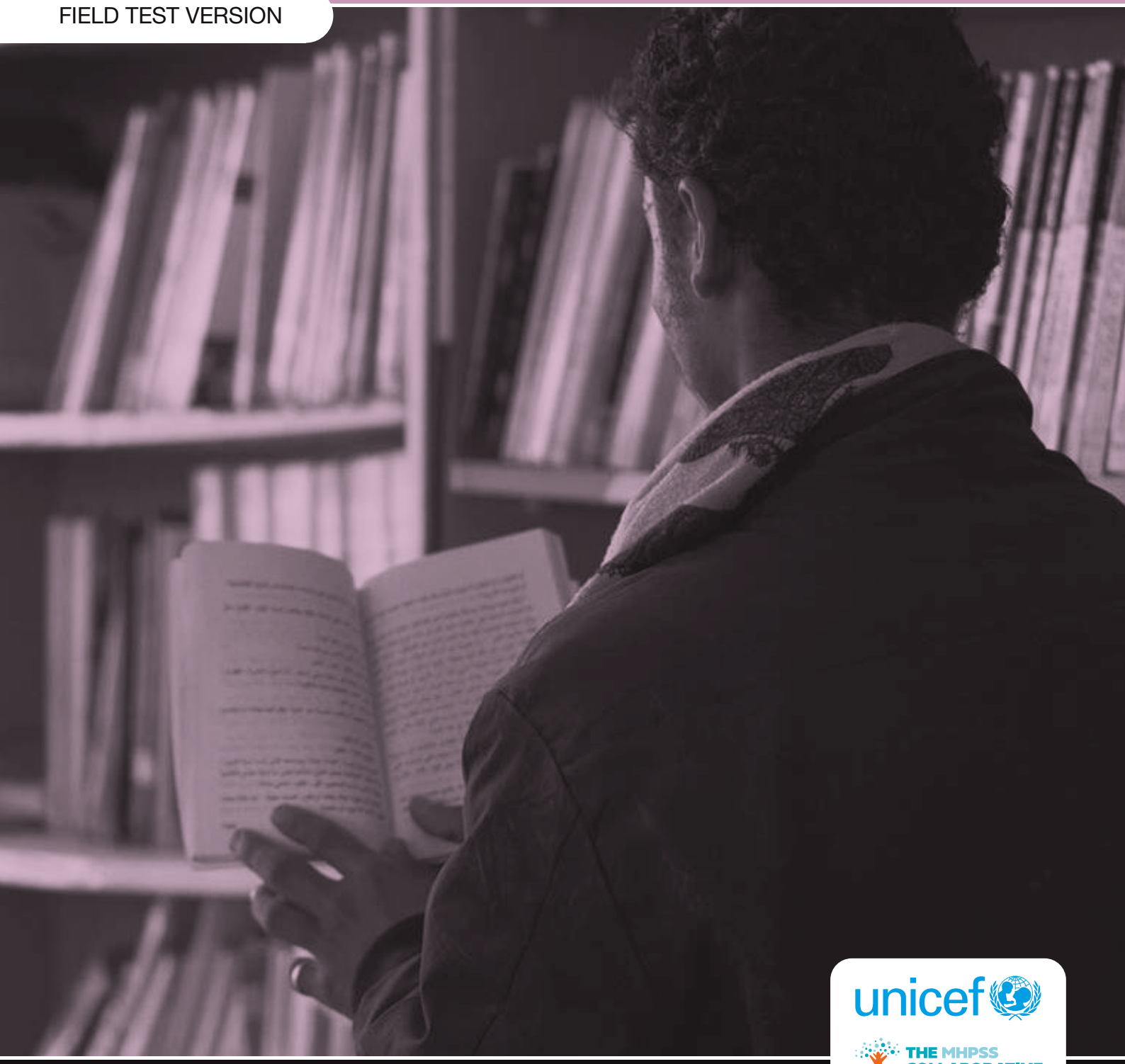
MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN CHILDREN ASSOCIATED WITH ARMED FORCES AND ARMED GROUPS PROGRAMMES

EVIDENCE REVIEW

FIELD TEST VERSION



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THE MHPSS COLLABORATIVE
FOR CHILDREN & FAMILIES IN ADVERSITY

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Front cover photo: Ali (not his real name), 16, reads in a public library in Yemen. In order to support his family, Ali ran away from home to join an armed group. In early 2020, after five months fighting on the frontline, he was released along with 68 other child soldiers by UNICEF and other international organizations. Photo © UNICEF/UN0456829/Fuad

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Abbreviations and acronyms

CAAFAG	Children associated with armed forces and armed groups
CB MHPSS	Community-based mental health and psychosocial support
CCCM	Community coordination and camp management
CFS	Child-friendly spaces
COVID-19	Coronavirus disease 2019
CP	Child protection
DDR	Disarmament, demobilization and reintegration
DRC	Democratic Republic of Congo
FSA	Free Syrian Army
IASC	Inter-Agency Standing Committee
IOM	International Organization for Migration
ISIL	Islamic State of Iraq and Levant
ISIS	Islamic State in Syria
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental health and psychosocial support
PFA	Psychosocial first aid
PTSD	Post-traumatic stress disorder
SDF	Syrian Democratic Forces
SGBV	Sexual and gender-based violence
SOPs	Standard operating procedures
TPO	Transcultural Psychosocial Organisation
UNDP	United Nations Development Organization
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1. Introduction

Globally, one in six children lives in a conflict zone. In the Middle East, the ratio is two in five (Østby et al., 2020). Children are increasingly exposed to violence and extreme hardship during and after war. Rates of children's association with armed forces and armed groups have doubled since 2012, and the exploitation of girls, in particular, is rising (Child Soldiers International, 2019). Since 2012, more than 30,000 cases of recruitment have been verified in 17 countries (United Nations, 2018). Girls associated with armed forces and armed groups totalled 893 in the 2018 report, four times more than the 216 recorded in 2017.

The use of children in armed forces and armed groups is a global practice. Contexts of recent concern include Afghanistan, Iraq, Democratic Republic of Congo, Central African Republic (CAR), Colombia, Syria, Somalia and South Sudan (UNICEF, 2016). Globally, between 250,000 and 300,000 children under the age of 18 are estimated to operate in the ranks of at least 57 rebel and government armed forces in ongoing conflicts.

Children associated with armed forces and armed groups (CAAFAG)

Children associated with armed forces and armed groups (CAAFAG) face the threat of witnessing or experiencing high levels of physical, psychological and sexual violence, including killings, extreme violence (Amone-P'Olak, 2009; Haer, 2017; Betancourt et al., 2008; Betancourt et al., 2013; Akello et al., 2010; Machel, 1996; Ager, Akesson, Stark et al., 2011; Stark, 2006) and stigma (Betancourt et al., 2020; Thabet et al., 2004; McKay & Mazurana, 2004; Akello et al., 2008; Tonheim, 2017). In some settings, over 70 per cent of CAAFAG report having been severely beaten by armed forces and armed groups, with similar rates reported by boys and girls (Amone-P'Olak, 2018; Tonheim, 2017).

In some complex emergencies, children are forced to commit violent acts that inflict emotional, psychological and physical harm on individuals and communities, including children themselves. Furthermore, many children who are alleged to have been associated with highly coercive and violent armed forces and armed groups are detained for extended periods without charge, in poor conditions, and without services (UNICEF, n.d.). Witnessing violence and involvement in armed conflict during childhood has long-term and even intergenerational consequences (Denov & Akesson, 2017; Machel, 1996; Wessells, 2016; Medeiros et al., 2020). Armed conflict affects children in many ways. War puts children at greater risk of death and being separated from their caregivers, exposure to violence including sexual violence, abduction or kidnapping by armed forces and armed groups, and recruitment and use by conflicting parties (Amone-P'Olak et al., 2016; O'Neil, 2018; Wessells, 2016; Akello et al., 2010).

Mental health and psychosocial wellbeing of CAAFAG

Violence and abuse affect CAAFAG in numerous ways, with serious implications for their safety and wellbeing. Responding to the immediate mental health and psychosocial support (MHPSS)[1] needs of CAAFAG and supporting their full reintegration is crucial for their opportunities for education and livelihoods – as well as for sustainable peace (ACPHA, 2020; Betancourt et al., 2020). However, the post-conflict mental health and psychosocial wellbeing of CAAFAG remain inadequately addressed. Systems of care are almost non-existent and typically are not sustained beyond emergency responses. In technical consultations

1 Mental health and psychosocial support is a composite term used to describe any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorders (IASC, 2007).

(see Methods, page 4), one representative of a donor organization pointed to the dearth of resources for this population, noting "Our partners that we fund in CAAFAG programming are typically using guidance that's not tailored to MHPSS for CAAFAG […] They are training case workers to understand that CAAFAG have different needs. But we haven't seen an evidence-based approach that understands those needs."

Robust evidence demonstrates that armed conflict increases both short- and long-term risks of mental and psychosocial dysfunction in children, and particularly for CAAFAG. Thomason (2018) reported that child soldiers felt guilt and shame, while other studies show high levels of post-traumatic stress disorder (PTSD) (Bayer et al., 2007; McMullen et al., 2013; Derluyn et al., 2015; Thabet et al., 2004). CAAFAG are at an elevated risk of mental health problems such as anxiety, depression, PTSD, social isolation due to stigma and externalizing behaviour, and children who have indirect involvement with violence often experience similar problems (Bolton et al., 2007; Denov, 2019; Denov & Kahn, 2019; Betancourt et al 2010; 2019).

