Spotlight Initiative
Mental Health and Psychosocial Supports (MHPSS) Brief

Instructions

NB: The structure of this brief is based on the structure of existing Spotlight technical guidance or briefs, including on Spotlight's six pillars here, technical guidance on innovation here, and guidance on engaging men and boys here. This brief aims to provide guidance on how one might integrate mental health (i.e. meaningfully mainstream mental health) into Spotlight's existing results framework; for reference, Spotlight's global results framework can be found here.

Guiding principles

1. Ensure the adoption of a **survivor-centred approach,** placing at the centre survivors' agency, voice and needs. This is particularly relevant for service providers, which are often important entry points for survivors of VAWG. Service providers should consistently apply a survivor-centred and trauma-informed approach (e.g. an approach that entails non-judgmental listening, validation and empathy, reduction of self-blame and shame, and information about the traumatic effects of violence) while ensuring confidentiality, safety and security, respect, non-discrimination and non-stigmatisation.[1]
2. Mental health and psychosocial support services (MHPSS) should be available and accessible to all women and girls regardless of gender, age, religion, ethnicity, migratory status, or any other identity. In line with the **principles of Leaving No One Behind (LNOB), equity and non-discrimination,** services should be located in convenient and safe places and be provided at convenient times taking into account, inter alia, care responsibilities. MHPSS services should also be available through remote communication methods, such as hotlines.[2]
3. Adopt a "**do no harm" approach**. Mental health support to survivors of VAWG deals with extremely sensitive issues and should "do no harm". Right-holders should be informed about the potential risks[3] linked to mental health and psychosocial support services (MHPSS) and should be fully engaged in all decision-making processes. All individuals involved in MHPSS should remain alert to possible adverse effects and unintended consequences and develop risk mitigation strategies.[4]

[1] WHO, 2012
[2] Essentials for quality multisectoral service provision to women migrant workers subject to violence, Spotlight Initiative, Safe and Fair, 2020
[3] Potential risks include if MHPSS is not delivered properly - i.e. if it is not a survivor centered or trauma informed approach, are additional harm or re-traumatization as well as emotional distress. Psychologists, therapists, counsellors and other front-line providers of MHPSS should also ensure that survivors are informed about potential external risks linked to their access to services-including stigmatization, marginalisation, systemic discrimination, pain for social deprivation, as well as physical unsafety, post-interview retaliation against survivors. In this regard, women benefiting from MHPSS services should be timely informed about unintended consequences of accessing MHPSS and existing referral mechanisms, particularly legal protection services and local protection mechanism.
[4] https://www.endvawnow.org/en/articles/1566-principles-of-psychosocial-care.html

4. Ensure that all prevention and response interventions are fully embedded into the **socio-ecological model**, which is reflected in the Spotlight Initiative's Theory of Change. As mental health is impacted by social, economic, political, and psychological factors - at household, community, state and global levels - it is crucial to adress mental health from a holistic and multi stakeholder perspective which acknowledges and embraces the complexity of deeply rooted power structures, social norms and beliefs around mental health and violence against women and girls (VAWG).
5. Promote **sustainability** by building on and strengthening existing resources and wider systems (e.g. existing community support mechanisms, formal/non-formal school systems, general health services, general mental health services, social services, etc.), enhancing coordination across and within organisations and sectors, strengthening local capacity, and supporting self-help.
6. Should you decide to focus **programming on perpetrators or future perpetrators,** please make sure that appropriate consultations are being held with experts and civil society organizations, as the evidence on such programmes' impact is mixed. Please also ensure that investments in such programmes do not divert resources from or come at the expense of programmes focused on survivors of VAWG. Specific precautions should be made when engaging in such programmes, and consideration about the safety of partners and children should be at the forefront of interventions. Evidence based experiences and programs should always be the basis for developing these (and other) interventions.

What? *(Definition/Purpose)*

Mental health is defined as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.[5]

Psychosocial is a term often employed to highlight the interplay between psychological aspects of experience and the wider context - including the political and social aspects of experience, social ecology, and culture and values - in which individuals and communities are embedded.[6] **Psychosocial support** includes a range of services offered by mental health professionals, including mental health counseling, and group support to spiritual support and can be provided by psychologists, social workers, and pastoral counselors, among others.[7]

While the terms mental health and psychosocial support are closely related and often used interchangeably, for many professionals, they reflect different and complementary approaches. Mental health (or mental health assessment and care) is often used within the health sector (though notably the sector has used the terms psychosocial rehabilitation and psychosocial treatment to refer to interventions aimed at treating individuals with mental disorders, as well). Practitioners and decision-makers outside the health sector, on the other hand, tend to refer to psychosocial well-being and psychosocial support and counselling. As the definition and use of these terms varies across sectors, organisations and countries, for the purpose of this technical brief, the term mental health and psychosocial support (MHPSS) will be used. MHPSS encompasses a wider range of stakeholders working in these fields and the multiple approaches taken to providing support services to survivors of VAWG.[8]

Why? Key points about why supporting mental health is important for ending VAWG

[5] World Health Organization. *Promoting mental health: concepts, emerging evidence, practice (Summary Report)* Geneva: World Health Organization; 2004

