GCERF
Preventing Violent Extremism and Terrorism

Instituti i Psikologjisë

United Nations Peacebuilding and Peace Support



MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN REHABILITATION AND REINTEGRATION PROGRAMMES: KEY LESSONS AND RECOMMENDATIONS FOR PRACTICE

REPORT

OCTOBER 2026

TABLE OF CONTENTS

List of Acronyms	3
Executive Summary	4
Introduction	4
KEY LESSIONS AND RECOMMENDATIONS FOR PRACTICE	5
1. MHPSS IS INTEGRAL FOR REINTEGRATION, NOT A SEPARATE SERVICE	5
2. KNOW WHAT MHPSS IS TREATING: DISTRESS GOES BEYOND TRAUMA AND MUCH OF IT IS NOT VISIBLE	7
3. WHERE SPECIALISTS ARE FEW, DELIVER THROUGH LAYERED AND TASK-SHARED SYSTEMS	11
4. WORK WITH THE FAMILY, NOT ONLY WITH THE INDIVIDUAL	13
5. COMMUNITY ACCEPTANCE IS A CLINICAL VARIABLE	14
6. SUSTAIN THE PEOPLE AND THE SYSTEMS THAT DELIVER THE SERVICES	16
WAY FORWARD	18
END NOTES	21
REFERENCES	24

Authors:

Prof. Dr. Aliriza Arënliu, Institute of Psychology, University of Prishtina
Asst. Dr. Linda Hoxha, Institute of Psychology, University of Prishtina
MA. Diadora Cërmjani, Institute of Psychology, University of Prishtina
Prof. Dr. Stevan Weine, University of Illinois, Chicago

Cover photo

A woman engages in an MHPSS activity to support her mental health and psychosocial well-being.

Picture credit: Aid Gate Organization (AGO) Iraq

LIST OF ACRONYMS

ABC	**Attachment and Biobehavioral Catch-up**
EBI	**Evidence-Based Intervention**
GCERF	**Global Community Engagement and Resilience Fund**
GCTF	**Global Counterterrorism Forum**
IASC	**Inter-Agency Standing Committee**
ISIS	**Islamic State of Iraq and Syria**
MHPSS	**Mental Health and Psychosocial Support**
PBPSO	**Peacebuilding and Peace Support Office**
PCIT	**Parent-Child Interaction Therapy**
PTSD	**Post-Traumatic Stress Disorder**
R&R	**Rehabilitation and Reintegration**
TF-CBT	**Trauma-Focused Cognitive Behavioural Therapy**
UN	**United Nations**

EXECUTIVE SUMMARY

This document compiles key lessons and practical recommendations for integrating Mental Health and Psychosocial Support (MHPSS) into Rehabilitation and Reintegration (R&R) programmes. It translates country-level experiences into practical recommendations to support future programme design, implementation, monitoring, and adaptation. These are intended to help teams integrate MHPSS more systematically into rehabilitation and reintegration efforts, anticipate common operational challenges, and strengthen approaches.

It draws on insights from a Community of Practice seminar convened by the Global Community Engagement and Resilience Fund (GCERF), the Institute of Psychology at the University of Prishtina and the United Nations Peacebuilding and Peace Support Office (PBPSO) in June 2026, as part of a series of R&R-focused events organised by GCERF, as well as a literature review in the area. The event held in June 2026 counted on contributions from practitioners across Iraq, Mali, Kenya, Kosovo and Kyrgyzstan. Across these contexts, a common line that emerges is that MHPSS should not be treated as a separate service or activity line, but as integral to sustainable reintegration.

We thank the speakers at the Community of Practice, Dwran A. Jasem, Project Manager and Mental Health Expert, ALTadhamun Iraqi League for Youth, Iraq; Fanta Ulrike Mariko, Monitoring, Evaluation, and Learning (MEAL) Manager at Femmes & Développement (FEDE), Mali; Dr Oscar Githua, Forensic Psychologist, Kenya; Rebeka Qena, Project Manager, Community Development Fund (CDF), Kosovo; and Tazhykan Shabdanova, President of the Foundation for Tolerance International (FTI), Kyrgyzstan, for their valuable contributions. We also acknowledge the support and inputs of Aliriza Arënliu, Linda Hoxha and Diadora Cërmjani, from the Institute of Psychology at the University of Prishtina; Stevan Weine from the University of Illinois; Mario Nascimento from UNPBSO; and Lilla Schumincky-Logan and Isabela Ottoni from the GCERF.

INTRODUCTION

The prolonged exposure to armed conflict often results in lasting effects across all segments of society. Members of armed groups experience a series of traumatic events while engaging in military operations. Issues are further exacerbated by cases of physical and sexual abuse and drug addiction, as well as forced recruitment and marriage. Community members, particularly women and children, are frequently victims of large-scale violence, which fosters fear and resistance. Addressing individual needs and overcoming generational trauma requires promoting holistic approaches that support full reintegration into civilian life, foster reconciliation, and contribute to the reconstruction of the social fabric.

Considering the above aspects, the provision of mental health and psychosocial support is critical for the effective rehabilitation of former members of armed groups and their sustainable reintegration. This entails supporting integrated, multisectoral interventions that enable the provision of clinical assistance and community-based activities tailored to local needs and capacities. Under this premise, MHPSS support goes beyond stand-alone activities and is rather inherent to interventions throughout the rehabilitation and reintegration of former members.

For instance, MHPSS assistance is essential for the release and reintegration of children associated with armed groups, and their reconnection with family members and receiving communities. It also lays the foundation for addressing the specific needs of women and girls associated with armed groups or affected by armed conflict. For all groups, MHPSS is essential for the social, economic, and political reintegration of former members. By addressing trauma, interventions can contribute to reconciliation and reduce stigmatisation.

Over the decades, practitioners have continually adapted interventions to field realities. Currently, conflict dynamics are increasingly complex due to the proliferation of non-state armed groups, regionalisation of violence, and the reduction of international financing. Rehabilitation and reintegration programmes are often underfunded, requiring the design of innovative solutions that are conflict-sensitive, context-specific, and culturally responsive.

Assessing the MHPSS needs and resources among former members, their families, communities, and institutional frameworks is key provide the necessary support and build on available capacities. In conflict-affected contexts, implementing whole-of-family and community-based activities can serve as an entry point and foster trust in MHPSS assistance, particularly in hotspot areas that lack institutional capacity. In many cases, former members of armed groups, victims, and communities can mitigate the effects of past traumas by regaining a sense of agency and self-control, which counters their exposure to violence and intractability. Across contexts, the use of arts, sports, literature, and dance can contribute to social connection and emotional regulation. Activities such as music therapy, storytelling, and artwork can provide affected communities with tools to absorb former members and, with the support of state institutions and the international community, ensure their sustainable reintegration into society.