High rates of post-traumatic stress symptoms have been observed in children who were exposed to wars in Bosnia, Cambodia, Central America, the Middle East and Rwanda (Attanayake et al., 2009). Similarly, longitudinal research in Sierra Leone demonstrates that some former child soldiers continue to experience depression, anxiety and psychosocial difficulties, with stigma and social exclusion continuing years after conflict has ended (Betancourt et al., 2008; Betancourt et al., 2020). CAAFAG who were used to brutalize their own communities may also be deprived of future social support from kith and kin and the wider community. The context in which this happens should be considered during reintegration.

Although the effects of conflict on CAAFAG are significant, there are other important aspects of CAAFAG experience during and after conflict that drive MHPSS risks. Many CAAFAG have had their education disrupted by conflict or because their families have not been able to keep them in school due to political insecurities, poverty, early marriage and a lack of childcare. Lack or disruption of educational structure among CAAFAG is often part of a series of cascading events, including loss of loved ones and drastic changes in daily routine, which adversely affects children's mental health and psychosocial wellbeing (Willis and Nagel, 2015).

While the many negative effects of children's association with armed forces and armed groups are clear, studies show that many children exhibit resilience following war experiences and are able to reintegrate into their communities following conflict (Wessells, 2016; Medeiros et al., 2020; Denov & Maclure, 2009; Annan et al., 2011; Okraku & Yohani 2020; Kohrt et al., 2010; Aggerman & Panter-Brick 2010; Betancourt et al., 2013). In Colombia, for example, studies have found that CAAFAG demonstrate good leadership skills (Rosenau et al., 2014) and that child soldiers often serve as peace builders in their communities (Martuscelli and Villa 2018).

Technical consultations for this review (see Methods, page 4) reinforced this point. One individual noted that some demobilized CAAFAG in Colombia said they felt they were "being treated as babies or infantilized and over-protected" in the post-conflict services they received. This contrasted with how the children saw themselves: as young adults who had "voluntarily joined an armed group with responsibilities and positions of power". The youth consultations (see Methods, page 4) with Colombian ex-combatants also emphasized this point. They noted that many people joined armed forces and armed groups voluntarily because they felt the guerrillas' fight against the government was their best option for gaining better living conditions and that they were treated comparatively well. One youth participant explained, "I joined the guerrillas when I was 11 because there was nothing else to do and we didn't even have enough to eat at home." Recognizing that there can be positive outcomes for children resonates with what many agencies working with CAAFAG have perceived as a paradigm shift from a disproportionate emphasis on victimhood, psychopathology and risk (Tonheim, 2014; Amone-P'Olak et al., 2014; Kohrt et al., 2010; Fernando & Ferrari, 2013).

Rationale for the Evidence Review

Using evidence-based approaches and interventions to improve mental health and psychosocial wellbeing outcomes among CAAFAG, their families and communities is crucial (SAMHSA, 2018). Evidence-based approaches should consider how MHPSS may improve children's and youths' wellbeing and how children formerly associated with armed forces and armed groups can be supported by families, communities and helping professionals. They should also consider strengthening sustainable systems to support the process of release, reintegration and transitions to adulthood, including the intergenerational impact of trauma. The global COVID-19 pandemic has also meant that many evidence-based approaches require adaptation guided by evidence, theories, models and frameworks (Moore & Metz, 2020).

Research on MHPSS in CAAFAG programmes is often neglected and is seldom given adequate technical, leadership or financial support. However, as research increases on MHPSS interventions for conflict-affected children (with varied attention to cultural context), so does research on interventions for CAAFAG (Mukdarut et al., 2017; Brown et al., 2017). Interventions include (but are not limited to) narrative exposure therapy (Schauer et al., 2017), performative theatre (Estrada-Fuentes, 2018), CBT (Bayer et al., 2007; McMullen et al., 2013), dance therapy (Stark, 2006; Ager et al., 2011), play therapy (Ertl et al., 2011), treatment of depressive symptoms (Bolton et al., 2007) and common elements from transdiagnostic treatments that include components of CBT as well as mindfulness and inter-personal group therapy (Betancourt et al., 2014).

The objectives of this review are: first, to review the evidence on MHPSS in the reintegration of CAAFAG and the prevention of re-recruitment; second, to highlight the most effective MHPSS programming implemented by local governments and humanitarian organizations; third, to recommend best practices and approaches to systems strengthening, drawing from both evidence-based practice and practice-based evidence; and last, to identify gaps in existing practices for CAAFAG.

2. Methods

This synthesis drew principally on an exhaustive desk review of MHPSS approaches and programming for CAAFAG, as well as considering what is both effective and feasible to implement. Examples from both evidence-based practice and practice-based evidence are also included (Kienzler, 2019). The desk review was supplemented by a series of consultations, including with professionals who have carried out research and/or had programme experience working in MHPSS and CAAFAG programmes (referred to in this document as technical consultations), as well as youth with lived CAAFAG experience (referred to as youth consultations). These approaches are elaborated upon below.

Desk review

The desk review was conducted by scanning academic literature, organizational reports, and grey literature (i.e., a rapid literature review) for evidence-based practices relevant to MHPSS in CAAFAG and related programming since 1995. The following concepts informed this search: children's exposure to war; children being recruited, abducted or involved in any activities with armed forces and armed groups; risk and protective factors for mental health and psychosocial wellbeing among children affected by conflict; and approaches, interventions and best practices for MHPSS among children and families in the context of conflict. Studies and reports were identified by using the following keywords: war, violence, war-affected children, conflict zone, armed forces and armed groups, MHPSS, mental health, psychosocial wellbeing, CAAFAG, child soldiers, Syria, ISIL and ISIS.[2] The desk review was conducted by distinct searches through the following databases: Global Health; Medline; Social Services Abstracts (ProQuest); Social Work Abstracts (Ovid); PsycINFO 1987– (Ovid); CINAHL Plus with Full Text; and Google Scholar.

In addition to online searches, international agencies participating in the Alliance for Child Protection CAAFAG Taskforce and Inter-Agency Standing Committee (IASC) MHPSS Child and Families Workgroup were also asked to share reports and internal documents with evidence relevant to identifying best practices for MHPSS in CAAFAG programming. The websites of agencies that self-identified as actively interested in this space were searched, including sites for War Child Holland, War Child UK, Save the Children International, International Rescue Committee, UNICEF, Terre des Hommes, Plan International, Plan Germany and HealthNet TPO.

Technical consultations

Individual, paired and small group one-hour, semi-structured interviews[3] were conducted via Zoom with 22 research, programme and technical experts with experience in MHPSS with CAAFAG from a range of local, national and international humanitarian and mental health organizations.[4]

The purpose of technical consultations was to gain an understanding of researcher and practitioner perspectives of what is working, what the challenges are and where there are gaps in delivery of MHPSS interventions in CAAFAG programmes. Interviews also provided insight into emerging MHPSS programming being implemented with CAAFAG. Many experts

2 Syria, ISIL and ISIS were added as query terms as a search strategy to identify the most current evidence for delivering MHPSS in CAAFAG programmes in hard-to-reach or complex contexts.

3 For a list of sample questions see Annex I.

4 Organizations included War Child UK, War Child Holland, SEED Foundation, International Rescue Committee, The Tavistock and Portman NHS Foundation Trust, Plan International Germany, The Centre for Victims of Torture, Save the Children, UNICEF, mhpss.net, academic institutions (Columbia University and McGill University) and development agencies (USAID).

shared tools and information related to these ongoing programmes. The additional information provided by the technical consultations strengthened the evidence review and the interpretation evidence.

Experts were initially identified through organizations that responded to email and in-meeting announcements requesting participation in the consultation through the Alliance for Child Protection CAAFAG Taskforce and the IASC MHPSS Child and Families Workgroup. Outreach for participation was also extended via email to individuals and organizations recommended by members of these groups.

Consultations with youth

Safe, meaningful individual interviews and focus group discussions were conducted with 19 youths with lived CAAFAG experience in Syria (N=8, all male, aged 21–24) and Colombia (N=11, 10 women and 1 man, aged 22–41 years), respectively. An additional focus group discussion was held in Colombia with a group of four children (2 girls and 2 boys) aged 8 to 14 years who were receiving support from a local provider and who were thought to be at particular risk of recruitment into armed groups. The purpose of youth consultations was to gather knowledge, opinions, judgements and insights, as well as evidence of the lived experiences of MHPSS among CAAFAG as it relates to the prevention of recruitment (and re-recruitment), release and reintegration. We asked participating organizations in the Alliance for Child Protection CAAFAG Taskforce and the IASC MHPSS Child and Families Workgroup to connect reviewers with networks engaging with youth with lived experience. To prioritize safeguarding, outreach was conducted only with youth within these networks. Considerations for youth engagement (see Annex II) in the consultative process were shared with potentially interested organizations to co-create a bespoke facilitation approach specifically tailored to organizational, programme and youth contexts. Semi-structured interviews and focus group discussions were facilitated by organization staff already known to and trusted by the youth. Interviews were semi-structured using the question list in Annex II as a conversation guide.

