

**COMMITTEE:** Special Organization for Mental Health

**QUESTION OF:** Integrating Mental Health Service into Humanitarian Responses for Refugees and Conflict Survivors

**SUBMITTED BY:** Brazil

**CO-SUBMITTED BY:** Bangladesh, Mexico

**SIGNATORIES:** Pakistan, Colombia, Nigeria, the Federal Democratic Republic of Nepal, Azerbaijan, Venezuela, Guyana, Panama, Singapore, France, Italy, Turkey, Algeria

*The General Assembly,*

*Acknowledges* that 123.2 million people had to leave their homes, and among those were 42.7 million refugees,

*Reaffirming* the World Health Organization's mhGAP Humanitarian Intervention Guide and its emphasis on integration of mental health and psychological support into the main healthcare systems in LEDCs and emergency settings for refugees,

*Emphasizing* the important action of the United Nations High Commissioner for Refugees (UNHCR) in establishing Mental Health and Psychosocial Support (MHPSS) frameworks in refugee camps and previous conflict zone areas around the globe,

*Keeping in mind* that the UN Refugee Agency (UNHCR) has taken community volunteers to train them in basic psychosocial skills to help those in need, as well as trained nurses and physicians, and sent funds to help mental health physicians and advocates for the inclusion of mental health care in health systems,

*Recognizing* the experience of conflict-affected countries, including Ukraine, where war has demonstrated the urgent necessity of systematic mental health support for civilians and displaced populations,

1. Calls for the mandatory integration of mental health and psychosocial support (MHPSS) into all UN peacekeeping, rebuilding, and humanitarian response efforts by:
  - a. Encouraging all UN action plans to include a dedicated MHPSS section to ensure that all physical as well as mental health needs are met, incorporating mental health assistance into all humanitarian aid initiatives,
  - b. Urging a specific section for mental healthcare within national Humanitarian Response Plans for all UN member states, and incentivizing countries through financial aid for healthcare infrastructure,
  - c. Suggesting that all treaties and peace agreements facilitated by the UN incorporate solutions that address the healthcare of refugees, with a focus on their mental health;
  
2. Urges Member States and humanitarian agencies to integrate training into mental health aid:
  - a. Mandate mandatory Psychological First Aid (PFA) training for all first responders, including local health workers, Red Cross/Red Crescent volunteers, psychology students, and community leaders, using a standardized WHO/IFRC curriculum adapted to cultural contexts (Including language training for the regions these responders will be sent to),
  - b. Establish national PFA training hubs within 12 months, prioritizing partnerships in high-risk regions such as Southeast Asia, the Middle East, and Africa, with technical assistance from agencies like Singapore International Foundation and PAHO,
  - c. Integrate PFA as Tier 1 MHPSS within emergency field hospitals and relief operations, ensuring 80% responder coverage measured by annual audits,

- d. Allocate 5% of humanitarian aid budgets to PFA capacity-building, with progress reports submitted to the UN General Assembly annually;
- 3. Suggests UN member states to integrate mental health services into primary health care delivery in conflict zones, humanitarian aid corridors, refugee camps, and countries housing conflict survivors fleeing from their home country:
  - a. Training general healthcare workers using the WHO mhGAP through a new UN initiative, educating them on the process of diagnosing and treating common mental health conditions seen in refugees, including PTSD, depression, anxiety, and suicidal thoughts,
  - b. Assisting national governments in severe need to establish mental health services within existing clinics, by providing neutral UN healthcare specialists, financial and technological assistance, as well as the manpower to do so,
  - c. Creating an international board of mental health specialists, where healthcare providers can converse on an encrypted digital platform protected from cyberattacks, to enable the sharing of data and discussion of the most effective practices in reducing mental health issues in refugees;
- 4. Encourages the creation of mental health hubs within humanitarian aid corridors, refugee camps, or areas safe from conflict during times of unrest, where individuals can work with specialized mental health experts and doctors:
  - a. Establishing permanent or semi-mobile mental health hubs and facilities coordinated by UNICEF, and integrating that into existing healthcare infrastructure,
    - i. Some hubs specifically equipped with aid for children and adolescents, staffing these hubs with teams of child psychologists, psychiatrists, and social workers provided by neutral global organizations and vetted by the UN,