KEY LESSONS AND RECOMMENDATIONS FOR PRACTICE



1. MHPSS IS INTEGRAL FOR REINTEGRATION, NOT A SEPARATE SERVICE

1.1 MHPSS is infrastructure, not an activity line

R&R programmes usually treat MHPSS as a set of discrete activities or budget lines: counselling, specialist consultations, and group sessions. However, experience in this domain shows that these fragmented approaches can limit the effectiveness of other reintegration components. Instead, MHPSS should be treated as a means for other interventions to work. MHPSS works on three fronts at once: people leaving armed or radicalised groups, receiving communities and survivors, and the practitioners who deliver the services.[i] From this perspective, the measure of MHPSS is whether people can function in daily life, not how many sessions or assessments were delivered.

Experience from Iraq illustrates this from a clinical perspective: material assistance assumes a level of cognitive, emotional and behavioural stability that people experiencing complex trauma may not have, meaning that assistance without psychological support may have limited impact.[ii] Practice from Kenya highlights a reverse but complementary relationship: people who have been disconnected from family and community for years may first need a basic economic foundation for psychological interventions to take hold.[iii]

1.2 Mental health and reintegration outcomes move together

Psychological recovery and reintegration outcomes develop together. For example, among Kosovo returnees and refugee populations, higher reintegration scores go with lower depression scores, and psychological recovery lags behind legal and administrative reintegration.[iv] This uneven pace of recovery means that progress on formal indicators does not necessarily reflect psychological well-being: families may appear successfully reintegrated according to administrative indicators while distress persists beneath the surface. This may manifest in caregivers disengaging from counselling, young people reconnecting with previous social networks, and children displaying fear and anger that reflect distress within the family environments.[v]

1.3 Embed MHPSS across all stages of reintegration

As MHPSS enables reintegration, it must be planned before return or disengagement. Introducing MHPSS only after an issue arises risks missing the window when trust is easiest to establish. In Kosovo, most training was delivered after repatriation because the project was accelerated, which left few home visits and no systematic treatment programme.[vi]

By contrast, in Iraq, staff were trained in trauma-informed care and specific therapeutic approaches before services began, with assessment forming the starting point for intervention.[vii] These experiences point to the importance of having protocols, referral pathways, staffing and supervision in place before cases arrive, with initiatives' budgets designed to support longer-term needs rather than on a single funding cycle.

MHPSS is not a stand-alone intervention but connected to rehabilitation and reintegration efforts. Considering the various groups, MHPSS support can be embedded across interventions (e.g., demobilisation/cantonment, rehabilitation support, long-term reintegration, support to victims).

RECOMMENDATIONS FOR PRACTICE

- Build MHPSS into the design and theory of change of R&R programmes from the start, rather than adding it as a separate activity.
- Put protocols, referral routes, staffing, supervision and staff training in place before the first cases arrive.
- Treat MHPSS as a core component and protect its budget line when other components overspend.
- Set MHPSS objectives that go beyond symptom reduction to include school attendance, employment retention, family stability, parenting and community participation.
- Make MHPSS available to host communities and to practitioners, not only to returnees.
- Link MHPSS and reintegration indicators in the monitoring framework so that donors and national authorities can see they depend on each other.
- Put MHPSS expertise into the inter-institutional bodies that make policy, plan, and evaluate, not only into service delivery teams.



2. KNOW WHAT MHPSS IS TREATING: DISTRESS GOES BEYOND TRAUMA AND MUCH OF IT IS NOT VISIBLE

2.1 Distress accumulates; it is not a single incident

R&R programmes often design MHPSS around an acute trauma model: one event, followed by recovery. Practice in R&R programmes presents a more complex picture. In Iraq, distress among family members returned from Syria comes from war exposure, together with long stays in overcrowded camps, relocation, complicated grief and ambiguous loss after the death or disappearance of relatives, and acute stress on return.[viii] In Kenya, practitioners identify a different cluster among disengaged clients: childhood abuse, trauma sustained during recruitment and deployment, and disillusionment on realising that the cause they joined operated as a criminal enterprise rather than a religious one. In Mali, survivors with severe behavioural and emotional difficulties require psychiatric management alongside psychosocial support.[ix] Taken together, these experiences are more consistent with patterns of complex post-traumatic stress than with a single-incident trauma profile.[x]

Trauma is physical as well as psychological, and the body stays on alert long after the threat has passed, meaning that MHPSS may need to address physical and emotional regulation alongside verbal approaches; and people move between the positions of victim (experiencing harm), perpetrator and survivor (reclaiming agency) over a life course. Former combatants may have been recruited by force or subjected to sexual violence, and someone harmed by violence may become open to recruitment through grievance. Assessment should therefore follow the accumulation of adversity across a person's history rather than the category under which they entered the programme.

2.2 Stigma and legal exclusion are clinical drivers, not context

Expecting rejection on return can be as disabling as a trauma history. One case from Iraq illustrates this: a twelve-year-old returnee in the country showed serious withdrawal and frequent school absence, linked both to earlier traumatic experiences and to her belief that the host community had rejected her. The programme addresses the belief both clinically and socially.[xi] Legal and material exclusion work the same way. Inability to obtain documentation in Iraq, loss of work and housing in Kosovo, and women's fear of losing custody act as daily stressors rather than as background conditions.[xii] These should be written into the care plan, not left in the context section.

2.3 Assessment is the first intervention

Practitioners in Iraq establish measures of post-traumatic stress, depression, anxiety, functional impairment and social support, and build individual plans on that baseline.[xiii] In Kenya, practitioners routinely use risk, needs, and resilience assessments. In Kosovo, public psychiatric services carry out an initial assessment on arrival covering trauma symptoms, psychosocial well-being and family functioning, and use it to adapt the interventions.[xvi]

How the assessment is done matters as much as what it covers, because returnees arrive at institutions with well-founded distrust. Explaining what the assessment is for, who sees the information and where confidentiality ends is what makes engagement and later intervention possible.[xv] Psychoeducation does similar work: it helps people understand their trauma responses, reduces self-blame and lets them take a more active part in recovery. Suicide risk belongs in the standard assessment, although some practitioners still fear that asking about suicide introduces the idea.[xvi] Assessment is a clinical and trust-building process, not a data collection exercise.

Equally important is that the terminology used in programme design shapes the clinical dynamic. A critical paradigm shift is treating the individual as an active 'participant' rather than a passive 'beneficiary.' Restoring the participant's right to self-determination through shared ownership of the therapeutic process dismantles learned helplessness, builds fundamental trust, and reinforces a new cognitive schema of agency.[xvii]

2.4 Children show distress through behaviour rather than words

Children rarely name fear or anxiety. Instead, they withdraw, become distrustful, struggle to concentrate and to regulate their behaviour, communicate less, lose motivation, or return to trauma-related themes in drawings and play.[xviii] Symptom-focused assessment often misses this. Adults around the child see these signs first, and practitioners and teachers usually need training and support before they can read them. One source is not enough. Parent-reported measures are useful but tend to underestimate internalising symptoms, particularly when the caregiver has been through the same events[xix], so reports from parents, teachers and frontline workers should be compared.