Report structure

This report highlights key concepts, defines terms, presents the findings of the evidence review synthesized across methods, raises key contextual considerations for MHPSS in CAAFAG programming, and makes recommendations for developing operational and contextual guidance.

First, the review elaborates on key concepts and considerations for MHPSS among CAAFAG. Next it describes approaches to delivering MHPSS and then considers risk and protective factors around mental health and psychosocial wellbeing that may be of particular importance to CAAFAG. The review then offers considerations around integrating MHPSS throughout the CAAFAG response before describing MHPSS tools for use with CAAFAG. The review concludes with a discussion of evidence gaps and recommended areas for further research.

3. Key concepts and considerations for MHPSS among CAAFAG

This section examines some of the key concepts and considerations for MHPSS among CAAFAG, including ongoing debates around language and terminology, the significance of gender, and best practices for working with CAAFAG in ways that reduce stigma.

CAAFAG and 'child soldiers'

Understanding conceptual variations in terms relevant to work with CAAFAG is fundamental to contextualizing prevention, release and reintegration programming. According to the Paris Principles (UNICEF, 2007), a child associated with armed forces and armed groups (CAAFAG) is "any person below 18 years of age who is or who has been recruited or used by an armed force or armed group in any capacity, including but not limited to boys and girls used as fighters, cooks, porters, messengers, spies or for sexual purposes. It does not only refer to a child who is taking or has taken a direct part in hostilities." CAAFAG may be used both across contexts and within contexts, and is inclusive notwithstanding age, gender, ethno-religious identity or role. It is also important to note that, although labels have a practical value, they should be used with discretion in interactions with CAAFAG and their families/communities to avoid the reinforcement of negative stereotypes.

The Paris Principles and Guidelines consider children in support functions to be as vulnerable as those in direct combat roles, and all CAAFAG are understood as victims of grave violations against children during times of armed conflict (Office of the Special Representative of the Secretary-General for Children and Armed Conflict, 2013). The term 'child soldier' appears frequently in the literature, and at least one study found the term CAAFAG to be stigmatizing because of its association with certain types of reintegration programmes and lack of agency attributed to former youth combatants (Kohrt et al., 2010). However, many humanitarian practitioners opt to use the term CAAFAG to acknowledge the complexity of children's experiences and challenges. This review uses the term CAAFAG to encapsulate the heterogenous profiles of children except when discussing literature or reports that specifically focus on child soldiers or other specific groups of associated children. In some settings, for example, CAAFAG are also referred to as 'militarized children' or 'children of ISIS'.

Narrow conceptualizations of CAAFAG can limit understanding of the challenges and consequences associated with children's diverse roles within armed forces and armed groups. Survivors of sexual violence are not always recognized as victims of armed forces and armed groups and the experiences of male CAAFAG, especially the rampant sexual violence they often face, may not be acknowledged. This can limit understanding of the unique challenges linked to performing support roles. The meaning that CAAFAG themselves attribute to their roles and experiences within armed forces and armed groups is also critical for designing relevant programmes. This is likely to differ drastically for children who were forcefully abducted or coerced into perpetrating violence and children who found some purpose or fulfilment in their association with armed forces and armed groups (Kohrt et al., 2016).

Mental health and psychosocial support (MHPSS)

The meaning of the term 'wellbeing', along with other broader notions of mental health, often varies based on context. A strong understanding of the local conceptualizations and idioms related to MHPSS is vital to make programming for CAAFAG meaningful and relevant. The World Health Organization defines health and wellness in broad terms as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (World Health Organization, 1948).

The primary objective of trauma-informed MHPSS for conflict-affected populations is not to treat symptoms or issues related to trauma but rather to provide supportive services in a way that is accessible and appropriate to those who may have experienced trauma. This includes both the promotion of wellbeing and the prevention of the activation of trauma.

Relatedly, when considering wellbeing in the wake of adversity and/or trauma, resilience refers to the assets and processes in and across all social ecological levels that have been shown to be associated with good development outcomes after a child's exposure to situations of armed conflict (Tol et al., 2008). It must be acknowledged that MHPSS support for CAAFAG, especially individualized medical approaches that are central to Western psychiatry, might not always be the first priority for the local population.

MHPSS of CAAFAG and non-associated children

Perhaps surprisingly, when the psychological wellbeing and problems of CAAFAG are compared with those faced by children in the same geographic areas who were not directly associated with armed forces and armed groups but were subject to indirect effects, their outcomes are similar, with the exception only of formerly associated children who were exposed to the most extreme forms of trauma (Betancourt et al., 2008; Betancourt et al., 2013; Blattman & Annan, 2010). This suggests that direct exposure to and witnessing of trauma, violence and loss are widespread in areas of armed conflict and affect both CAAFAG and children who are not associated (Kohrt et al., 2008; Betancourt et al., 2008). It emphasizes the need to strengthen mental health and social services in conflict-affected settings as a part of building back better in the relief to development transition (Hallegatte et al., 2018). Technical consultations also reinforced this point. One respondent noted that specialized services can "be very stigmatizing and harmful [despite] a lot of good intention", adding that "The first thing kids need is a safe enough environment where their group is not ostracized or stigmatized."

At the same time, it is important to note that, typically, the services available to CAAFAG remain extremely limited, if available at all. Eight male Syrian youths (aged 21–24 years), all of whom had been associated with armed groups during their childhood, indicated that they had not received any services to support their mental health or wellbeing, which they attributed to a complete absence of services in northeast Syria. They noted that while they see the situation as improving, the number of organizations working to provide services to CAFAAG is extremely limited.

Similarly, in Colombia, consultations with ex-combatants suggest that their access to mental health services was minimal. They noted that they received some assistance at the beginning of the reintegration process, but that it was intermittent or only happened once. The participants expressed a need for these services, noting that they continue to be affected by anxiety, worry and feelings of hopelessness.

Stigma towards CAAFAG and related psychosocial problems

Stigma is a common psychosocial problem faced by CAAFAG returning home to their communities and represents a major risk factor for suffering and distress (McMullen et al., 2013). In a study in El Salvador, CAAFAG who experienced stigma scored higher on a psychological impact measure, as did youth who experienced feelings of disappointment upon return home (Betancourt et al., 2013). Longitudinal evidence from Sierra Leone indicated that stigma predicted higher levels of hostility and externalizing behaviour as well as lower levels of prosocial behaviours over time, even after adjusting for war exposures (Betancourt et al., 2010; Betancourt et al., 2020). Betancourt et al. (2008) and Betancourt et al. (2020) found that years after the end of the Sierra Leonean civil war, former child soldiers continue to experience abuse, neglect and stigma, and demonstrate increased psychosocial distress as a result of negative attitudes from the community. Moreover, child soldiers also maintained higher levels of internalizing (anxiety and depression) symptoms compared with children who did not experience the same social rejection.

Research in Uganda compared stigma among abductees and non-abductees and found that abducted children showed similar levels of family and community rejection, whereas non-abductees were more likely to engage in prosocial behaviours such as participation in politics and community activities (Blattman, 2009). Another study in northern Uganda found that among war-affected youth returning from captivity by the Lord's Resistance Army, killing and perpetrating violence may be just as toxic a risk factor for PTSD and other psychosocial outcomes as being a victim of violence (Amone-P'Olak et al., 2017). Children who are not directly associated with armed forces and armed groups but belong to families with perceived ties to armed forces and armed groups also suffer from stigma and reduced access to basic services (education, health services, social services), and face the risk of revenge and retaliation as well as exclusion from social activities.

The stigma directed at CAAFAG can pose challenges for practitioners. In technical consultations, some noted that community members are not always comfortable

sending their children to the same social services as CAFAAG. Even trained practitioners may not have the contextual or cultural knowledge needed to respond to CAAFAG and some may have concerns for their personal wellbeing and safety. For example, one participant in a technical consultation mentioned that clinicians may be scared that children are still affiliated with ISIS and might share their names. Others may have experienced violence at the hands of CAAFAG and may have difficulty reconciling children associated with armed forces or armed groups or as victims as well as perpetrators of violence.

Gender and MHPSS among CAAFAG

Although child soldiering has largely been portrayed as a phenomenon that affects boys, girls represent up to 40 per cent of child soldiers across armed conflicts (UN Security Council, 2015). In 2018, the United Nations Special Representative for Children and Armed Conflict of the Secretary-General reported that there were nearly 900 girls confirmed to be associated with armed forces and armed groups – four times more than the 216 recorded in 2017 (United Nations, 2018). Highlighting the grave mental health and psychosocial functioning threats facing female CAAFAG, the 2019 report found that girls as young as seven were raped in Myanmar. In South Sudan, there are multiple confirmed reports of girls being gang raped by armed men. The technical consultations emphasized the impact that conflict has on girls.

Another issue of concern is the disproportionate attention given to CAAFAG who have visible mental health and psychosocial dysfunction. This often manifests in violent, aggressive and confrontational behaviour, often referred to as 'externalising' symptoms (Betancourt et al., 2020). In many patriarchal contexts, it is socially unacceptable for girls to engage in externalizing behaviours. They are forced to stifle their mental distress and psychosocial needs in the interest of performing the prescribed gender roles (Kohrt & Worthman 2009; McKay, 2004). As one participant in the technical consultations described, "If you do not [perform these expected gender roles], there are repercussions. There would be violence against you in the household/family setting and the possibility of being isolated and excluded is higher. For boys, violence is expected… they are encouraged to be violent. It is not necessarily viewed as a negative behaviour. We must also remember our own gendered roles and one of the constraints at the initial level is the absence or silencing of girl role models who can play an active role in encouraging girl CAAFAG. The humanitarian setting in general is very male dominated."