[6] Tol, Reis, Susanty, & de Jong. (2010). From: UNHCR's mental health and psychosocial support, 2013

[7] American Psychological Association, APA Dictionary of Psychology

[8] Guidelines on MHPSS in Emergency Settings, IASC, 2007

General Background

Mental health is impacted by multiple and intersecting social, economic, political, and psychological factors - at household, community, state and global levels - as well as by the accessibility to and availability of coordinated quality services. The level of adversity (or stressors) generally faced can also impact survivors and perpetrators' mental health, including their ability to exhibit resilience in the face of adversity. As noted by the WHO, the burden of mental health disorders continues to grow, with significant impacts on health and major social, human rights and economic consequences globally.[9] The global health pandemic, coupled with economic and food insecurity, unemployment, and movement restrictions, among other crises, has further exacerbated mental health challenges and VAWG.

While it is important to underscore that mental health disorders do not necessarily cause violence against women and girls (and, in fact, those facing mental health disorders are often disproportionately targets of violence, as statistics in the UK, for example, have shown[10]), mental health disorders can contribute to the perpetuation of VAWG *and* can be a widespread consequence of VAWG. On the latter, research has shown that intimate partner violence (IPV) places women at risk for negative health consequences, including increased mental health disorders, [11] and women and girls who are at risk of or have experienced violence report increased incidences of depression, anxiety, and post-traumatic stress disorders, among others.[12]

Women and girls experiencing multiple and intersecting forms of discrimination are often disproportionately at risk of violence, and of experiencing mental health disorders. In emergency settings or during protracted crises, this risk is further heightened for all women and girls, though particularly for those subjected to multiple forms of discrimination[13].

Why is it important to integrate MHPSS into VAWG programming?

As mental health disorders can be both a consequence of violence against women and girls, as well as a potential driver of violence, a holistic approach to VAWG programming should integrate MHPSS, focusing on response and prevention. As reflected by the model below (which focuses on health broadly, but could be adapted for MHPSS), MHPSS should be considered a crucial component of primary and secondary prevention interventions, as well as an essential dimension of a comprehensive approach to VAWG and those at risk of experiencing violence.[14] Different and complementary types of MHPSS should be provided to survivors of VAWG with survivors by a range of actors, including community actors, front-line service providers, and specialised MHPSS personnel.

[9] WHO. Mental disorders. Nov 2019.

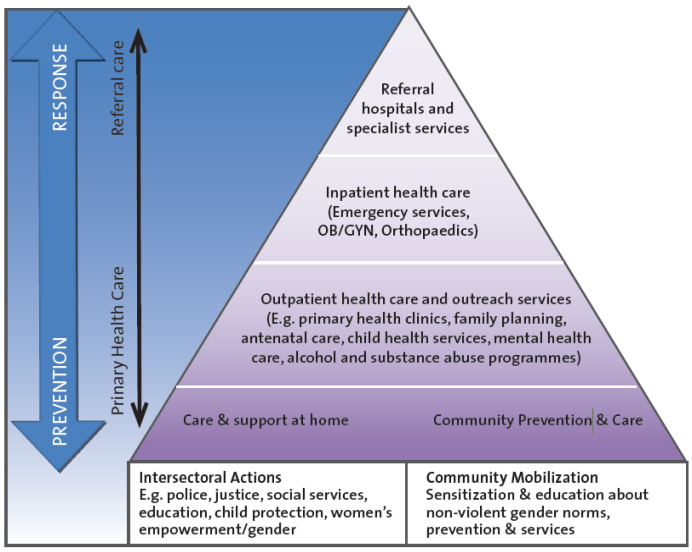
[10] https://www.mentalhealth.org.uk/statistics/mental-health-statistics-domestic-violence

[11] Nathanson, Alison M et al. "The Prevalence of Mental Health Disorders in a Community Sample of Female Victims of Intimate Partner Violence." *Partner abuse* vol. 3,1 (2012): 59-75. doi:10.1891/1946-6560.3.1.59

[12] The Effects Of Violence On Health, Health Affairs, 2019

[13] https://www.centreformentalhealth.org.uk/sites/default/files/2020-06/CentreforMentalHealth_CovidInequalities_0.pdf

[14] WHO et al. Mental health and psychosocial support for conflict-related sexual violence: principles and interventions.



Source: Adapted from Lawn JE et al, Lancet, 2008 30 years of Alma Ata

Drilling down further, the importance of integrating MHPSS into prevention efforts, and services - and the contours of each - is discussed below (acknowledging the continuum across these interventions).

Why integrating mental health in <u>prevention</u> efforts (with men and boys) is important to tackling VAWG:

While prevention spans a range of interventions and approaches, this technical brief focuses primarily on work with men and boys on power, masculinities, and social norms.