Drawing, storytelling, theatre, play, and life-mapping give children a way to communicate what direct questioning cannot reach, and they build engagement at the same time.[xx] Conversely, structured clinical frameworks emphasise utilising manualised Evidence-Based Interventions (EBIs), such as Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), to safely restructure complex trauma narratives, and Attachment and Biobehavioral Catch-up (ABC) or Parent-Child Interaction Therapy (PCIT) to rehabilitate maternal sensitivity and secure attachment dyads[xxi].

RECOMMENDATIONS FOR PRACTICE

- Design for complex and continuing trauma rather than single events, and expect grief, ambiguous loss and somatic symptoms alongside traumatic stress.
- Work on bodily regulation and stabilisation as well as verbal and cognitive interventions.
- Assess what the person reports, not only the legal category they entered under, since one person may be a victim, a perpetrator and an affected family member at once.
- Set a baseline with established instruments and repeat the measures to track change in functioning.
- Cover self-care, daily tasks, social contact, parenting and school attendance alongside symptoms, because these determine whether reintegration holds.
- Treat informed consent, confidentiality and feedback of results as part of the clinical work rather than as administration.
- Keep psychoeducation running for caregivers, teachers and frontline workers.
- Include suicide and self-harm risk in routine assessment, with written safety plans and referral routes.
- Treat stigma, legal status, documentation, custody fears and interrupted schooling as active clinical drivers.
- Use creative, activity-based and non-verbal methods with children, and compare parent reports with what teachers and frontline workers observe, since the two often differ.
- Have people help design their own intervention plan rather than receive a fixed package.
- Transition programmatic language and clinical practice to treat individuals as active participants co-creating their treatment plans, rather than passive recipients of a fixed service package.

MHPSS PROGRAMMING KEY PRINCIPLES

These principles should guide the design, delivery and evaluation of MHPSS within R&R programmes.

- Trauma-informed. Ask what a person has experienced rather than what is wrong with them, and make sure institutional requirements do not repeat the coercive conditions they came from.
- Strengths-based. Find, amplify and leverage existing resilience, indigenous survival skills and coping resources, actively transforming the participant's deficit-focused cognitive schema into one of inherent capability.
- Person-centred. Let the person help set priorities and pace, within a structured clinical framework.
- Culturally and contextually grounded. Work with traditional, spiritual and community practices such as music, storytelling and art, and recognise that recovery is judged by community norms as well as clinical ones.
- Family and community anchored services. Treat the household and the receiving community as part of the intervention.
- Gender and age responsive. Women, men, adolescents and young children face different needs, different stigma and different barriers to seeking help.
- Do no harm. Apply this to participants and to staff, since people involved in recruitment may target service providers.
- Continuity over intensity. Moderate support sustained over time usually does more than intensive work that stops abruptly.
- Evidence-informed and documented. Choose interventions with evidence to support them, adapt them to the context, and record the adaptations and results.

3. WHERE SPECIALISTS ARE FEW, DELIVER THROUGH LAYERED AND TASK-SHARED SYSTEMS

3.1 Specialist scarcity is the normal operating condition

Specialist mental health capacity is scarce in every context represented. In contexts like Iraq, Kenya, Kyrgyzstan, and Mali, specialists are few, concentrated in capitals and larger towns, and effectively unavailable in the rural areas where many returnees and survivors live. This is the standing condition rather than a gap awaiting investment. The question is how to use the few specialists who exist for the work only they can do, and how to support others to deliver the rest.[xxii]

3.2 Put basic support in the hands of people already there

When there is a scarcity of specialists, basic psychosocial support is delivered through people already present in communities and services. Task sharing is the most consistent answer. In Kyrgyzstan, it means training social workers, teachers, school psychologists, social pedagogues, and sometimes municipal officers to identify psychosocial needs, provide basic emotional support, and refer on.[xxiii] In Kenya, paraprofessionals work alongside professionals in community education on how radicalisation happens and how harm passes from those who have suffered to others. In Mali, the work is built on existing resources: community health workers, community and religious healers, local associations, and health structures, on the premise that these actors remain after internationally financed projects end and can sustain identification and referral.[xxiv]

3.3 Group and peer approaches normalise help-seeking and show who needs more

Several practitioners treat group work as a central component rather than an add-on. In Mali, group meetings for survivors are the foundation for everything else. Participants share experiences and regain confidence, and more vulnerable individuals are identified and referred. In one project phase in which discussion groups were the only mental health activity, the final evaluation showed significant improvement in survivors' psychosocial status. Because local community animators run the groups, they continue after the project.[xxv] In Kyrgyzstan, local task forces and women-led self-help groups create trusted spaces that outlast the formal interventions.[xxvi] In Iraq, peer support groups bring together returnees and host community members in schools and shelters and have become part of the wider integration work.[xxvii] Group formats are among the most scalable for non-specialists to deliver, and they build social connections that individual sessions cannot.[xxviii]

3.4 Triage explicitly and make referral work in both directions

When demand exceeds capacity, the choice is between explicit and implicit triage. In Iraq, practitioners used three tiers: immediate specialised care for acute functional impairment, severe dissociation or self-harm risk; group counselling and family support for people facing serious social rejection; and empowerment, problem-solving and early entry into socio-economic activities for those with enough baseline resilience.[xxix] Case management was adjusted as caseloads changed, with referral routes to hospitals, other organisations and government services. In Mali, continuity of care was maintained by community facilitators, case managers, and partner health structures, with the most severe cases referred to specialised partners.

Referral pathways need to run upward to specialist and psychiatric services and outward to education, livelihoods, legal aid and protection. They should be documented, known to frontline staff and tested. Weak inter-institutional coordination is a constraint in any context, and in Kosovo, strengthening municipal referral mechanisms remains the central unfinished task.[xxx] International guidance points in the same direction as practice, toward coordination mechanisms and case files that carry assessment results forward to the next caseworker instead of leaving them with the agency that produced them.[xxxi] The absence of defined frameworks for service delivery and coordination is a principal gap in R&R programming for returning women and children.[xxxii]

RECOMMENDATIONS FOR PRACTICE

- Map available capacity at the design stage, including geographical coverage, and build delivery around scarcity rather than an ideal staffing ratio.
- Train and supervise frontline workers, paraprofessionals and community facilitators to provide basic psychosocial support, identify distress and refer.
- Prioritise people already embedded in the community: community health workers, teachers, religious leaders and local associations who will still be there when the project ends.
- Make sure assessments and case records follow the person to the next service rather than staying with whoever produced them.
- Make training practical, repeated and supervised, with refreshers and peer learning, since one training will not change practice.
- Treat group, peer and self-help approaches as core interventions and run them consistently.
- Document referral routes in both directions, to specialist care and outward to education, livelihoods, legal aid and social protection.
- Protect specialist time for complex assessment, high-risk cases and supervision, or it will be absorbed by routine casework that others could handle.
- Give frontline workers access to specialist consultation on complex or high-risk cases.



