON

Sawa Aqwa was developed based on evidence that despite the critical role families play in ensuring adolescent mental health and protection outcomes, there is a severely limited evidence-base for family interventions in humanitarian settings, especially in South West Asia and North Africa.⁴⁹ Sawa Aqwa grew out of formative qualitative research with families and a systematic review of existing family interventions in low-and-middle income countries, through a participatory process of intervention development with Community Advisory Boards comprising adolescents and caregivers across multiple sites, and international and local experts in family interventions and MHPSS in the region. The theory of change is displayed in [Fig. 3](#). The aim was to develop a contextualized intervention that addressed the social ecology of

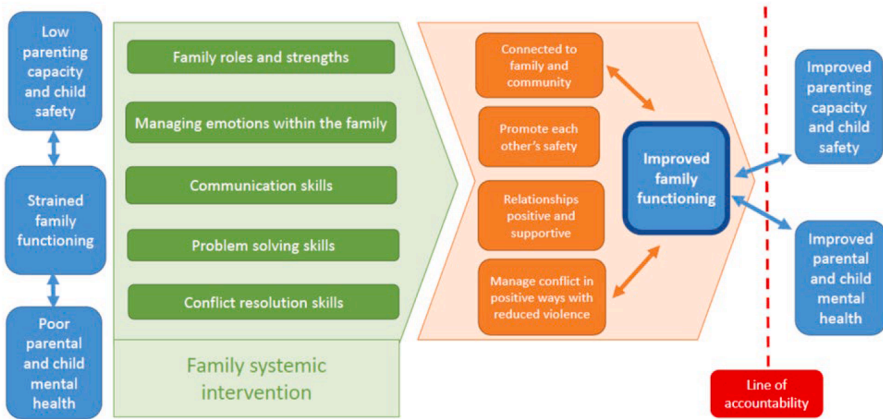


Fig. 3. Theory of change for the Sawa Aqwa (Stronger Together) family-focused psychosocial support intervention. (Created in Microsoft Powerpoint.)

adolescents, suitable for non-specialist delivery and wide-scale implementation in Lebanon and other similar contexts.

Sawa Aqwa involves 6 weekly sessions, and one booster session 1 month later. Sessions involve 90-min meeting with the whole family and an additional 30-min for parents only. Sessions include (a) family roles, strengths and goals, (b) joint emotional regulation, (c) communication, (d) problem management, and (3) conflict resolution. A fully powered hybrid Type II effectiveness-implementation randomized control trial with over 350 families demonstrated effectiveness of the intervention for adolescent and mother reported family functioning, caregiver mental health, parenting, and adolescent wellbeing for adolescents who completed the intervention,²⁴ as well as for optimal implementation in terms of costing, format, training, supervision and maintenance of quality.

Using an integrated implementation framework drawing on both the Roadmap to Impact and EPIS (Fig. 4), we focused on quality and feasibility as indicators of successful implementation ultimately leading to greater impact. For quality, the Sawa

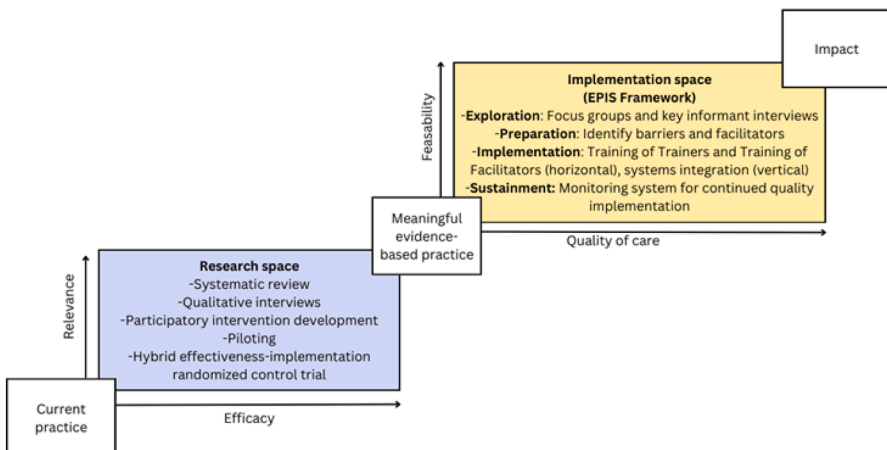


Fig. 4. Integrated implementation framework. (Created in Canva.)

Aqwa team identified high attendance (adolescents, caregivers) and adherence through fidelity assessments (facilitator self-report, and supervisor observation). Core areas of implementation strength and challenges were identified through training evaluations of facilitator competence and session observation using the FamACT competency checklist from the WHO/UNICEF EQUIP toolkit.⁵⁰ For feasibility, investigators monitored and compared the cost of the intervention using UNICEF's structured costing tool, comparing it to adolescent and group interventions already being delivered, helping to map the potential caseload and timeframe of delivery per facilitator and providing the tools and foundational experience to implement and monitor implementation in real-world settings with greater reach.

To scale-out, War Child Alliance developed the intervention further in the context of Jordan. Based on feedback and lessons learned in the hybrid type II study, modules were added to address specific family needs based on additional qualitative research with adolescents and their caregivers,⁵¹ to include managing disagreements, strengthening parenting, and managing difficult emotions. The intervention was tested in a feasibility trial with 62 families in Jordan, replicating findings from Lebanon. Efforts for both scale-out and scale-up have been made. While scale-up efforts include the continued delivery of the intervention by implementing partners, such as War Child and Terre des Hommes Italia in Jordan and Lebanon—further training of facilitators conducted by Premières Urgences Internationales to deliver the intervention to families during the war on Lebanon—further scale-out efforts have been made. These include adaptation of the intervention to families in Iraq through GIZ and Green Deserts, the integration of the FamACT competencies into clinical psychology and social work training programs in Lebanon, and integration into a core module of the Diploma in Child and Adolescent Mental Health in Humanitarian Settings in the Middle East and North Africa, a capacity building initiative co-led by Save the Children and the American University of Beirut.

SUMMARY

There is great potential for implementation science to inform the scale-up and scale-out of contextually relevant evidence-based MHPSS services in conflict-affected and humanitarian settings. This can ultimately lead to strengthened and more sustainable MHPSS systems through pathways that consider quality, feasibility, cost, context, accessibility, acceptability and reach. It is time to shift focus from what works to *how* it works, for whom under what circumstances, and how evidence-based interventions can be scaled with quality, sustainability and reach. Implementation science can help answer these questions. Global efforts, such as through the Minimum Services Package for MHPSS developed by UNICEF/WHO can help to support local contextually relevant implementation by, among other things, aiming to deliver faster, better informed responses supported by best practice guidelines, standards, and tools. Through a shift in the focus of MHPSS research efforts in humanitarian settings building beyond the many successful randomized trials to now explicitly studying strategies for scaling evidence-based MHPSS interventions with quality and sustainment, we will be better able to inform decisions to support the mental health of children and families living through turmoil.

INSIGHTS TO ACTION

- Implementation at scale should be informed by evidence for optimal pathways to scale, to maximize reach while maintaining quality.

- In complex humanitarian settings, systemic and structural barriers, and contexts of occupation and ongoing violence, are major challenges.
- Consideration for quality, feasibility, cost, context, accessibility, acceptability and reach are essential for the strengthening and sustainment of mental health systems.

DISCLOSURE

The authors have no financial disclosures or conflicts of interest to disclose.

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