- VAWG is deeply rooted in an unequal and asymmetrical distribution of power (perpetuated by intersecting systems of supremacy, such as patriarchy, white supremacy/racism, and occupation/colonialism, among others).[15] Evidence shows that mental health disorders can and have been associated with an increased risk of experiencing violence, and of perpetrating intimate partner violence (IPV). For example, men with depressive disorder, anxiety disorder, alcohol use disorder, drug use disorder, attention deficit hyperactivity disorder, and personality disorders have a higher risk of perpetrating IPV. **As such, a mental health dimension should be an integral part of comprehensive and gender transformative interventions aimed at encouraging men and boys to embrace healthy models of masculinity.**[16]
- Shifting harmful practices and behaviours is an important part of tackling root-causes of VAWG. At the individual level, supporting men and boys to understand that VAWG is unacceptable is key, as perpetrators can struggle to recognise their actions as violent or the impact of their actions on their families and communities. **Identifying certain (abusive) behaviours as violence against women and girls - through**

[15] In addition to an expression/conceptualization of power as power "over" rather than power together/collectively.

[16] Mental disorders and intimate partner violence perpetrated by men towards women: A Swedish population-based longitudinal study, Rongqin Yu and others, 2017

mental health or psychosocial supports - provides an important step toward changing perpetrators' behaviours.

Why integrating mental health in response services is important to tackling VAWG:

- Violence against women and girls often results in multiple negative consequences on women's and girls' mental health and psychosocial well-being. For this reason, survivors of VAWG may require acute and, at times, long term care, particularly mental health care.[17] **Therefore, prioritising mental health and psychosocial support services in VAWG response is crucial to ensure that survivors receive a comprehensive and quality response package.**
- Survivors of VAWG may experience symptoms of trauma without recognizing these as such. **Therefore, availability of and accessibility to quality and integrated mental health services becomes vital to effectively respond to cases of VAWG, and reduce the risk of re-traumatisation.**
- Even where mental health and psychosocial support services are available/integrated into VAWG, they are often underfunded, understaffed, considered as "non-essential" services, and/or of insufficient quality. **Advocacy and support for improved quality, coordination, scope or coverage, and funding continue to be needed**, particularly to ensure accessibility for women and girls who suffer intersecting and multiple forms of discrimination, such as migrant women, refugee women, women with disabilities, women living with HIV and AIDS, or women living in remote or rural areas.
- Additional obstacles preventing women and girls from accessing quality, culturally sensitive and age-appropriate sectoral services persist, including a lack of knowledge of available mental health services, survivors' fear of reporting due to the stigma of victimization, as well as the cost of services. **These must be addressed through a comprehensive approach to services.**

[17] ESP, module on health

Fostering well-being and mental health of front-line service providers working with survivors of VAWG

Vicarious trauma is a widespread effect of the empathetic engagement with trauma survivors. While practitioners working in the field of mental health are generally disproportionately affected by vicarious trauma due to their direct and profound engagement on extremely sensitive issues with survivors of VAWG, also other frontlines, such as doctors and police officers, can be affected by it.

Vicarious trauma is a complex and critical dimension to be addressed by comprehensive response interventions with the aim of: a) Promoting self-care and mental health of front-liners; b) Encouraging access to specialized and targeted MHPSS; c) Enhancing access of front-liners to information, knowledge and targeted tools to timely and effectively identify and tackle the consequences of vicarious trauma . This is critical not only to enhance the quality of response services but also to ensure sustainability of results.

Acknowledging the importance of encompassing this critical dimension in comprehensive VAWG programmes, this brief will focus on mental health challenges and its interlinkages with VAWG from the perspective of survivors of VAWG.

How?
This section detail *how* MHPSS could be mainstreamed into Spotlight Initiative's Global Results Framework (with a focus on Pillar 3 and 4)

PART A: Understand the Latest Evidence and Learning

Acknowledging both the existing evidence and knowledge gaps on the inter-linkages between mental health and VAWG (particularly for the prevention component), this section provides a summary of the latest thinking, evidence, and practice-based learning that can help to inform programming.

Part A also guides the identification of areas in need of additional research/evidence, for the purpose of advocating for increased access to and availability of mental health services for survivors.

PREVENTION

Addressing the mental health dimension in prevention programmes, including through a fostered engagement of men and boys

The below captures the latest evidence and learning on integrating MHPSS into prevention work, including with men and boys. The evidence is derived from a range of sources (listed below in the section on "Tools and Resources"), and then mapped onto / organized by Spotlight Initiative's existing results framework in order to help

demonstrate how the Initiative might concretely (and meaningfully) mainstream/integrate MHPSS into its existing outputs.

Ensure the inclusion of a mental health component into programmes aimed at promoting gender equitable social norms, attitudes and behaviours change at community and individual levels (Output 3.1)

- Ensure that national and/or sub-national evidence-based programmes aimed at promoting gender-equitable norms, attitudes and behaviours (including comprehensive sexuality education programmes) integrate a mental health component, focusing on the intersection of VAWG and mental health.
- Additional financial and human resources should be allocated for this, and clear lines of accountability/responsibility should be detailed. Additional indicators (to track progress) should be reflected in existing programmes' monitoring efforts to meaningfully reflect the mental health dimension. Recourse processes should be outlined as well (for rights holders to access should mental health not be properly integrated - ie through a survivor-centered and trauma-focused lens). These actions, along with others, help to ensure the meaningful implementation of mental health into existing programmes, so that existing programmes are purposefully adjusted (rather than simply engaging in a "ticking the box" mainstreaming exercise).