4. WORK WITH THE FAMILY, NOT ONLY WITH THE INDIVIDUAL

4.1 Practitioners across contexts moved to family-level work

Across contexts, MHPSS work becomes more effective when it moves from individual to family-level interventions. In Iraq, systemic family interventions are used to repair relationships damaged by camp conditions and loss, alongside parenting programmes, and the current focus is on relatives who are reluctant to accept a returning family member.[xxxiii] Similar work on positive parenting and non-violent discipline is extended to education and social service professionals. In Mali, families are part of the intervention, and recovery is judged partly by whether the family and community recognise the change. In Kosovo, practitioners found that progress made with children at school is undone at home unless the mother is also engaged. [xxxiv] A rapid review of R&R programming for returning women and children identifies extended families as essential actors alongside child welfare, mental health professionals, teachers and community leaders.[xxxv]

4.2 Caregiver mental health predicts children's outcomes

Caregiver mental health cannot be dissociated from children's recovery and reintegration outcomes. In the Kosovo study, parental depressive symptoms were associated with children's conduct problems and parental post-traumatic stress with hyperactivity and peer difficulties. Parental post-traumatic stress and reintegration scores are the most consistent predictors of children's behavioural outcomes.[xxxvi] The pattern is familiar from refugee and post-conflict families. Parents with untreated trauma have less patience, less consistency and less emotional availability; the household stays under strain, and the child's sense of security suffers. This is how distress passes from one generation to the next.[xxxvii]

4.3 Fathers are often absent, and what that disrupts can be treated

Returnees are mostly women and children, with fathers imprisoned, dead or absent. In Kosovo, 90% of returned children do not live with their biological father, and this is a significant predictor of their behavioural outcomes.[xxxviii] Practitioners in Iraq report the same pattern, with role confusion among children, adolescents taking on adult responsibilities early, and grief left untreated.[xxxix] Group work that repairs caregiver-child interaction, addresses parenting stress and practices, and creates space for family and collective grief does something individual counselling cannot replace. Family structure is not the variable to act on: for children returned from ISIS territories, emotional security within the family matters more than its composition.[xl]

4.4 Psychosocial support needs practical family stabilisation alongside it

Family-level MHPSS is most effective when paired with practical support that stabilises the household and reduces the daily stressors that sustain distress. In Kosovo, this means catch-up classes and school reintegration for children alongside vocational training, small grants and parenting support for caregivers.[xlii] In Iraq, livelihood support was treated as a condition for sustaining psychological recovery, together with help securing documentation, civil registration and legal rights.[xliii] In Mali, income-generating activities are combined with psychosocial support and follow-up.[xliii] Economic participation should be understood partly as a mental health intervention, given its association with depression outcomes and reintegration scores.[xliv] A review of 17 studies found that pairing psychosocial support with cash or asset transfers improved mental health, well-being, and economic indicators more consistently than no intervention did.[xlv]

RECOMMENDATIONS FOR PRACTICE

- Assess and treat the household as the unit of intervention, not only the person referred.
- Support caregivers and the receiving family: parenting under strain, the caregiver-child relationship, and space to work through grief and loss.
- Address unresolved loss directly, including with families who do not know what happened to a missing husband, father or brother.
- Work with relatives who do not want the person back. Refusal to accept a returning family member is a reintegration problem, not a background.
- Aim at the sense of safety inside the family rather than its structure. The structure often cannot be changed; safety can.
- Address economic, material and MHPSS needs in parallel, recognising how they interact and their combined impact on psychological recovery and sustainable reintegration.
- Support the caregiver directly, since most of these households are headed by single mothers and the children's outcomes follow hers.
- Judge progress partly on whether family and community can see the change, not only on symptom scores.



5. COMMUNITY ACCEPTANCE IS A CLINICAL VARIABLE

5.1 Clinical gains do not survive a rejecting environment

Practitioners agree that stigma is one of the largest barriers to recovery and that a person can be clinically rehabilitated and still relapse if the community rejects them.[xlvi] The Kosovo experience shows that reintegration does not happen because services exist, but when people feel safe, accepted and part of the place they live in.[xlvii]

Community preparation is therefore part of the MHPSS intervention rather than a parallel communications activity, which is also the position taken in the first paper of this series.[xlviii] Research shows that trusted local figures can shift community attitudes toward reintegration, but that details of the individual case, including what the person did, how much choice they had, and their age, often weigh more.[xlix]

5.2 Design for inclusion rather than parallel provision

Separate services can themselves stigmatise. Kosovo's approach was to begin with separate sessions where trust and safety required it, then move deliberately into mixed groups. In practice, this meant catch-up classes for returned children before transition into mainstream schooling, and recreational activities alongside other children in schools and community settings.[l] In Iraq, school-based programmes included all children and parenting programmes included local parents, which delivered psychoeducation to the wider community and reduced stigma at the same time.[li] The long-term stakes are documented. In a prospective study of former child soldiers in Sierra Leone, trajectories of stigma and of family and community acceptance predicted adult mental health. Those whose social integration improved did almost as well as those who were socially protected throughout, while the socially vulnerable group had raised anxiety, depression and probable post-traumatic stress and were around three times more likely to attempt suicide.[lii]

5.3 Address stigma about mental health itself

Practitioners also work on the stigma attached to seeking help. In Kyrgyzstan, this is strong enough that some frontline workers were uncomfortable discussing mental health or did not see it as part of their role.[liii] In Mali, reducing mental health stigma is an explicit purpose of training community actors.[liv] Community discussions, psychoeducation and informal activities make these conversations ordinary. Communities affected by long conflict have often built their own means of reconciliation and coping through music, storytelling and sport, and these are resources to build on rather than replace.

RECOMMENDATIONS FOR PRACTICE

- Budget and staff stigma reduction as part of the MHPSS intervention.
- Deliver services inclusively where possible, and where separate provision is needed, plan the move to mixed groups from the start.
- Run community-level psychoeducation to normalise help-seeking and reduce stigma about mental health.
- Build on existing community, traditional and creative practices instead of setting up parallel models.