Okraku and Yohani (2020) argued that disarmament, demobilization and reintegration (DDR) programmes have revealed gender differences. In Angola, Mozambique, Sierra Leone and northern Uganda, former female child soldiers have faced barriers both in accessing services and with general reintegration. For instance, in Sierra Leone, children were required to turn in a weapon in order to receive services as CAAFAG. However, few female CAAFAG owned weapons, leading many to go without formal DDR services. While some studies suggest no gender differences regarding mental health problems among CAAFAG, combat experience and domestic violence were significantly associated with all mental health outcomes (Okraku and Yohani, 2020).

Regarding MHPSS gender differences, studies suggest that, in some settings, female former CAAFAG experience more severe psychosocial problems than boy soldiers. In Sierra Leone, for example, Betancourt and colleagues (2008) found that female former CAAFAG demonstrated significantly lower levels of confidence and prosocial behaviours across the post-conflict period than male former CAAFAG (Betancourt et al., 2008). In a follow-up study, however, Betancourt (2020) found that 15 years after the Sierra Leonean civil war ended, male former CAAFAG reported significantly higher levels of post-traumatic stress symptoms than female former CAAFAG. Betancourt also found that the significant difference in prosocial attitudes between male and female former CAAFAG observed in the 2008 study had reduced, with no significant difference observed (Betancourt et al., 2020).

Similarly, Betancourt et al. (2020) found that, although female former CAAFAG reported higher rates of stigma and lower community and family acceptance than males in earlier studies (2002–2004), by 2017, 15 years after the war ended, female former CAAFAG reported lower levels of perceived stigma and higher levels of family acceptance than male former CAAFAG. This suggests that gender differences may not remain the same over time and should be expected to change as CAAFAG mature and in concert with changing dynamics across the social ecology.

Studies have also noted interactions between gender and community acceptance, with results indicating differences in the ways families and communities treat returning boys and girls. In Sierra Leone, immediately after the war ended, female former child soldiers experienced lower rates of acceptance than their male counterparts and were commonly viewed as sexually impure (Denov, 2010).

4. Approaches to MHPSS for CAAFAG

The evidence review identified common approaches that offer useful theoretical and practical foundations for the design and evaluation of MHPSS programming for CAAFAG. Many of these approaches are mutually reinforcing and complementary. They can, and often should, be layered and implemented within multisectoral interventions. For example, child rights-based approaches overlay neatly with approaches that focus on promoting resilience, psychosocial wellbeing, and so on. The following section elaborates on different approaches identified in studies and across programmes.

Child rights-based

The recruitment and use of children in armed conflict violates their rights and persists despite it being prohibited (for children under 15) under international humanitarian law and defined as a war crime by the International Criminal Court. In the wake of armed conflict, the reintegration needs of CAAFAG are different from those of adults (Global Coalition for Reintegration of Child Soldiers, 2020) and must also be seen in the context of the general experience of children, youth and families affected by war. Child rights-based approaches to supporting the needs of CAAFAG and war-affected youth and families recognize that children have rights enshrined in the UN Convention on the Rights of the Child and emphasize their autonomy and agency (United Nations, 1989). They encourage careful consideration of the individual child and his or her best interests. Children's right to participation in decision making must be a central component of programming. The principles of a child rights-based approach should be applied and integrated across all phases of CAAFAG reintegration, from the earliest phases of the humanitarian response to development and peacebuilding activities.

Resilience as a process and the need for enabling environments

Through an approach focused on resilient outcomes, rehabilitation and reintegration programmes are designed to cultivate positive coping skills among CAAFAG through activities at multiple levels of children's social ecology (individual, family and community). An approach focused on resilient outcomes pays close attention to developing enabling environments to support healthy reintegration of CAAFAG as well as to gender and age differences among CAAFAG, and the interaction of individual factors with threats, risks and resources in the community. In addition, exclusively focusing new services and support on CAAFAG needs must be done in the context of the overall strengthening of mental health and social services for all war-affected children, youth and families (Betancourt & Ettien, 2010).

A child's resilience is shaped by risk and protective factors operating in his or her social ecology. The child's individual trauma, coping strategies and strengths interact with risk and protective factors at family, peer group and broader community levels, as well as within the policy and cultural/historical context. Children demonstrating resilience may exhibit healthy coping mechanisms, good problem-solving skills, and the ability to pursue life opportunities that promote their wellbeing while also contributing to healthy functioning in their families, peer groups and larger community.

Approaches that promote resilient outcomes can shed light on potential areas for strategic intervention by bolstering protective processes across a child's social ecology (Ager & Metzler 2017; Shakya, 2010; Williams & Drury, 2011). Studies suggest that the protective factors that moderate the impact of war-related adversities in children include a strong bond between the primary caregiver and the child, the social support of teachers and peers, and a shared sense of values (Werner, 2012; see also Table 1 on page 13).

Extra caution should be taken, however, when conceptualizing resilience as a trait of individual children rather than a broader social-ecological process. Denov and Akesson (2017, p. 4) argue that "researchers and practitioners may risk overemphasizing resilience in children, assuming that all will or have the capacity to bounce back, as such, recognizing the dynamic interplay of capacity and adversity, trauma, and resilience – within unique sociocultural contexts are thus essential".

Specialized care approaches

Specialized MHPSS approaches entail interventions that focus on identifying and treating individuals who display emotional and behavioural signs of pathology, including mental health problems, depression, anxiety and PTSD, with a focus on interventions to treat mental illness (Betancourt & Williams, 2008). These types of approaches typically require trained mental health providers to implement them. Often, these are Western psychiatric approaches that have been criticized for a lack of cross-cultural relevance and effectiveness in many non-Western countries experiencing complex humanitarian emergencies (Antić, 2021). This point was reinforced in some of the technical consultations. As one clinical psychologist put it, "The literature is dominated by Western tendencies, which overvalue verbal intervention. I'm not saying CBT [cognitive behavioural therapy] isn't good enough and there is some evidence that it may work – but this is not a modality where one-size-fits-all; it's not necessarily good for everybody."

At the same time, research over the years has demonstrated a tremendous amount of innovation to bridge the gap between MHPSS needs and available, effective and ethical services. Recent efforts have documented that, with strong approaches to training and supervision, some frontline stabilization- and skills-focused mental health interventions can be delivered by well-trained and supervised lay workers linked to larger systems of care (Betancourt et al., 2014).

The IASC pyramid covers a number of services. These range from addressing basic needs (such as those for food and shelter) to addressing symptoms of common mental disorders (e.g., anxiety and depression) via trauma-informed interventions delivered by lay workers (e.g., Betancourt et al. 2014) to targeted and indicated services (such as trauma-focused PTSD treatment) delivered by highly trained professionals (e.g., Wilker et al., 2020). For all interventions, implementation in a culturally sensitive and contextually responsive manner is essential to ensure the effectiveness of MHPSS interventions.

In the consultations, a practitioner described how they link psychosocial interventions with psychiatric approaches. "[We] start with playful activities, making therapy [focus on] what they would like to do – it could be art, football, tennis, racquet ball. The bond is so important for them, and from there we can move on to more traditional therapy using different approaches such as CBT, working on their thought patterns, work on self-identity, as they struggle to try to make sense of their experience."

Psychosocial approach

A psychosocial approach focuses on restoring CAAFAG's losses and disrupted social context after traumatic events and aims to rebuild the infrastructure needed to provide safety, health services and education programmes. Betancourt & Williams (2008) defined psychosocial approaches to MHPSS as those targeting the restoration of functioning among client populations negatively affected by conflict, for example, by providing routines, predictability and engagement. Psychosocial approaches avoid disease labels, employ cultural practices, and integrate services with other helping systems, for example, school-based mental health programmes. An example of psychosocial programming for CAAFAG would be arts or recreation activities that provide a safe space for children to make social connections with others and restore some semblance of normal childhood activities.

Ecological (multi-level) approach

Although MHPSS has traditionally been embedded in and linked to health and protection activities, support for mental health and psychosocial functioning among war-affected children is increasingly integrated into the work of other sectors, such as nutrition, education and youth employment promotion (Weissbecker et al., 2019; Betancourt et al., 2021). Such integration opens up tremendous opportunities for addressing the gap in MHPSS services for war-affected children, youth and families.

Multi-level approaches consider the dynamic and interactive ecological systems that influence the mental health and psychosocial wellbeing of CAAFAG and facilitate the promotion of individual mental health and wellbeing, family support, educational support, community support, structural conditions, public safety, and gender-based violence interventions (Wessells, 2012). In this approach, MHPSS interventions are carried out simultaneously with and throughout the process of CAAFAG reintegration. They take into account MHPSS care, support and referral networks, ensuring that CAAFAG and MHPSS interventions do not occur in isolation.