Promote critical dialogue and exchange, including with men and boys, around power imbalances and existing linkages between VAWG and MH (Output 3.2)

- Design community mobilization interventions aimed at shifting norms around VAWG and tackling widespread stigmatisation of mental health disorders (in general) and access to related-services. Engage community members and leaders designing both tailored approaches for target groups (e.g. boys and men), and system-wide strategies to transform social norms and generate critical reflections around power imbalances and existing linkages between VAWG and MH.
- Develop and/or strengthen community advocacy platforms to foster community dialogues, public information and advocacy campaigns, around the linkages between mental health disorders and VAWG, reducing stigmatisation of those benefiting from MHPSS and increasing awareness about the connections between mental health and VAWG (three connections/pathways to potentially discuss: those struggling with mental health disorders are more likely to experience VAWG; mental health disorders are a common consequence of VAWG; and those (men) suffering with mental health disorders can perpetuate violence).
- Ensure the integration of a mental health component into campaigns aimed at challenging harmful social norms and gender stereotyping. Through a participatory approach, develop and include targeted messages to increase awareness around the impact of MH disorders on VAWG, reduce stigmatisation benefitting from MHPSS., and enhance help-seeking behaviours.
- As help-seeking is often perceived as "feminine" behaviour, seeking help can challenge men's view of their own masculinity. Through campaigns and community advocacy platforms, these assumptions should be

challenged and men should be encouraged to question their own beliefs around the connections between MH and violence, recognise their actions as a form of VAWG, and seek support to specialised services.[18]

Enhance knowledge and understanding of decision and opinion makers on how to raise awareness about the interlinkages between MH and VAWG

(Output 3.3)

- Integrate knowledge and information about MH into capacity building activities for journalists, influencers and bloggers increasing their ability to sensitively report and raise awareness on the linkages between MH and VAWG.
- Foster understanding and knowledge, through targeted capacity building activities and advocacy efforts, of informal decision makers and decision makers in relevant institutions, on the importance of addressing and integrating mental health's needs and related challenges into legislation and policies.

SERVICES

The below captures the latest evidence and learning on integrating MHPSS into services to respond to VAWG. The evidence is derived from a range of sources (listed below in the section on "Tools and Resources"), and then mapped onto / organized by Spotlight Initiative's existing results framework (in order to help demonstrate how the Initiative might concretely (and meaningfully) mainstream/integrate MHPSS into its existing outputs).

Ensure the provision of integrated mental health support services to survivors of VAWG in-line with quality standards and tools in selected countries
(Output 4.1)

- Raise awareness among decision-makers about the importance of long-term planning and investment in comprehensive response services, inclusive of MHPSS, for survivors of VAWG and for professionals working with survivors. To achieve sustainable results, services should be properly funded and staffed and the level of quality and coordination should meet internationally agreed standards.
- Ensure the adoption of and access to survivor-centered, trauma-informed, quality essential services, including MHPSS (e. g. psychologists, therapists, counsellors). Survivor-centered and trauma-informed MHPSS services prioritise, for instance, providing information about the traumatic effects of violence; exchanging with survivors on the most appropriate response to their needs; adapting programmes and services to survivors' trauma and mental health-related needs; and offering resources and referral. Access is critical not only to the health and safety of survivors, but to prevent recurring cycles of violence. Ethical

[18] See the University of Melbourne article "Supporting Men to End Family Violence".

and safety guidelines prioritizing the confidentiality, respect, safety and security of survivors should be maintained at all times.

- Similarly, ensure the full integration of a "Do No Harm" approach in services, since mental health support to survivors of VAWG deals with extremely sensitive issues. This might be done, for instance, by promoting critical reflections and exchange on universal human rights, deeply rooted power dynamics, as well as on the value of participatory approaches and effective multi-stakeholder coordination.
- Following the "Do No Harm" approach, the privacy of patients must be protected by the law to avert marginalisation and systemic discrimination against women and girls who suffer from mental health illnesses. In addition, confidentiality encourages survivors to seek help and support and protect them against social stigma.
- Mental health support services should be culturally and age appropriate. Therefore, they should be established in a participatory, safe and socially appropriate manner and they should build on and/or reinforce existing services and referral pathways including local, indigenous and traditional health systems.
- In emergency settings and during protracted and/or intersecting crises, mental health support is an important resource for survivors and women and girls at risk of experiencing violence. The availability of counsellors and psychologists is important to address urgent demands for mental and psychosocial support, to cope with emerging challenges and foster resilience, and to disrupt cycles of violence, particularly among women and girls who may face an increased level of VAWG. In these contexts, implement minimum responses in the field of MHPSS, which should be seen/understood as essential, high-priority and life-saving responses/services that should be implemented as soon as possible. [19]
- If there is a shortage in specialised mental healthcare providers, health workers may be required to take on this role. Counselling services may also be provided by social workers, community-based support groups and religious groups.[20] WHO also envisages access to Informal Community Mental Health services. [21]
- Promote an enhanced integration of support systems for survivors of VAWG, ensuring that mental health support services are integrated within wider systems (e.g. existing community support mechanisms, formal/non-formal school systems, general health services, general mental health services, social services, etc.). This will foster sustainability and reduce stigmatisation of women and men benefitting from them.