6. SUSTAIN THE PEOPLE AND THE SYSTEMS THAT DELIVER THE SERVICES

6.1 Recovery does not follow the project timeline

Practice shows that recovery does not follow the rhythm of funding cycles. Kenya's experience shows that rehabilitation and reintegration do not happen in six to twelve months, and that short programmes can produce distrust and a sense of abandonment. In Kosovo, trauma recovery takes years, while other project elements depend on how long funding lasts.[lv] The Kyrgyzstan case shows that short interventions can achieve some stabilisation but not full recovery.[lvi] This mismatch is well-documented in internationally funded MHPSS programming and is not specific to these contexts, which is why sustainability and integration into existing systems have become priorities in the field.[lvii]

6.2 Invest in the well-being of the people delivering services

Frontline workers, paraprofessionals and clinicians in these settings carry heavy caseloads, are exposed to distressing material and often come from the affected communities themselves. In Kosovo, frontline workers were identified as carrying heavy emotional loads and needing supervision and psychosocial support of their own.[lviii] Kyrgyzstan ran dedicated training on burnout, emotional resilience and stress management.[lix] In Iraq, supervision programmes were built to maintain service quality and prevent secondary traumatic stress.[lx] It is equally important to ensure that professionals are aware of and able to share their security concerns, practice self-care, and seek supervision and consultation.[lxi]

6.3 Ethics and confidentiality need active attention

Working with returnees, particularly in small communities, carries risks that routine clinical practice does not. Practitioners in Kenya identified the temptation to discuss unusual cases outside supervision as a specific failure point, and argued that it is better not to see a client than to see them in conditions where harm is possible.[lxii] Experience also shows that disengaged clients require a higher duty of care than a "normal" clinical client. It is essential to follow ethical protocols, observing confidentiality and privacy, and employing the 'do no harm' principle.[lxiii]

In Iraq, rigorous clinical archiving was identified as a necessity. Clinical records must maintain strict structural integrity, explicitly demarcating between the participant's self-reported distress and the practitioner's objective clinical observations (e.g., measurable psychometric scores). Documentation must preserve the multi-causality of the psychological condition, retaining every contributing factor exactly as presented, whether stemming from conflict, financial collapse, or subsequent socio-legal trauma, and expressly avoid 'smoothing' narratives into a single acute event to ensure the clinical record remains technically accurate and professionally neutral.[lxiv]

6.4 Capacity lasts when it sits inside institutions

The most durable results came from training and knowledge transfer placed inside permanent structures. In Kosovo, a training-of-trainers programme run by the Ministry of Internal Affairs, the Community for Development Fund, and the Institute of Psychology produced a manual, a network of certified trainers, and online courses embedded in university teaching, leaving capacity with national institutions rather than a project team.[lxv] In Kenya, the move from a government-led counter-extremism strategy to a whole-of-society approach created space for government, civil society, faith-based organisations, and donors to work together, with capacity built through training and supervision of professionals and paraprofessionals. These are the mechanisms through which support outlasts a funding cycle.

RECOMMENDATIONS FOR PRACTICE

- Plan MHPSS over several years, and where funding is short, plan the handover from the first day instead of closing abruptly.
- Provide clinical supervision, peer support and workload management for staff delivering MHPSS.
- Address burnout, resilience and secondary traumatic stress with staff directly, including paraprofessionals.
- Make sure ethical protocols on confidentiality, privacy and do no harm are understood and applied by professional and paraprofessional staff.
- Transfer capacity into permanent structures from the start, through certified trainer networks and accredited training.

WAY FORWARD

Several priorities are identified based on the extensive MHPSS work carried out by GCERF partners in Iraq, Kenya, Kosovo, Kyrgyzstan and Mali in the framework of preventing violent extremism and supporting re-offending through rehabilitation and reintegration.

1. Consider MHPSS as a foundational part of R&R programmes

The first concerns where MHPSS sits in programme design. Across all five countries, MHPSS is usually added after other components have been planned, and it is among the first budget lines cut when costs rise elsewhere. Building it into the design and theory of change, with a protected budget line, would address much of what they described. Donors and national authorities have a direct part in this, since the timeframes they set determine what programmes can plan for. Two assumptions were questioned repeatedly. First, psychological recovery can be shown within a standard funding period. Second, a single professional can cover clinical, social, and religious roles that, in practice, require a team.

2. Collect structured data on MHPSS indicators in all interventions

The second concerns evidence. Data on long-term outcomes remain limited, particularly for children who returned at a young age and are now entering adolescence.[lxvi] Practitioners collect relevant information continuously through assessment, case management and monitoring, but it is rarely recorded in a form that allows comparison between programmes or countries. Agreement on a small set of indicators, on the instruments used to measure them, and on minimum documentation standards would make comparison possible. This depends less on new research funding than on organising data that is already being produced.

3. Adapt MHPSS responses to resource constraints

The third concerns what is done about limited capacity. The operational responses are already in use: layered delivery, task sharing with trained and supervised frontline workers, group and peer approaches, work with families, and capacity continue to be built within institutions that continue after a project closes. What is missing is a systematic evaluation of these adaptations and a way to transfer what has been learned between countries operating under similar constraints. Sustainability and integration into existing systems are now recognised as priorities across the wider MHPSS field.[lvii] The practice of R&R programmes also shows that separate services for returnees do less than existing services strengthened to handle complex and long-term needs, and that, where services are strengthened in this way, returnees indicate how well the wider system is working.[lviii]

4. Strengthen cross-country knowledge exchange and shared practice

The fourth priority concerns strengthening cross-country knowledge exchange and shared practice. An observation emerging from the experience of the five countries mentioned in this document was the apparent absence of a common or structured practice for sharing knowledge, experiences, and lessons learned across countries. While there is a range of approaches to addressing similar challenges, these experiences remain largely situated within individual programmes and national contexts, with limited mechanisms for systematically bringing them together. Creating opportunities for structured cross-country exchange could enable practitioners to learn from approaches developed in comparable settings, identify transferable practices, and avoid repeatedly developing solutions to similar challenges in isolation. Events such as a regional community of practice or another regular knowledge-exchange mechanism could help transform dispersed practical experience into a shared resource, particularly in contexts where specialised expertise and resources are limited.

MHPSS PLANNING CHECKLIST

Design and funding

- Is MHPSS in the programme design, theory of change and budget from the start, with its own protected line?
- Are protocols, referral routes, staffing and supervision in place, and staff trained, before the first cases arrive?
- Are MHPSS indicators linked to reintegration indicators in the monitoring framework?
- Is MHPSS expertise represented in the bodies that plan and evaluate the program, not only in delivery teams?
- What are the MHPSS and related services available?

Assessment

- Do you use structured instruments covering symptoms, behavioural functioning, risk and social support, and repeat them to track change?
- Does the assessment cover daily functioning, including self-care, school attendance, work and social contact?
- Do consent procedures explain what the assessment is for, how the information will be used, who has access and where confidentiality ends? Are the results explained back to the person?
- Is suicide and self-harm risk assessed routinely, with a written safety plan and referral route?
- Are non-verbal and activity-based methods used with children, and is parent report checked against what teachers and frontline workers see?