Ecological or multi-level approaches encourage the integration of evidence-based MHPSS services throughout and across a child's social ecology. This means that issues of adequate staffing and policy and financial supports for MHPSS and social service systems must be given priority attention, including research into the barriers to and facilitators of service integration, their potential for sustainability, and strategies to ensure that their quality improves over time.

MHPSS interventions should likewise be integrated into existing services and structures (e.g., health clinics, schools, etc.) to improve access and reduce potential stigma and discrimination for vulnerable children and families seeking care and support (IASC, 2019). A number of studies describe stigma as manifesting in social rejection, with references to addiction and to former CAAFAG "acting as if still in the army", resulting in name-calling and maltreatment (Johannessen & Holgersen, 2014).

Family-centred approach

Many studies emphasize the importance of families in children's recovery and wellbeing during and post conflict. To prevent and mitigate mental distress and disorder among CAAFAG, a safe home environment, family unity, acceptance and support are among key factors that can be cultivated at the family level (Betancourt et al., 2013). An approach that is family-oriented, culturally acceptable, age appropriate and predicated on children's rights is likely to be more effective and sustainable. At the family level, caregivers and relatives of CAAFAG should have access to the support they need. Family is the first and most effective source of support in a child's immediate social ecology. Such key attachment figures are fundamental to the enabling environment needed to promote mental health and wellbeing among CAAFAG and are critical as CAAFAG make the transition into civilian life in the aftermath of war (United Nations, 1989; Ager, 2006).

Community-based participatory approach

Community-based approaches highlight that communities can be the most effective drivers of their own care and change. They emphasize programme recipients' meaningful involvement in guiding MHPSS programming across all stages of the CAAFAG response (IASC, 2019). At the community level, MHPSS may include activities to promote social cohesion, raise awareness of and sensitivity to the needs of CAAFAG during the reintegration period, and encourage positive behaviour change. Although community-based approaches are not rare in practice, few studies have been conducted to rigorously evaluate the effectiveness of such MHPSS approaches in addressing the MHPSS needs of CAAFAG (see Cilliers et al., 2016).

Ager and colleagues (2010) offer one example of a community-based approach which focused on the reintegration of female CAAFAG. This intervention demonstrated positive effects on both community integration and individual mental health (Ager et al., 2010). Girls and young women in both the intervention and comparison communities made significant progress towards integration, and the intervention was also associated with improved mental health outcomes and higher ratings on some aspects of relationship quality. Moreover, this use of a community-based approach demonstrated that for CAAFAG who had found the greatest challenges in reintegrating, the intervention appeared to offer additional support for community acceptance and inclusion in women's social activities (Ager et al., 2010). The promising results from this study and others suggest that future research is needed to examine the potential of community-based approaches to serve MHPSS within CAAFAG responses.

In northern Democratic Republic of Congo (DRC), a pilot study of a family-focused, community-based psychosocial intervention with CAAFAG used a multi-level approach to integrate a life skills leadership programme, relaxation training drawn from TF-CBT, and mobile cinema screenings to address stigma and to model community acceptance (O'Callaghan et al., 2014). Each participant was encouraged to bring one caregiver to the sessions, with the overall goals of the programme being to cultivate prosocial behaviour and reduce conduct problems. Compared with those not enrolled in the programme, youth who received services reported a significant reduction in traumatic stress reactions. After three months, there were reductions in internalizing symptoms and increases in prosocial behaviours. Caregivers also noted a decline in conduct problems.

An innovative feature of this and other interventions is the use of *community advisory boards* composed of community leaders and local youth to address challenges that arose during implementation (O'Callaghan, 2014). In the DRC study, community advisory boards were led by a community pastor who had a master's degree in trauma interventions for youth. The pastor provided feedback on the appropriateness of interview questions and data collection. Throughout the intervention, the lead researcher met weekly with four adults and four youth to assess the programme and propose changes to improve effectiveness, such as having a graduation ceremony. This strategy of incorporating community advisory boards into mental health interventions is well aligned with broader

guidelines and best practices on working with war-affected populations, in which humanitarian workers and affected communities build equitable partnerships that serve to support and empower vulnerable communities.

Arts-based approach

Using words and language is not always the best way to capture the reality and experience of those who witnessed severe conflict, especially children born in conflict settings (Denov et al., 2018). Moreover, insights related to MHPSS can be taken from both the artistic creation itself and the child's own interpretation of what she or he created in an arts-based approach. In a study with CAAFAG, art was found to be an empowering and effective recovery tool to help war-affected populations.

Denov and Shevell (2021) conducted a study with youth born out of rape in Rwanda. They examined the use of an arts-based autobiographical mapping tool to understand the lived experiences and found that this method helped the youth to cope with the stigma associated with their past, especially at the societal level. They described the method as an effective tool that enabled them to illustrate a positive picture of their future. The researchers concluded (p. 21) that the "mapping tool represents an important addition to arts-based methods that can be used with populations who have experienced profound forms of violence and marginalisation".

Multi-layered psychosocial educational workshops using music, art, theatre, sports, photography and team-building activities to teach the children about trust, unity, non-violence and conflict resolution can help CAAFAG to process the trauma of armed conflict. These activities can cultivate a safe space for open dialogue and give children the opportunity to dream and envision their future if offered as part of an ongoing and trusting therapeutic relationship.

It is important to recognize that, although each of these approaches has merit, relying on one approach to MHPSS alone for CAAFAG may be insufficient. Often, a combination of approaches may be required based on the context, nature, severity and political ramifications of the conflict. Drawing from the strengths of the art-based approach, organizations can include artistic and creative components in ethical and multi-layered approaches to support the mental health and wellbeing of CAAFAG.

5. Key risk and protective factors for CAAFAG MHPSS and wellbeing

A number of important MHPSS risk and protective factors operate across the social ecology of a child affected by conflict. Table 1 (below) highlights the major MHPSS risk and protective factors described in the published and grey literature. This section draws from the literature to describe several key examples of promising target areas for multi-layered MHPSS programming with CAAFAG (Mohamed & Thomas, 2017; Karadzhov, 2015; Betancourt et al., 2010; Fazel et al., 2012; Tol et al., 2013; Denov, 2010).

Social and civil identity

The Paris Principles' definition of reintegration emphasizes how a shift in the civil identity of former CAAFAG should occur alongside the reintegration process to facilitate their transition into a civil life (UNICEF, 2007). In terms of mental health and psychosocial wellbeing, during the process of reintegration CAAFAG go through an important process of reimagining their identity from that of association with an armed force or armed group to a civilian life within a family and community. Children who were born into armed forces and armed groups may find the process of reimagining their identity even more challenging as life with the armed force or armed group is all they have known. In this sense, reintegration involves helping each child to reconstruct her or his own place and role in the social ecology (Wessells, 2009). Children's understanding and rationalization of what has happened, i.e., their 'personal narrative', is thus key to their mental health and psychosocial wellbeing. Moreover, having a positive social role can provide former CAAFAG with a sense of place in civil life, improve their behaviours, and therefore produce a change in their social identity (Wessells, 2006).

CAAFAG can hold multiple identities, one of which may be that of soldiers or the sons or daughters of those involved in armed forces and armed groups. A huge shift in children's identities occurs as they become

Table 1 Protective/promotive and risk factors for mental health and psychosocial wellbeing among CAAFAG during reintegration – adapted from Weine et al. (2020)

	Risk factors	Protective factors
Child/Adolescent	Traumatic events, displacement, stressors due to experiencing or witnessing violence, externalizing symptoms, disability, learning difficulties	Access to services, family support, psychosocial support (emotional, informational and instrumental)
Caregiver/Family	Mental health problems among parents, family separation, family conflict, domestic violence	Access to services, religious support, social support, family cohesion, and programmes to prevent gender-based violence
Community/Society	Stigma (mental health and other), bullying, rejection, social isolation, discrimination, structural violence, stereotyping, poverty, unemployment, economic hardship, ongoing and historical conflict, lack of services, stigma around mental health	School enrolment, mental health sensitization (teachers, community), peer support, recreational activities, enhanced safety inside and around school, social support, community participation, faith and religious support, community leader roles, vocational training, local stability, financial support, active engagement of NGOs and civil society

affiliated with armed fighters and groups, and this might have an impact, according to Wessells (2006), on their reintegration process. Previous studies on child soldiers in Sierra Leone suggest that people feared children who were part of the RUF (Revolutionary United Front). Some saw them as a symbol of fear, with their presence associated with mass violence and human rights violations (Wessells, 2016). More attention should be paid to the social identity of CAAFAG before and after conflict, and how the redevelopment of their identity can contribute to stigma and community reactions as they seek reintegration into civilian life.

Family acceptance and responsive caregiving

Family acceptance is strongly linked to positive MHPSS outcomes among former CAAFAG (Betancourt et al., 2020). Commenting on the importance of family and community acceptance, one individual in the technical consultations said, "The problem is that when reintegration takes place and CAAFAG go back to the family or community, they remember the trigger or reason why they joined the army in the first place and there is a risk that they will join the armed group again." This point was also stressed in the consultations with Syrian youth. The group mentioned that their own families and close circles of people around them were a key in restarting a new life. They also pointed to the importance of raising awareness in communities about the importance of helping their children and youth who have been associated with armed conflict.