Strengthen the capacity of service providers working in the field of MHPSS as well of those working with survivors of VAWG
(Output 4.1)

[19] Guidelines on MHPSS in Emergency Settings, IASC, 2007. The primary purpose of these guidelines is to enable humanitarian actors and communities to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergency. The focus of the guidelines is on implementing minimum responses, which are essential, high-priority responses that should be implemented as soon as possible in an emergency. Minimum responses are the first things that ought to be done; they are the essential first steps that lay the foundation for the more comprehensive efforts that may be needed (including during the stabilised phase and early reconstruction).

[20] http://apps.who.int/iris/bitstream/handle/10665/42788/924154628X.pdf?sequence=1

[21] https://www.who.int/mental_health/policy/services/2_Optimal%20Mix%20of%20Services_Infosheet.pdf

- **Mental health staff** (psychologists, therapists, counsellors, etc.) should be trained on the root- causes and consequences of VAWG. Psychologists, therapists, and other counsellors should own the tools and knowledge to offer a survivor- centered approach, including by providing non-judgmental listening, validation and empathy, fostering a reduction in self-blame and shame, and supporting women and girls to develop/refine coping mechanisms and self-reliance.
- **Front-line service providers**, such as police officers, social workers and health service providers, are key points of contact for survivors seeking support. Thus, it is crucial to enhance their capacity and understanding of survivors' mental health challenges and needs, as well as their understanding of communication and attitude techniques aimed at fostering trust, reducing stigmatisation, shame and blame of survivors.
- Service providers - including particularly psychologists, therapists, and other counsellors - should be **trained in understanding deeply rooted-gender stereotypes and biases** that pose barriers to the accurate identification and treatment of mental health disorders. For instance gender stereotypes (including with regard to the proneness to emotional problems or "hysteria" in women and alcohol problems in men) appear to reinforce social stigma and pre-existing stereotypes along gendered lines, and constrain help seeking behavior. Similarly, underdiagnosing women or not taking complaints seriously denies women critical health services. Equally, gendered differences exist in patterns of help seeking. Women are more likely to seek help from and disclose mental health problems to their primary health care physicians while men are more likely to seek specialist mental health care and are the principal users of inpatient care. Service providers should be aware of these biases and patterns.
- Following capacity building activities on mental health, **provide ongoing follow-up and support** (training / capacity building should not be a one-off), and monitor to help ensure that interventions are implemented in line with internationally recognised norms and standards.

Further strengthen the inclusion of mental health support services in existing referral pathways and foster coordination and information sharing mechanisms on EVAWG (Output 4.1)

- **Undertake a mapping exercise of existing services,** including mental health service providers, and through a participatory and transparent process, develop a service directory to be shared online and off-line with survivors of VAWG.Foster coordination and referral mechanisms among service providers, UN Agencies, and civil society organisations working with survivors of VAWG, ensuring the i**nclusion of mental health support services in existing referral mechanisms and holistic response services.**
- Ensure the **development and/or reinforcement of procedures and protocols across services and providers** for consistent and timely information sharing and referral, and ensure they are clearly communicated to survivors.
- Helplines are often the first-contact service for survivors. Helplines' staff should be trained and equipped to provide accurate, precise and timely information about mental health support services available to survivors.

Explore the potential of new technology to provide MHPSS services

(Output 4.2)

- As a result of social distancing measures and the closure of in-person services during COVID-19, there has been an increased reliance on technology and the use of online methods for medical needs (e.g. tele-counselling). In line with ethical and safety guidelines, telecounselling and remote pshychosocial support can provide critical support to women and girls who are at risk of, or subjected to violence, including those facing multiple and intersecting forms of discrimination.[22]
- Specific security measures should be taken to ensure safety, protection and confidentiality of survivors. Conferencing platforms or video chat should ensure privacy and protection of the survivor(s). The service provider and the caller should agree on a safe word or a code to be used to change the subject of the conversation if the caller feels unsafe. The service provider is encouraged to show and remind the survivor how to delete communications from the mobile appliances and computers so that there is no record of the information shared. [23]

PART B: Apply this to Programming

This section details sample actions (i.e various types of interventions / activities / good practices) that Spotlight programmes could consider implementing to mainstream MHPSS across outcomes/pillars, informed by the latest evidence/lessons presented in Part A. The second column in the table provides examples of existing Spotlight Initiative activities / interventions that have integrated MHPSS (offering a *concrete* example of how programmes are already integrating MHPSS and could further expand this work)

Pillar 1: Laws and Policies	
Sample actions	**Example(s) from SI Programme(s)**
- Support the revision and/or draft of laws and policies aimed at clearly identifying a comprehensive range of social services to address the mental and psychological consequences of VAWG. - Advocate for legislative reform to protect the privacy of MH patients against systemic discrimination faced by women and girls seeking support from mental health institutions. - Support the full participation and engagement of women who have experienced violence and face	- In **Papua New Guinea,** the Department of Justice and Attorney General (DJAG), with technical support from the SI Initiative, is currently finalising the Health Protection Bill to enhance protection of survivors of VAWG and accessibility to GBV and SRH prevention and response services. The Women's Health Protection Bill will ensure the inclusion of the right to medical and psychological care free of charge for survivors of VAWG. - In **Trinidad and Tobago**, the Spotlight Initiative initiated a research study aimed at reviewing the