MHPSS PLANNING CHECKLIST

Delivery where specialists are few

- Have you mapped the specialist capacity actually available, including outside the capital, and designed around it?
- Are frontline workers, paraprofessionals and community facilitators trained, supervised and able to consult a specialist on difficult cases?
- Is training repeated and supervised rather than delivered once?
- Do you have a written triage framework setting out which cases go to individual specialist care, which to group or family support, and which to inclusion and socio-economic activities?
- Do referral routes run in both directions, to specialist and psychiatric services and outward to education, livelihoods, legal aid and social protection? Are they documented and tested?
- Do assessments and case records follow the person to the next service?

END NOTES

[i] Nascimento, M. (2026). Keynote Speech at the opening of the online session R&R Series n.2: Mental Health and Psychosocial Support in Rehabilitation and Reintegration.

[ii] Global Community Engagement and Resilience Fund & Institute of Psychology, University of Prishtina. (2026). Mental health and psychosocial support in rehabilitation and reintegration [Community of practice online webinar, R&R Dialogue Series No. 2, 1 June 2026]. Speakers: M. Nascimento (United Nations Peacebuilding and Peace Support Office); O. W. Githua (Centre for Human Rights and Policy Studies, Kenya); D. A. Jasem (ALTadhamun Iraqi League for Youth, Iraq); F. Mariko (FEDE, Mali); R. Qena (Community Development Fund, Kosovo); T. Shabdanova (Foundation for Tolerance International, Kyrgyzstan).

[iii] GCERF & Institute of Psychology (2026).

[iv] Arënliu, A., Hoxha, L., Cërmjani, D., Konjufca, J., & Weine, S. (2024). From Syria to home: A comprehensive analysis of repatriation, resettlement, reintegration, rehabilitation, resilience and mental health of Kosovo's returned citizens. Institute of Psychology, University of Prishtina "Hasan Prishtina"; Doctor, A. C., Ingram, H. J., Margolin, D., Mines, A., & Vidino, L. (2023). Reintegration of foreign terrorist fighter families: A framework of best practices. National Counterterrorism Innovation, Technology, and Education Center. https://digitalcommons.unomaha.edu/nciterepor tsresearch/1

[v] Betancourt, T. S., McBain, R., Newnham, E. A., & Brennan, R. T. (2015). The intergenerational impact of war: Longitudinal relationships between caregiver and child mental health in postconflict Sierra Leone. Journal of Child Psychology and Psychiatry, 56(10), 1101–1107. https://doi.org/10.1111/jcpp.12389; Ellis, B. H., Cardeli, E., Bloom, M., Brahmbhatt, Z., & Weine, S. (2020). Understanding the needs of children returning from formerly ISIS-controlled territories through an emotional security theory lens: Implications for practice. Child Abuse & Neglect, 109, 104754. https://doi.org/10.1016/j.chiabu.2020.104754

[vi] Arënliu et al. (2024).

[ivii] GCERF & Institute of Psychology (2026).

[viii] GCERF & Institute of Psychology (2026).

[ix] GCERF & Institute of Psychology (2026).

[x] Cloitre, M., Hyland, P., Bisson, J. I., Brewin, C. R., Roberts, N. P., Karatzias, T., & Shevlin, M. (2019). ICD-11 posttraumatic stress disorder and complex posttraumatic stress disorder in the United States: A population-based study. Journal of Traumatic Stress, 32(6), 833–842. https://doi.org/10.1002/jts.22454

[xi] GCERF & Institute of Psychology (2026).

[xii] Arënliu et al. (2024); Jasem, D. A. (2026). Balancing needs and capacity in MHPSS for returnees [Written contribution to the GCERF–Institute of Psychology community of practice webinar]. ALTadhamun Iraqi League for Youth.

[xii] GCERF & Institute of Psychology (2026).

[xiv] GCERF & Institute of Psychology (2026).

[xv] GCERF & Institute of Psychology (2026).

[xvi] GCERF & Institute of Psychology (2026).

[xvii] Jasem, D. A. (2026). Balancing needs and capacity in MHPSS for returnees [Written contribution to the GCERF–Institute of Psychology community of practice webinar]. ALTadhamun Iraqi League for Youth.

[xviii] Arënliu et al. (2024) ; Qena, R. (2026). Lessons from Kosovo on assessing and supporting returning adults, children and families [Written contribution to the GCERF–Institute of Psychology community of practice webinar]. Community Development Fund.

[xix] Achenbach, T. M. (2006). As others see us: Clinical and research implications of cross-informant correlations for psychopathology. Current Directions in Psychological Science, 15(2), 94–98. https://doi.org/10.1111/j.0963-7214.2006.00414.x

[xx] Qena (2026).

[xxi] Jasem, D. A. (2026). Balancing needs and capacity in MHPSS for returnees [Written contribution to the GCERF–Institute of Psychology community of practice webinar]. ALTadhamun Iraqi League for Youth.

[xxii] Inter-Agency Standing Committee. (2007). IASC guidelines on mental health and psychosocial support in emergency settings. Inter-Agency Standing Committee.

[xxiii] GCERF & Institute of Psychology (2026).

[xxiv] GCERF & Institute of Psychology (2026).

[xxv] GCERF & Institute of Psychology (2026).

[xxvi] GCERF & Institute of Psychology (2026).

[xxvii] GCERF & Institute of Psychology (2026).

[xxviii] Singla, D. R., Kohrt, B. A., Murray, L. K., Anand, A., Chorpita, B. F., & Patel, V. (2017). Psychological treatments for the world: Lessons from low- and middle-income countries. Annual Review of Clinical Psychology, 13, 149–181. https://doi.org/10.1146/annurev-clinpsy-032816-045217; Tol, W. A., Barbui, C., Galappatti, A., Silove, D., Betancourt, T. S., Souza, R., Golaz, A., & van Ommeren, M. (2011). Mental health and psychosocial support in humanitarian settings: Linking practice and research. The Lancet, 378(9802), 1581–1591. https://doi.org/10.1016/S0140-6736(11)61094-5; World Health Organization & United Nations High Commissioner for Refugees. (2015). mhGAP humanitarian intervention guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies. World Health Organization. https://www.who.int/publications/i/item/9789241548922

[xxix] GCERF & Institute of Psychology (2026).

[xxx] GCERF & Institute of Psychology (2026).

[xxxi] Global Counterterrorism Forum. (2018). Addressing the challenge of returning families of foreign terrorist fighters: Good practices. https://www.thegctf.org

[xxxii] Bunn, M., Zolnikov, T. R., Engel, L., Ellis, B. H., & Weine, S. (2023). Rehabilitation and reintegration of women and children returning from violent extremist contexts: A rapid review to inform program and policy development. Terrorism and Political Violence, 36(5), 455–487. https://doi.org/10.1080/09546553.2023.2169143

[xxxiii] GCERF & Institute of Psychology (2026).