There is strong research in support of making investments in families as part of the DDR process. In El Salvador, former child soldiers indicated that the relationship with their family was the most useful factor that facilitated their process of reintegration (Hill & Langholtz, 2003). In Sierra Leone, higher levels of family acceptance were linked to lower average levels of emotional distress among former child soldiers (Betancourt et al., 2020). Supportive parenting was associated with better psychosocial adjustment in Ugandan child soldiers (Betancourt et al., 2010). In a follow-up study with formerly associated youth in Sierra Leone, Betancourt et al. (2020) found that CAAFAG that were "socially vulnerable" in the post-conflict period, (i.e., had low levels of community and family acceptance), demonstrated increased risk of anxiety/depression above the clinical threshold and possible PTSD, and were almost three times more likely to attempt suicide – even 15 years after the end of the civil war.

Feeling accepted, loved and cared for by their family can have a positive effect on the ability of former CAAFAG to re-establish a sense of belonging to their family and community. Strengthening of families and family bonds should be seen as a key strategy in achieving successful MHPSS interventions and reintegration. The centrality of family is reflected in a wide range of international conventions and policy statements. The UN Convention on the Rights of the Child refers to the family as key in ensuring the wellbeing of children (United Nations, 1989). Trust-building and social acceptance interventions should therefore begin at the family level and gradually extend to include neighbours and other community members.

Caregiver mental health and relationships

In many conflict-affected communities, parents and caregivers of war-affected children not only experience the psychological stress of war but also daily stressors (Miller et al., 2020; Amone-P'Olak et al., 2014). Daily stressors include poverty, inadequate or unsafe housing, "uncertainty regarding the future, humiliating treatment by local authorities, separation from social support networks, and an inability to adequately protect and provide for their children" (Miller et al., 2020, p. 2). In addition to daily stressors due to conflict and post-conflict conditions, women in particular are at elevated risk of both gender-based violence and intimate partner violence (Tol et al., 2013). Violence across the family's social ecology can affect caregivers' abilities to provide the support their children need during and after conflict. The same is true when parents of a child who is associated with armed forces and armed groups. In families such as these, caregivers face the extra challenge of dealing with the psychological impact of their child's involvement, as well as the broader social effects, including stigma and community exclusion, resulting from their child's association with armed forces or armed groups (Wessells, 2016).

Although some studies suggest that some CAAFAG demonstrate higher levels of externalizing and aggressive behaviour towards their parents or caregivers, others show that CAAFAG who were abducted exhibit few hostile attitudes and tend to avoid confrontation rather than react aggressively (Annan et al., 2011). The quality of the relationship between children and their parents can have an impact on the child's wellbeing (Betancourt, 2017, 2015; WHO, 2018; Fazel et al., 2012). In this context, Miller and Jordans (2016) found that having a supportive caregiver relationship and good peer relationships can protect a child from recruitment into armed forces and armed groups. In this same manner, the intergenerational impact of war must also be considered as parents' exposure to trauma can be a risk factor for poor mental health and developmental outcomes in later generations (Betancourt et al., 2018).

Nurturing care

Interventions that strengthen the capacity of parents and caregivers can provide the support and nurturing care that children need to thrive. In doing so, they may also help address some of the risks associated with the intergenerational impact of war (Barnhart et al., 2019; Healy et al., 2018; WHO, 2018). It has also been found that programmes that help caregivers to teach their children skills such as emotion regulation, problem solving and social skills, can help children build resilience (Betancourt et al., 2019; Jensen et al., 2020). In a recent systematic review, Pedersen et al. (2019) examined the evidence for family and parent-focused interventions' effect on mental health outcomes for children and youth and identified treatment components present in promising interventions.

Parent and family-focused interventions, such as psychoeducation, parent and family-skills training, and behavioural, psychosocial and trauma-focused CBT may be beneficial to children in low- and middle-income countries. However, a major gap in the implementation of family-based interventions is that they seldom involve both parents, with most engaging mothers disproportionately (Barnhart et al., 2019). More evidence is needed to illustrate the effects, if any, of engaging multiple or diverse caregivers, especially when working with CAAFAG.

For example, Articolo 12 and the International Rescue Committee (2020) developed a family-based intervention toolkit to help parents of CAAFAG support their children. Its primary goal is to provide effective tools and parenting skills for parents and caregivers to prevent the recruitment of children in conflict zones. It also aims to help CAAFAG in their reintegration process and ensure that they have adequate support from their parents and caregivers.

Education and livelihoods

Numerous studies in the review found that CAAFAG felt ill-equipped to contribute to their family economy upon return to civilian life. A study from Sri Lanka observed that former child soldiers felt that they had gained educational opportunities through their association with armed forces and armed groups (de Silva et al., 2001). Attending school and training programmes is considered critical in helping CAAFAG attain a sense of normality and safety in their everyday lives while also increasing their future employment opportunities (Betancourt & Khan, 2008). A study from Uganda found that former child soldiers who were given the opportunity to continue their education reported lower levels of depression than those who entered vocational training directly (Ovuga et al., 2008).

In addition to educational opportunities, entry into the labour force is seen as enabling youth to redefine themselves and to shift their identity from soldier to civilian. Wessells (2006) found, for instance, that former girl soldiers in Sierra Leone suffered from greatest psychosocial stress due to poverty and limited livelihood opportunities. MHPSS should also include how to relieve economic stresses for former CAAFAG and their families, and how to provide self-confidence and hope for female CAAFAG. The youth consultations also highlighted the importance of livelihoods training. For many in the group of Syrian former CAAFAG, education and jobs training were the highest priority. Similarly, former combatants in the Colombian group were concerned that they could not secure employment despite having received some education and training.

Social support, community participation and acceptance

Social support and community acceptance may also promote successful reintegration and positive psychosocial outcomes. Sierra Leone research suggests that higher levels of social support were associated with increased adaptive and prosocial behaviours and attitudes (Betancourt, 2020). In Nepal, being older, abduction into an armed group, living in a nuclear family, being from a Buddhist minority ethnic group and not living in a Hindu high-caste community were associated with more social support from family and community. Peer support was the strongest predictor of lower PTSD, lower functional impairment and improved hope (Kohrt et al., 2010). Studies from Sierra Leone also suggest that community acceptance and retention in school were associated with higher levels of prosocial behaviours and lower levels of internalising problems (Betancourt et al., 2010).

6. Integrating MHPSS throughout the CAAFAG response

MHPSS in the prevention of recruitment and use

Very little research has been conducted on evidence-based approaches to preventing the recruitment and use of children by armed forces and armed groups. However, the literature has elaborated on the theoretical underpinnings that support the connection between MHPSS and the protection of children's rights in conflict settings (see Harrison et al., 2021). Community-based attacks and forced conscription of CAAFAG have been associated with widespread community demoralization, high levels of depression and anxiety, the perpetuation of memories related to past events of violence and loss, and worries about current life circumstances and the future (Betancourt et al., 2008; Cilliers et al., 2016). Moreover, the capacity for communities, families and youth to claim children's rights to protection is often limited by the conditions of violence (Harrison et al., 2021).

Children do not normally join armed forces or armed groups for reasons of ideology or based on their mental health status (Wessells, 2006). The factors that influence child involvement with armed forces and armed groups, including those characterized or listed as violent extremist or terrorist, are numerous, multidimensional and different for each child (UNU, 2018). However, one of the major push factors for children to be recruited by armed forces and armed groups is the loss of family members (Wessells, 2016; UNICEF, 2018). The loss of caregivers during conflict compromises children's fundamental need and right to security. Such a loss may cause grief and place children at risk of negative mental health and psychosocial consequences (O'Connor et al., 2021).

Separation from family and caregivers can also predispose children to unsafe situations and increase their risk of exploitation and manipulation. During consultations in Colombia, youth shared that they were regularly exposed to family- and state-based violence. Many had witnessed violence, threats by armed forces and armed groups, displacement, evictions, sexual violence or economic insecurity. While most did not share details about their personal experiences, these types of risk factor may make them more vulnerable to joining armed forces and armed groups. At the same time, however, participants also said that they generally did not like to talk about how they felt.

MHPSS at the time of release

Article 39 of the UN Convention on the Rights of the Child states that "parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child." MHPSS services are currently recommended to be incorporated into all CAAFAG programming actions, starting with release and throughout all stages of reintegration which should consider a life course approach and greater investments in systems strengthening as a part of the relief to development continuum (Betancourt & Ettien, 2010; ACPHA, 2020).

Although there is little evidence explicating the range and quality of MHPSS services available to CAAFAG across conflict settings in the very early stages following release, all CAAFAG should be enabled with immediate equitable access to MHPSS support without any kind of discrimination and judgement based on their involvement in conflict. In one technical consultation there was a report of an interim care centre in South Sudan where a trained psychologist is the first point of contact for CAAFAG entering the formal release process. This arrangement is not the norm, however, as the resources for clinical assessment and intervention are scarce in South Sudan and many other conflict-affected communities.

MHPSS during reintegration

> *"Removing us from the war would lessen our hatred for the RUF. It hadn't crossed their minds that a change of environment wouldn't immediately make us normal boys…"*
>
> Ishmael Beah (2007, p. 135), former CAAFAG, Sierra Leone, and author of *A Long Way Gone*

Reintegration usually entails a long-term social process of gaining acceptance, becoming functional in the social context, and developing appropriate relations with families, peers, communities, authorities, institutions and organizations (Wessells, 2006). Current efforts to reframe the process of reintegration, as it relates to the humanitarian-development-peacebuilding nexus, seek to upgrade the definition to better acknowledge children's agency and emphasize the focus on a child's process of becoming an active and engaged member of a peaceful society (Ladisch, 2013).