[22] Remote Service Provision for Women Migrant Workers at Risk or Subject to Violence, Spotlight Initiative- Safe and Fair, 2021
[23] Remote Service Provision for Women Migrant Workers at Risk or Subject to Violence, Spotlight Initiative- Safe and Fair, 2021

mental health challenges in the advocacy for, development of, or the revision of laws/and polices on VAWG. - Considerations can be given to prevention programmes and other measures (such as protection orders) for perpetrators or repeat offenders of VAWG with mental health issues. However, please make sure that appropriate consultations are being held with experts and civil society organizations, as the evidence on such programmes' impact is mixed. Please also ensure that investments in such programmes do not divert resources from or come at the expense of programmes focused on survivors of VAWG. Specific precautions should be made when engaging in such programmes, and consideration about the safety of partners and children should be at the forefront of interventions. Evidence based experiences and programs should always be the basis for developing these (and other) interventions.	implementation of the Domestic Violence Act. The study will have an emphasis on the access to and content of psycho-social services.
Pillar 2: Institutions	
Sample actions	**Example(s) from SI Programme(s)**
- Strengthen existing institutions that are dedicated to and equipped for the provision and monitoring of MH services that target survivors of VAWG. - Enhance the capacity of the justice system or related judicial and legal institutions to monitor the implementation of laws and policies related to protection and comprehensive services. - Support local institutions to design and implement MHPSS policies and foster coordination protocols and mechanisms. - Foster cross-sectoral collaboration including between government institutions and non-state actors, such as civil society organizations, feminists and women's rights defenders, faith-based organizations and mental health advocates to	- In **Malawi**, the Spotlight Initiative (SI) offered scholarships aimed at complementing the Malawi Government's newly updated policy for facilitating girls to return to school after giving birth. To ensure a high retention rate among scholarship recipients, SI supported the availability of psychosocial support and standby mentors in all schools attended by the selected girls.

implement targeted policies and interventions that prevent and respond to VAWG and MH.	
Pillar 3: Prevention	
Sample actions	**Example(s) from SI Programme(s)**
Design and support long-term prevention initiatives encompassing the multiple levels of the socio-ecological model, as per examples below: - Social norms change campaigns, advocacy activities and community dialogues on the linkages between MH and VAWG and risk factors - Promote and foster collective dialogues at community level (e.g. community counselling) aimed at addressing and reducing stigma or shame that communities might feel because of intersecting forms of discrimination faced (this may help support mental health and well-being) - School-based interventions to reach girls and boys and stimulate critical reflections around VAWG and MH - Relationship-level interventions, that work intensively with couples, to increase awareness about IPV/VAWG and MH - Perpetrators programmes to promote social norm and behaviour change, including by discussing the intersection of mental health and VAWG - Workshops and capacity building activities that engage men and boys and challenge gender stereotypes and norms aimed at questioning their behaviours and beliefs around MH and VAWG	- Since April 2020, Spotlight **Zimbabwe,** in partnership with Padare Men's Forum on Gender, has built a movement among men and boys to prevent VAWG and achieve positive transformation at the community level. As part of the process, Padare Men's Forum on Gender offered psychosocial support and counselling to assist men to cope with COVID-19 stresses and shocks and to develop acceptable coping mechanisms. The virtual counselling services reached more than 500 men and boys. [24]

[24] Annual Reports 2020

Pillar 4: Essential Services	
Sample actions	**Example(s) from SI Programme(s)**
- Ensure the provision of integrated mental health and psychosocial support services to survivors of VAWG to reduce mental health and psychosocial consequences of VAWG and enhance psychological recovery and social integration. - Ensure proper alignment of mental health services for survivors with internationally agreed standards (e.g. safety, consent, confidentiality, rights-based approach and others as outlined in the Essential Service Package of Women and Girls Subject to Violence- Module 1) - Ensure the provision of information, targeted tools and dedicated services to front-line service providers working directly with survivors of VAWG to timely and effectively identify and tackle and/or potential risk and unintended consequences on survivors' benefiting from mental health services (e.g. stigmatization, marginalisation, systemic discrimination, as well as physical unsafety, post-interview retaliation against survivors) - In remote and hard-to-reach areas, establish Informal Community Mental Health services ensuring that women facing multiple and intersecting forms of discriminations are not left behind. - Support and facilitate capacity building activities for service providers on the intersection of MH and VAWG, including the consequences of VAWG on MH and psychosocial well-being, and communication techniques to be used with survivors. - Through training and capacity building activities, support the eradication of gender biases amongst health care providers, psychologists and therapists	- In **Malawi** the protection cluster identified Mental Health and Psychosocial Support (MHPSS) as a key gap in responding to COVID-19, as a result of which, demand for Psychological First Aid (PFA) increased, alongside the surge in cases of SGBV/HPs. Based on the rapid needs and gap assessment of MHPSS Services in all the SI districts, the SI increased the availability and quality of psychosocial care for survivors in SI districts leading to 12,769 vulnerable women and girls receiving PFA services. Furthemore, 23 Social Welfare, Health, CSO and District Council staff were trained on Interpersonal Group Therapy (IPGT) and 40 officials were certified as trainers in Psychological First Aid (PFA).[25] - In **Mozambique,** SI provided assistance - through the provincial directorates and youth associations - to health district services to reshape their service model during the outbreak of COVID-19 and provide remote psychosocial assistance to women and girls at risk or experiencing violence. The remote psychosocial assistance was provided by specialized staff from provincial and district authorities and youth associations which partnered with the formal health system. In addition, WhatsApp groups for girls and boys (students) were created to report cases of violence and call for support. Awareness raising sessions continued to be provided door-to-door by activists.