[xxxiv] GCERF & Institute of Psychology (2026).

[xxxv] Bunn et al. (2023).

[xxxvi] Arënliu et al. (2024).

[xxxvii] Betancourt et al. (2015); Mooren, T., van Ee, E., Hein, I., & Bala, J. (2023). Combatant parents and their children: Intergenerational consequences of war trauma. Frontiers in Psychiatry, 14, 1096401; Powers, A., Stevens, J. S., O'Banion, D., Stenson, A. F., Kaslow, N., Jovanovic, T., & Bradley, B. (2022). Intergenerational transmission of risk for PTSD symptoms in African American children: The roles of maternal and child emotion dysregulation. Psychological Trauma: Theory, Research, Practice, and Policy, 14(7), 1099–1106; Schick, M., Morina, N., Klaghofer, R., Schnyder, U., & Müller, J. (2013). Trauma, mental health, and intergenerational associations in Kosovar families 11 years after the war. European Journal of Psychotraumatology, 4(1), 21060. https://doi.org/10.3402/ejpt.v4i0.21060

[xxxviii] Arënliu et al. (2024).

[xxxix] GCERF & Institute of Psychology (2026).

[xl] Ellis et al. (2020).

[xli] GCERF & Institute of Psychology (2026).

[xlii] GCERF & Institute of Psychology (2026).

[xlii] GCERF & Institute of Psychology (2026).

[xliv] Arënliu et al. (2024).

[xlv] Tanski, M., Wei, D., Singh, S., Avendano Pabon, M., Bahure, V. K., Jordans, M. J. D., Lund, C., Roy, S., Singh, R., Thapa, A., Tol, W. A., & Evans-Lacko, S. (2025). Poverty-reduction interventions combined with psychological interventions: A systematic literature review. Scientific Reports, 15, Article 38829. https://doi.org/10.1038/s41598-025-24736-8.

[xlvi] GCERF & Institute of Psychology (2026).

[xlvii] GCERF & Institute of Psychology (2026).

[xlviii] Clubb, G., Winterbotham, E., Altier, M.-B., Davies, G., & Ike, T. (2026). Building trust in rehabilitation and reintegration through public communications: A practitioner guide. Global Community Engagement and Resilience Fund & University of Leeds.

[xlix] Altier, M. B. (2023). Criminal or terrorist? Fear, bias, and public support for prisoner re-entry programs. Terrorism and Political Violence, 35(1), 83–103; Blair, G., Littman, R., Nugent, E. R., Wolfe, R., Bukar, M., Crisman, B., Etim, A., Hazlett, C., & Kim, J. (2021). Trusted authorities can change minds and shift norms during conflict. Proceedings of the National Academy of Sciences, 118(42), e2105570118; Clubb, G., Altier, M.-B., Kobayashi, Y., Davies, G., & Brownsord, E. (2024). Combating the terrorist stigma: Communicating rehabilitation and reducing barriers to reintegration. Terrorism and Political Violence, 1–18.

[I] GCERF & Institute of Psychology (2026).

[Ii] GCERF & Institute of Psychology (2026).

[Iii] Betancourt, T. S., Thomson, D. L., Brennan, R. T., Antonaccio, C. M., Gilman, S. E., & VanderWeele, T. J. (2020). Stigma and acceptance of Sierra Leone's child soldiers: A prospective longitudinal study of adult mental health and social functioning. Journal of the American Academy of Child & Adolescent Psychiatry, 59(6), 715–726.

[Iii] GCERF & Institute of Psychology (2026).

[Iiv] Mariko, F. (2026). MHPSS and reintegration in Mali: Balancing needs, continuity of care and complementary interventions [Written contribution to the GCERF–Institute of Psychology community of practice webinar]. FEDE.

[Iv] GCERF & Institute of Psychology (2026).

[Ivi] GCERF & Institute of Psychology (2026).

[Ivii] Tol, W. A., Le, P. D., Harrison, S. L., Galappatti, A., Annan, J., Baingana, F. K., Betancourt, T. S., Bizouerne, C., Eaton, J., Engels, M., Hijazi, Z., Horn, R., Jordans, M. J. D., Kohrt, B. A., Koyiet, P., Panter-Brick, C., Pluess, M., Rahman, A., Silove, D., … van Ommeren, M. (2023). Mental health and psychosocial support in humanitarian settings: Research priorities for 2021–30. The Lancet Global Health, 11(6), e969–e975. https://doi.org/10.1016/S2214-109X(23)00128-6

[Iviii] GCERF & Institute of Psychology (2026).

[Iix] GCERF & Institute of Psychology (2026).

[Ix] GCERF & Institute of Psychology (2026).

[Ixi] Githua, O. W. (2026). Balancing Needs and Capacity in MHPSS for Returnees. [Written contribution to the GCERF–Institute of Psychology community of practice webinar].

[Ixii] GCERF & Institute of Psychology (2026).

[Ixiii] Githua (2026).

[Ixiv] GCERF & Institute of Psychology (2026).

[Ixv] GCERF & Institute of Psychology (2026).

[Ixvi] Bunn et al. (2023).

[Ixvii] Tol et al. (2023).

[Ixviii] Qena (2026).

REFERENCES

Achenbach, T. M. (2006). As others see us: Clinical and research implications of cross-informant correlations for psychopathology. Current Directions in Psychological Science, 15(2), 94–98. https://doi.org/10.1111/j.0963-7214.2006.00414.x

Altier, M. B. (2023). Criminal or terrorist? Fear, bias, and public support for prisoner re-entry programs. Terrorism and Political Violence, 35(1), 83–103.

Arënliu, A., Hoxha, L., Cërmjani, D., Konjufca, J., & Weine, S. (2024). From Syria to home: A comprehensive analysis of repatriation, resettlement, reintegration, rehabilitation, resilience and mental health of Kosovo's returned citizens. Institute of Psychology, University of Prishtina "Hasan Prishtina".

Betancourt, T. S., McBain, R., Newnham, E. A., & Brennan, R. T. (2015). The intergenerational impact of war: Longitudinal relationships between caregiver and child mental health in postconflict Sierra Leone. Journal of Child Psychology and Psychiatry, 56(10), 1101–1107. https://doi.org/10.1111/jcpp.12389

Betancourt, T. S., Thomson, D. L., Brennan, R. T., Antonaccio, C. M., Gilman, S. E., & VanderWeele, T. J. (2020). Stigma and acceptance of Sierra Leone's child soldiers: A prospective longitudinal study of adult mental health and social functioning. Journal of the American Academy of Child & Adolescent Psychiatry, 59(6), 715–726.