Addressing the mental health and psychosocial needs of CAAFAG and other children affected by conflict is a crucial aspect of a successful reintegration process. MHPSS plays a critical role in enabling former CAAFAG to transition from war to a sustainable life, and the success or failure of MPHSS during reintegration directly affects children (McMullen et al., 2013). For successful, sustainable reintegration, MHPSS is essential to support children in reclaiming self-esteem (by drawing upon existing social care systems where they exist) and acknowledging children as rights-holders and individuals with agency who can empower and help protect themselves as well as contribute to society through their healthy reintegration (GCRCS, 2020).

CAAFAG may find it hard to navigate their reintegration and experience psychosocial distress during and after conflict. Moreover, living with mental health conditions can exacerbate challenges and distress across a child's reintegration journey. Lack of access to MHPSS services has been found to be one of the factors that contribute to this struggle. For example, Boothby's (2006) longitudinal study with a small sample of former child soldiers from Mozambique found that after 16 years "none of these children is truly free from his past. All continue to struggle with psychological distress that is linked to their child soldiering experiences" (p. 176). Sustainable reintegration is achieved when the political, legal, economic and social conditions needed for children to maintain life, livelihood and dignity have been secured (Paris Principles, Article 2.8).

Reintegration requires trust building (Wessells, 2006). In contexts where CAAFAG are reintegrating, trained MHPSS providers can play important roles to support their recovery and reintegration processes (IASC, 2007). Attempting to reunite children with their families and communities is important. However, sensitization and reconciliation efforts are sometimes necessary before a child is welcomed back home and require consideration over the longer term. In Sierra Leone, in the immediate aftermath of the conflict, attention was given to community-driven sensitization campaigns (Wessells, 2012; Betancourt, 2020), but these were not maintained over the long term, even though the effects of stigma and community rejection continued to play into dynamics of successful reintegration. In rolling out such campaigns, a longer-term view and long-term investment is important over the course of the development and adjustment of war-affected youth.

For MHPSS multisector reintegration programming, tensions exist between the choice of vocational training versus a return to formal education or catch-up education modules (Okraku et al., 2020). Since many CAAFAG are over the age of 18 when they demobilize, they often find that returning to formal education does not address their economic needs (Peters, 2007). Even so, many CAAFAG who were attending school when they became involved with an armed group wish to complete their schooling, and there are examples of accelerated learning programmes that have been used with success (Özerdem & Podder, 2011). Ultimately, as rights-holders, war-affected youth should be able to participate in such decisions with viable options presented that allow them to restore as many of their prior hopes and ambitions as possible. There is evidence that return to schooling, participation in livelihoods programmes and the use of cash transfers are improved when combined with evidence-based MHPSS programming (Blattman et al., 2007; Betancourt et al., 2014; Betancourt et al., 2019).

Repatriation and MHPSS

Repatriation refers to the return of CAAFAG to their community of origin following separation from caregivers and/or abduction by armed forces or armed groups. MHPSS implementing organizations have an important but perhaps undervalued role in the repatriation of CAAFAG. During the period of repatriation, CAAFAG and other conflict-affected children may be especially vulnerable. Humanitarian groups play an important role, especially in poor and politically unstable states where official institutions may lack sufficient resources to provide relief.

In the wake of armed conflict, children and families are compelled to make stressful decisions about permanent resettlement options or to return to their home countries.

As seen in the case of Kosovo, the MHPSS response for CAAFAG can offer assistance in coping with trauma, as well as helping children survive and adjust in their environment. Technical consultations emphasised, for example, that the suitability and course of repatriation depends on whether there is a home for the child, as in some cases the parents have been killed, families displaced, or the children were used to terrorise their own communities.

Repatriation should be carried out in the best interests of the child and take into account her or his circumstances in order to ensure that it is not harmful to the child (Wessells, 2009; Williamson et al., 2017). For CAAFAG navigating the repatriation process, evidence-based MHPSS interventions may be used within multi-layered programming to support their emotional safety and help ease them into life in the community. Multisectoral, multi-level models that promote individual mental health and wellbeing, family support, educational success, community support, structural conditions and public safety are promising (Weine et al., 2020).

MHPSS in the prevention of re-recruitment and re-association

In the design of reintegration programmes and effective MHPSS interventions, limited attention has been given to how mental health can affect re-recruitment and re-association among former CAAFAG. Living in violent families, poverty, lack of food or other basic necessities, lack of education and opportunities in civilian life, social isolation, traumatic experiences and loss of family members and relatives all shape the risks of re-recruitment (UNICEF, 2019). Reintegration programming that not only responds to but proactively supports families to meet their basic needs is likely to be the most effective, since the vulnerability of CAAFAG is embedded within a protective environment in which parents, families, communities, local and sub-national authorities and governments all contribute to the care and protection of children (GCRGS, 2020).

Growing evidence suggests that MHPSS actors should assess the needs and wellbeing of CAAFAG in long-term programming and not only at the time of release and reintegration. This highlights the importance of systems strengthening to ensure sustainability and to set the stage for communities and local and national governments to manage the MHPSS of CAAFAG in the post-emergency era. This is especially important given the numerous humanitarian emergencies involving children, globally.

7. MHPSS tools to use with CAAFAG

Evidence in this review suggests that interventions may be implemented across the social ecology of CAAFAG to promote mental health and psychosocial wellbeing and to prevent disorder and psychosocial distress. At the same time, few studies have examined the effectiveness of these tools to understand and address the MHPSS needs of CAAFAG in particular. Given that CAAFAG and war-affected children are exposed to similar conflict-related, socio-ecological conditions that increase their risk of mental and psychosocial dysfunction, this review cast a wide net to capture the range of MHPSS tools that may be used effectively to serve the MHPSS needs of war-affected children, with special attention paid to tools that have already been used with CAAFAG.

MHPSS interventions for conflict-affected children identified in the review are presented in Table 2. Examples range from targeted intervention tools and approaches, for instance Narrative Exposure Therapy, school-based programmes, and group-based cognitive behavioural therapy (CBT), with detailed descriptions in the following sections. As Table 2 shows, many interventions are focused on the individual or household level, demonstrating a gap in evidence for multi-layered MHPSS interventions serving CAAFAG (i.e., across non-health and protection sectors). The following intervention tools have been used to implement and evaluate MHPSS programmes for conflict-affected children broadly, or with CAAFAG in particular.

Table 2 MHPSS interventions used with conflict-affected children across the social ecology

Individual	Caregiver and family-focused	School and education	Livelihood	Community based
Early childhood interventions (ECIs) Narrative exposure therapy (KIDNET) Trauma-focused Cognitive Behavioural Therapy (TF-CBT) Art therapy Helping Adolescents Thrive (HAT) Early Adolescent Skills for Emotions (EASE)	Home visiting interventions *Sugira Muryango* ('Strong Families, Thriving Children', FamilyTalk) Teaching Recovery Techniques Problem Management Plus	Classroom-based Interventions School-based Psychosocial Structured Activities Youth Readiness Intervention Sensitization campaigns	Youth Readiness Intervention Poverty reduction policies and programmes	Ceremonies, celebrations Sensitization campaigns

Early childhood interventions (ECIs)

ECIs address deficiencies and stressors faced by children and families with children under the age of five and promote positive development during the critical early years of life. ECIs target various domains of a child's development, including physical, emotional, social and cognitive development outcomes, the latter of which facilitate school readiness. Some ECIs take a multi-level approach to support the economic development of the parent and/or caregiver, parent education, parenting skills and prenatal wellbeing or the integration of both early childhood development promotion and the prevention of violence (Betancourt et al., 2019; Jensen et al., 2020). *Sugira Muryango*, for example, was developed for use in post-genocide Rwanda using a mixed-methods adaptation of the FamilyTalk intervention developed by Beardslee and colleagues (Betancourt et al., 2011).

Although the main goal of ECIs is to strengthen mental health and wellbeing, prevent the development of new problems, and reduce and improve symptoms of dysfunction by focusing on both children and their developmental ecology, they can also help to address risks of intergenerational violence from an early age (Jordans et al., 2016). Guidelines call for the use of intervention techniques that are evidence-based, which address myriad challenges and risks for children's poor development, and which are scalable. Interventions should focus on modifiable risk factors, such as child cognitive and behavioural deficits or parental caregiving skills and mental health (Karoly et al., 2006). For CAAFAG, special attention should be paid to the importance of preventing or reversing family separation as the presence of parents is essential for the secure attachment and mental health of children (Miller et al., 2016).

Overall, effective ECIs benefit from timeliness (early in life), address multiple levels of socio-ecological influence, and use frameworks based on child rights principles.