[25] Annual Reports 2020

to prevent (gendered) underdiagnosis and /or overdiagnosis of MH disorders among survivors. - Promote regular multi-stakeholder reviews of the response strategy, ensuring the integration of mental health services within existing referral mechanisms and networks.	
Pillar 5: Data	
Sample actions	**Example(s) from SI Programme(s)**
- Advocate and/or enhance data collection, analysis and disaggregation systems capturing the linkages between VAWG and MH disorders. - Through participatory monitoring and evaluation, promote the collection of data and information on the level of satisfaction of survivors of VAWG around MH services and VAWG programmes. - Enhance capacity of researchers and enumerators to safely and ethically collect data and information from groups suffering from mental health disorders and diseases.	- In **Trinidad and Tobago**, the Roxborough Police Youth Club collected data on violence and abuse experienced by elders (aged 60 and above) who suffer from Alzheimer's and other health conditions. The Roxborough Police Youth Club trained enumerators to ethically and safely facilitate communication with vulnerable respondents. Based on the results of the study, the association conducted targeted training with social workers, psychologists, counselors and community policing on how to address the specific needs of survivors suffering from mental health disorders.
Pillar 6: Women's Movement	
Sample actions	**Example(s) from SI Programme(s)**
- Support the integration of and referral to CSOs, including women's rights/feminist organizations, providing mental and psychological support to survivors across different pillars. - Strengthen women's movements by prioritising and protecting women rights defenders' mental health and psychological well-being through access to quality psychosocial support. - Strengthen and further support CSOs, and particularly local/grassroots groups, that provide MHPSS, among other essential services, to	- In **Samoa,** SI partnered with the NGO Faataua le Ola (FLO), which focuses on suicide prevention, including for cases of domestic violence. FLO was selected as one of the essential frontline mental health and suicide prevention response services available in Samoa during the outbreak of COVID-19. FLO established a free lifeline and offered confidential counselling services to callers. FLO also trained its staff on effective communication, as well as conducting prevention community outreach.[26]

[26] Annual Reports

survivors of VAWG. Ensure the provision of knowledge, tools and resources to ensure that CSOs providing direct services, including community counselling, to survivors can meaningfully integrate a MH component in their response packages. - Ensure that CSOs, and particularly local/grassroots groups, and women's movements are meaningfully engaged in and can contribute to the development of policies and legislative processes on MH and VAWG.	- In **Timor- Leste,** the SI launched a EVAWG Forum to expand opportunities for CSO engagement in EVAWG and increase their visibility. To support activists and women's rights defenders, the EVAWG Forum provided mentoring and accompaniment services with the aim of: a) Addressing the physical and psychological impacts of working on VAWG; b) Reduce risk of experiencing burnout and; c) Contribute to the sustainability of VAWG organizations and the women's movement.

For Further Exploration and Consideration

This sections lists Ideas that are worth exploring further, possibilities for innovation, and additional questions or considerations

1. Additional discussion/reflection needed on whether SI should work on MHPSS and VAWG further: is SI well-placed to integrate MHPSS meaningfully into our results framework / our work going forward? Is it needed? What do our teams say? Is this dimension of work relevant/needed in the various contexts in which we work? Would other organizations etc. be better placed (and our role could be to support those)?
2. Further exploration of online MHPSS counseling as an integrated service for survivors or those at risk of experiencing violence.
3. Vicarious trauma is a widespread consequence of direct and empathic engagement with survivors of VAWG. While this critical issue is widely acknowledged, there is still limited evidence on its consequences and potential strategies to effectively tackle it.
4. Further exploration on how SI could integrate community counselling - perhaps in its existing work with communities on social norms - to address and reduce stigma or shame that communities might feel because of their marginalized status (ie addressing the impact of systemic racism, sexism, colonialism, or other intersecting supremacies/forms of discrimination on individuals and communities - in order to improve mental health and reduce violence).
    a. As we explore further, keep in mind: Community counselling should not replace the role of duty bearers (i.e. the state/government institutions should not shift responsibilities as duty - bearers onto community organizations).
5. Double check the brief as we firm it up to ensure that the framing throughout is evidence based and grounded in a social ecological model (not biomedical). This would include:
    a. Further review/discussion needed to ensure that the sample actions included in this brief (particularly around MHPSS services) are evidence based, survivor centered and trauma-informed, and do not pathologize or (re)traumatize women and girls (recalling that mental health care has

(and can) retraumitize or pathogloze if not delivered though a survivor center, trauma-informed, rights based lens (e.g. examples of llongstanding and ongoing pathologizing of gender and sexual orientaition and identities in their plurality; or LGBQTI folks, to be gay was classified as a mental health disorder in the DS); or "interracial" coupling in the US context for example)

b. Double check to ensure the brief chiefly frames the intersection of VAWG and MR around the 1) the negative health consequences of VAWG, including on mental health 2) those facing mental health challenges are more vulnerable to violence, rather than perpetrating violence/contributing to VAWG. Want to ensure that we don't inadvertently push a narrative that those in mental health crises/or with mental health disorders are violent/likely to commit VAWG (mental health disorders can contribute, of course, but the other dimensions seem to be more prevalent/relevant).