Blair, G., Littman, R., Nugent, E. R., Wolfe, R., Bukar, M., Crisman, B., Etim, A., Hazlett, C., & Kim, J. (2021). Trusted authorities can change minds and shift norms during conflict. Proceedings of the National Academy of Sciences, 118(42), e2105570118.

Bunn, M., Zolnikov, T. R., Engel, L., Ellis, B. H., & Weine, S. (2023). Rehabilitation and reintegration of women and children returning from violent extremist contexts: A rapid review to inform program and policy development. Terrorism and Political Violence, 36(5), 455–487. https://doi.org/10.1080/09546553.2023.2169143

Cloitre, M., Hyland, P., Bisson, J. I., Brewin, C. R., Roberts, N. P., Karatzias, T., & Shevlin, M. (2019). ICD-11 posttraumatic stress disorder and complex posttraumatic stress disorder in the United States: A population-based study. Journal of Traumatic Stress, 32(6), 833–842. https://doi.org/10.1002/jts.22454

Clubb, G., Altier, M.-B., Kobayashi, Y., Davies, G., & Brownsord, E. (2024). Combating the terrorist stigma: Communicating rehabilitation and reducing barriers to reintegration. Terrorism and Political Violence, 1–18.

Clubb, G., Winterbotham, E., Altier, M.-B., Davies, G., & Ike, T. (2026). Building trust in rehabilitation and reintegration through public communications: A practitioner guide. Global Community Engagement and Resilience Fund & University of Leeds.

Doctor, A. C., Ingram, H. J., Margolin, D., Mines, A., & Vidino, L. (2023). Reintegration of foreign terrorist fighter families: A framework of best practices. National Counterterrorism Innovation, Technology, and Education Center. https://digitalcommons.unomaha.edu/ncitereportsresearch/1

Ellis, B. H., Cardeli, E., Bloom, M., Brahmbhatt, Z., & Weine, S. (2020). Understanding the needs of children returning from formerly ISIS-controlled territories through an emotional security theory lens: Implications for practice. Child Abuse & Neglect, 109, 104754. https://doi.org/10.1016/j.chiabu.2020.104754

Githua, O. W. (2026). Balancing Needs and Capacity in MHPSS for Returnees. [Written contribution to the GCERF–Institute of Psychology community of practice webinar].

Global Community Engagement and Resilience Fund & Institute of Psychology, University of Prishtina. (2026). Mental health and psychosocial support in rehabilitation and reintegration [Community of practice online webinar, R&R Dialogue Series No. 2, 1 June 2026]. Speakers: M. Nascimento (United Nations Peacebuilding and Peace Support Office); O. W. Githua (Centre for Human Rights and Policy Studies, Kenya); D. A. Jasem (ALTadhamun Iraqi League for Youth, Iraq); F. Mariko (FEDE, Mali); R. Qena (Community Development Fund, Kosovo); T. Shabdanova (Foundation for Tolerance International, Kyrgyzstan).

Global Counterterrorism Forum. (2018). Addressing the challenge of returning families of foreign terrorist fighters: Good practices. https://www.thegctf.org

Inter-Agency Standing Committee. (2007). IASC guidelines on mental health and psychosocial support in emergency settings. Inter-Agency Standing Committee.

Jasem, D. A. (2026). Balancing needs and capacity in MHPSS for returnees [Written contribution to the GCERF–Institute of Psychology community of practice webinar]. ALTadhamun Iraqi League for Youth.

Mariko, F. (2026). MHPSS and reintegration in Mali: Balancing needs, continuity of care and complementary interventions [Written contribution to the GCERF–Institute of Psychology community of practice webinar]. FEDE.

Mooren, T., van Ee, E., Hein, I., & Bala, J. (2023). Combatant parents and their children: Intergenerational consequences of war trauma. Frontiers in Psychiatry, 14, 1096401.

Powers, A., Stevens, J. S., O'Banion, D., Stenson, A. F., Kaslow, N., Jovanovic, T., & Bradley, B. (2022). Intergenerational transmission of risk for PTSD symptoms in African American children: The roles of maternal and child emotion dysregulation. Psychological Trauma: Theory, Research, Practice, and Policy, 14(7), 1099–1106.

Qena, R. (2026). Lessons from Kosovo on assessing and supporting returning adults, children and families [Written contribution to the GCERF–Institute of Psychology community of practice webinar]. Community Development Fund.

Schick, M., Morina, N., Klaghofer, R., Schnyder, U., & Müller, J. (2013). Trauma, mental health, and intergenerational associations in Kosovar families 11 years after the war. European Journal of Psychotraumatology, 4(1), 21060. https://doi.org/10.3402/ejpt.v4i0.21060

Shabdanova, T. (2026). Strengthening frontline workers to expand access to MHPSS in Kyrgyzstan [Written contribution to the GCERF–Institute of Psychology community of practice webinar]. Foundation for Tolerance International.

Singla, D. R., Kohrt, B. A., Murray, L. K., Anand, A., Chorpita, B. F., & Patel, V. (2017). Psychological treatments for the world: Lessons from low- and middle-income countries. Annual Review of Clinical Psychology, 13, 149–181. https://doi.org/10.1146/annurev-clinpsy-032816-045217

Tanski, M., Wei, D., Singh, S., Avendano Pabon, M., Bahure, V. K., Jordans, M. J. D., Lund, C., Roy, S., Singh, R., Thapa, A., Tol, W. A., & Evans-Lacko, S. (2025). Poverty-reduction interventions combined with psychological interventions: A systematic literature review. Scientific Reports, 15, Article 38829. https://doi.org/10.1038/s41598-025-24736-8

Tol, W. A., Barbui, C., Galappatti, A., Silove, D., Betancourt, T. S., Souza, R., Golaz, A., & van Ommeren, M. (2011). Mental health and psychosocial support in humanitarian settings: Linking practice and research. The Lancet, 378(9802), 1581–1591. https://doi.org/10.1016/S0140-6736(11)61094-5

Tol, W. A., Le, P. D., Harrison, S. L., Galappatti, A., Annan, J., Baingana, F. K., Betancourt, T. S., Bizouerne, C., Eaton, J., Engels, M., Hijazi, Z., Horn, R., Jordans, M. J. D., Kohrt, B. A., Koyiet, P., Panter-Brick, C., Pluess, M., Rahman, A., Silove, D., … van Ommeren, M. (2023). Mental health and psychosocial support in humanitarian settings: Research priorities for 2021–30. The Lancet Global Health, 11(6), e969–e975. https://doi.org/10.1016/S2214-109X(23)00128-6

World Health Organization & United Nations High Commissioner for Refugees. (2015). mhGAP humanitarian intervention guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies. World Health Organization. https://www.who.int/publications/i/item/9789241548922