- ii. Women-only, men-only, or family-oriented areas when culturally appropriate,
    - iii. Ensuring continued care through scheduled follow-ups and monthly check-ins (or however long requested by patients),
  - b. Partnering with NGOs like Doctors Without Borders, the International Medical Corps, and more to provide digital counseling to individuals in conflict zones, expanding the scope of mental health aid within inaccessible zones, and targeting the root cause of most refugees' mental health issues,
    - i. Deploying secure tele-mental health platforms that are compatible with unstable internet access and available in rural areas equipped with multilingual online and personal counseling platforms with anonymous support channels for trauma survivors,
    - ii. Training NGO staff with local officials to deliver technology to patients, providing them the means and resources to attend these healthcare checkups, backed by funding from the UN Fifth Budgetary Committee;
  - c. The creation of a standardized mental health screening system for refugees and conflict survivors, including:
    - i. Initial psychological assessments upon arrival at humanitarian facilities using internationally recognized tools,
    - ii. Classification of refugees and conflict survivors into three groups according to the severity of their psychological needs: mild, moderate, and severe, to provide tailored support and interventions;
5. Requests donor states, international financial institutions, and humanitarian funding mechanisms to ensure sustainable financing for mental health services by:
- a. Determining a fixed percentage of humanitarian health funding specifically for mental health and psychosocial support programs,
    - i. Suggest converting a certain percentage of healthcare and humanitarian aid funding from the United Nations to go specifically to mental health assistance – for example, 5% each year, modifying as needed,

- b. Integrating mental health funding into existing humanitarian response plans, such as UNHCR and IOM response frameworks, rather than relying on short-term or ad hoc donations,
  - c. Encouraging public–private partnerships with foundations, academic institutions, and humanitarian NGOs to support innovation, training, and service delivery,
  - d. Suggests that the global community and willing economically developed countries (MEDCs) provide support to overburdened and lesser economically developed national health systems that lack the capacity to integrate specialized mental health services due to an overwhelming amount of refugees and immigrants;
6. Recommends the training and capacity-building of humanitarian personnel to strengthen mental health response by:
- a. Providing mandatory basic mental health and psychosocial support training for humanitarian workers, including field staff, volunteers, and local responders,
  - b. Training non-specialist workers to deliver low-intensity psychosocial interventions under professional supervision, increasing reach in resource-limited settings,
  - c. Create different sections depending on different areas of trauma, such as,
    - i. Childhood,
    - ii. PTSD,
    - iii. Anxiety,
    - iv. Trafficking,
    - v. Depression,
    - vi. Personality disorders,
  - d. Provide access to prescriptions and legal medications for those who need it to aid mental health issues;

7. Supports the incorporation of classic culture and traditions into mental healthcare to make the process more comfortable and enticing for the mentally ill as well as educating the general public about mental illness by:

- a. Recruiting and training interpreters, mediators, and other local community facilitators to work with doctors and mental health specialists, learning from them and observing how to provide mental health care to refugees and survivors, and providing that care once medical professionals leave,
- b. Elements like art and music will connect these people in recovery, providing significant psychosocial support,
- c. Incorporating TV programmes that teach children how to manage their emotions and traumatic experiences through the behaviors of popular, beloved characters that use WHO-approved coping strategies they resort to while facing their own, fictional problems,
  - i. These programs can be altered to fit the cultures of the regions they are being aired in to increase the acceptance of the coping methods by refugees and IDPs around the globe,
- d. Distributing educational materials such as brochures, videos, online resources, and public information to spread awareness and remove stigma about mental health,
  - i. Integrating school and publicly available programs, workshops, and seminars to educate on mental health'

8. Establishes an international minimum standard for mental health support in humanitarian crises, including:

- a. Trained mental health specialist will be mandated depending on refugee population intake in conflict zones and surrounding countries,
- b. Mandatory psychological first aid within the first 72 hours after displacement,
- c. Child-friendly safe spaces in all refugee camps and humanitarian centers;