6. More research/evidence needed **on identifying and tracking individuals** at risk of perpetrating violence or experiencing violence; or tracking/identifying repeat offenders. We had two bullet points included in the brief previously that touch on this: (1) Ensure that primary and secondary prevention interventions[27] include VAWG/ IPV risk identification (including assessing underlying risk factors for VAWG) and prevention services for at-risk populations, including both those at risk of perpetuating violence and those at risk of experiencing violence.[28] Exposure of children to family violence should also be considered a risk factor of perpetrating violence in adult relationships; (2) Through a multiple and coordinated approach, such as health facilities, in and out of school a settings, the media, and others, ensure that at-risk populations are **identified** in a timely manner, including through the use of innovative ICT, and referred to appropriate prevention programmes and/or support services, as needed. These should engage at-risk populations in processes to understand deeply rooted-cases of VAWG and, if needed, respond to early signs of VAWG to disrupt the cycle of violence at its initial stages.[29]
    a. There is concern around the identifying and tracking bit:
        i. **privacy** issues
        ii. concerns about **targeting minority communities**, including by using ICTs (capturing data on individuals and sharing across govt agencies and services can (and has!) been used perversely to target marginalized communities. For example, in the US, the government surveilled Muslim communities (particularly post-9/11 but also well before) because of islamophobia and a presumption of violence or the potential to be violent when we know that white supremacy/supremacists are in reality a significantly larger threat). Maybe the UK is doing something similar with their terrorism programme too (see Shahd's comment)
        iii. Concerns about perpetuating an **exclusively carceral or punitive response** to VAWG/MH, specifically toward repeat offenders, which raises broader questions, such as "what does

[27] Primary prevention refers to "any action, strategy or policy that works to stop domestic violence from occurring in the first place. Primary prevention seeks to reduce the overall likelihood that anyone will become a victim or perpetrator of domestic violence by creating conditions that make violence less likely to occur". Secondary prevention refers intervening and responding to violence that has already occurred in order to stop violence from happening again. Secondary prevention interventions can include shelter, counseling, safety planning, and protective orders. See The Rhode Island Coalition Against Domestic Violence (RICADV) definitions here.

[28] See: Mental disorders and intimate partner violence perpetrated by men towards women: A Swedish population-based longitudinal study

[29] See: Mental disorders and intimate partner violence perpetrated by men towards women: A Swedish population-based longitudinal study

accountability look like - is it (feminist) carceral / punitive or restorative? What does protection look like (i.e. is it protection orders? Or broader community systemic redress? Or both?

iv. How do we frame these issues/work on these issues in a way that understands the immediacy and need for (individual) protection (though for example protection orders) but also the systemic nature of VAWG and how tracking and identifying individuals at-risk of perpetuating violence can (and has) been used to pathologize communities (ie the idea that black communities are inherently more violent) or target minority communities (i.e. Musilims in the US being surveilled and targeted)

b. What does "ensure that specific risk factors experienced by this group are taken into account and that their needs are addressed both by the justice system and by dedicated service providers" look like?

Tools and Resources

The resources listed below - from which the evidence and lessons in this brief are drawn - provide a range of information on the intersection sof MHPSS and VAWG

Insert links to tools here

- Guidelines on MHPSS in Emergency Settings, IASC, 2007
- Essential services package for women and girls subject to violence, Module 2: health essential services, UN Women, UNFPA, WHO, UNDP and UNODC, 2015
- Promoting mental health: concepts, emerging evidence, practice (Summary Report) Geneva: World Health Organization; WHO, 2004
- Remote Service Provision for Women Migrant Workers at Risk or Subject to Violence, Spotlight Initiative-Safe and Fair, 2021
- Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery, International Rescue Committee, 2018
- Tools for Transformation: Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations an Organizational Reflection Toolkit, National Center on Domestic Violence, Trauma and Mental Health, 2018
- Mental health and psychosocial support for conflict-related sexual violence: principles and interventions, WHO, 2012
- Operational guidelines: community based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families (field test version)., UNICEF, 2018
- Clinical management of mental, neurological and substance use conditions in humanitarian emergencies: mhGAP Humanitarian Intervention Guide (mhGAP-HIG). WHO and UNHCR, 2015
- Psychological first aid: guide for field Workers WHO, War Trauma Foundation and World Vision Internationall,WHO, War Trauma Foundation and World Vision International, 2011
- Responding to intimate partner violence and sexual violence against women WHO clinical and policy guidelines, WHO, 2013

- Germanwings tragedy prompts dialogue about MH stigma, privacy laws. *Mental Health Weekly, 25*(14), 1-8. https://doi.org/10.1002/mhw.30138