Home visiting and psychosocial support

Intergenerational home visiting interventions target the needs of children and caregivers simultaneously. Family environment interventions have demonstrated the ability to promote protective elements of caregiver–child relationships and increase access to hard-to-reach populations, and can be tailored to the needs of each family (Peacock et al., 2013; Grantham-MacGregor & Smith, 2016). In post-genocide Rwanda, a family strengthening intervention delivered via home visiting was found to improve parent–child relationships and indicators of child development while also reducing harsh punishment of children and intimate partner violence (Betancourt et al., 2018; Jensen et al., 2020). Such family-based interventions have promise for MHPSS promotion with CAAFAG, especially when they are embedded within protection, health, education and other services to facilitate greater reach. In order to support the healthy reintegration of CAAFAG who have been separated from their caregivers, family-based interventions could be tested that prepare both the young person and the family for the highs and lows expected upon reunification. Such interventions could also continue to work with CAAFAG and caregivers after reunification to build skills in communication, conflict resolution and problem solving (Betancourt et al., 2014).

Child-friendly spaces

In addition to home visiting interventions, other studies have examined the effectiveness of child-friendly spaces outside of the home that seek to promote the mental and psychosocial wellbeing of young children (Metzler et al., 2019). Individual-level and group-based interventions have also been conducted with conflict-affected children and CAAFAG. Art therapy carried out by trained mental health practitioners, for example, shows promise in supporting children towards longer-term healing following conflict and in enhancing resilience in communities (Jabbar & Betawi, 2019). Child-friendly spaces in schools, early education centres and health clinics are indicated as a focal point for early childhood MHPSS delivery.

8. Intervention tools for school-aged CAAFAG

Promising MHPSS approaches have been attempted with school-aged youth, with such interventions taking a broadly socio-ecological orientation delivered in individual or group-based formats. Some are situated in classroom, school and employment promotion settings.

Individual and group-based treatment

Few studies have examined the efficacy and effectiveness of individual and group-based treatments among CAAFAG. However, individualized and group-based treatment approaches have been implemented across diverse settings for conflict-affected children. The acceptability and fit of such treatments may depend on culture as well as on the severity of mental or psychosocial problems.

Narrative Exposure Therapy (NET) was developed, for example, as a brief treatment "for the psychological sequelae of torture and other forms of organized violence". This individual therapy can be delivered by trained lay workers in low-resource settings. The main intervention element of NET – known as KIDNET when used with children and adolescents – is the construction of a trauma narrative (Shauer et al., 2017).

KIDNET was delivered successfully as a tool to treat PTSD among former child soldiers in Uganda and the DRC, and with asylum seekers resettled in Germany (Ertl et al., 2011; Onyut et al., 2005; Ruf et al., 2010). NET has also been used to support the MHPSS of Somali refugees living in a Ugandan refugee camp and with youth orphaned by the Rwandan genocide (Shaal et al., 2009). In all studies, NET resulted in significant reductions in PTSD symptoms compared with either a control group or another form of treatment, with effects maintained or enhanced over time.

Helping Adolescents Thrive (HAT) is a toolkit designed to promote and protect adolescent mental health and reduce self-harm and other risk behaviours. The toolkit comprises four interlinked strategies and two implementation approaches, including tools to support the work of programme managers. Five recommendations for mental health promotive and preventive interventions for adolescents were developed based on the evidence synthesis and 'Evidence to Decision' frameworks. First, universally delivered psychosocial interventions should be provided for all adolescents. Second, psychosocial interventions should be provided for adolescents affected by humanitarian emergencies. Third, psychosocial interventions should be considered for pregnant adolescents and adolescent parents, particularly to promote positive mental health (mental functioning and mental wellbeing) and improve school attendance. Fourth, indicated psychosocial interventions should be provided for adolescents with emotional symptoms. Fifth, indicated psychosocial interventions should be provided for adolescents with emotional symptoms. The intended audience for the HAT recommendations includes national policy makers, planners, and managers of government and non-governmental health care programmes, as well as people working in international health and development agencies (Helping Adolescents Thrive, 2021).

Early Adolescent Skills for Emotions (EASE) was designed to help conflict-affected adolescents manage stress, solve problems and cope in effective ways. The intervention was created for adolescents and their caregivers based on empirically supported methods recommended by the WHO to confront internalizing problems. Feasibility trials were conducted in Jordan, Lebanon, Pakistan and Tanzania, with major findings and lessons learned forthcoming. Research is also underway in Jordan and Lebanon, and is due to begin in Pakistan (Brown et al., 2019; Mental Health Innovation Network, 2021).

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)

TF-CBT is another individual intervention developed to assist school-aged youth with their recovery from trauma. TF-CBT is a phased, evidence-based mental health intervention that entails promotion of youth coping skills and the processing of trauma experiences, and provides closure to the treatment experience (Cohen et al., 2012). In Zambia, a TF-CBT intervention was delivered by trained and supervised lay counsellors to conflict-affected children as young as five, with significant reductions in trauma symptoms and improvement in functioning (Murray et al., 2015). In Palestine, trained counsellors delivered a TF-CBT programme called Teaching Recovery Techniques to groups of youth. Post-test analyses demonstrated significant reductions in PTSD, depression, traumatic grief and mental health difficulties (Barron et al., 2013). Several studies have demonstrated TF-CBT effectiveness in the DRC, targeting boys affected by armed conflict and female youth who had experienced sexual violence (McMullen et al., 2013; O'Callaghan et al., 2013).

Youth Readiness Intervention (YRI)

The Youth Readiness Intervention (YRI) is a common-elements-based, transdiagnostic intervention (a modular, flexible approach that can be applied to a range of mental health and psychosocial conditions) which integrates the active elements of CBT with interpersonal psychotherapy. The intervention was developed to be integrated within educational and employment settings to help war-affected youth, including CAAFAG, address symptoms of anxiety, depression and interpersonal impairments that can limit life opportunities. The YRI uses a group-based format to confront issues relating to emotion regulation among conflict-affected youth to improve daily functioning (Betancourt et al., 2014). Results from a pilot of the YRI in Sierra Leone showed significant post-intervention effects on emotion regulation, prosocial attitudes and social behaviour, and reduced functional impairment. Moreover, youth who received the YRI were rated by teachers to have better behaviour and as being better prepared for the classroom environment. YRI participants were also six times more likely to stay in school compared with youth who did not receive the intervention. The YRI is currently being tested within youth entrepreneurship programmes for war-affected youth aged 18–30 and is demonstrating an impact on anxiety and depression as well as labour market participation (Betancourt et al., 2021).

Other school- and education-based tools

It is well understood that formal education is one of the first social institutions to be disrupted by conflict and complex humanitarian emergencies. However, when communities are stabilized and youth are reintegrated and/or forced to relocate into more secure environments, the classroom presents a useful location to embed and deliver MHPSS services. In northern Uganda, the school-based Psychosocial Structured Activities programme entailed 15 sessions focused on resilience for youth recovering from trauma (Ager et al., 2011). In the study, ethnographic methods were used to identify local constructions of child wellbeing from their first-person perspective (e.g., meanings of 'social' and 'happy'), caregivers (e.g., 'unstressed' and 'open') and teachers (e.g., 'cooperative' and 'respectful'). Comparisons of youth from pre- to post-intervention indicated that youth enrolled in the programme had significantly higher ratings of wellbeing compared with non-participants in both child and caregiver reports.

Other school-based MHPSS interventions have been implemented for conflict-affected children in Burundi, Nepal and Sri Lanka, with varying degrees of effectiveness (Jordans et al., 2016; Tol et al., 2012). Across the studies, personal factors such as the age and gender of the young people, as well as their ongoing exposure to daily stressors, significantly influenced the effectiveness of the MHPSS tools. For instance, the school-based intervention among war-affected youth in Sri Lanka was more effective in reducing symptoms of behaviour problems among younger participants than among older participants (Tol et al., 2012).

While school-based interventions have promise in addressing youth wellbeing and mental health, and the classroom setting is conducive to the delivery of such MHPSS programming, it is important to consider how these approaches will be operationalised – in particular, if classroom-based programming should be delivered to gender- or age-segregated groups. Additional caution is suggested in deciding who will deliver school-based interventions to avoid over-tasking and over-burdening teachers. Instead, a separate group of individuals may be located and trained to deliver MHPSS services for CAAFAG and other war-affected children and youth meeting inclusion criteria for issues like mental health symptoms and functional impairments in educational contexts.

9. MHPSS assessment tools to use with CAAFAG

A wide range of assessment tools have been used to measure and understand the major domains of mental health and psychosocial wellbeing, from individual measures to caregiver reports and observational measures of the child's social and developmental ecology. Table 3 presents a non-exhaustive list of measures used to assess MHPSS in conflict-affected children that were identified in the desk review and technical consultations. These measures demonstrated variable quality in assessing the intended constructs across the settings they were used in, highlighting the importance of selecting standardized and/or well-validated tools to assess mental health and psychosocial wellbeing. Care should be taken in the selection and use of measurement tools for MHPSS assessments of CAAFAG and/or their social ecology.

Table 3 Tools used to assess key MHPSS domains among children affected by armed conflict

Disabling distress and MNS Disorder (1/3)	Disabling distress and MNS Disorder (2/3)	Disabling distress and MNS Disorder (3/3)	Coping	Functioning	Subjective wellbeing	Social behaviour (1/2)	Social behaviour (2/2)	Social connectedness
Acholi Psychosocial Assessment Instrument (APAI)	Gaza Traumatic Event Checklist (GTECL)	Revised Child Manifest Anxiety Scale (RCMAS)	Adolescent Coping for Problem Experiences (A-COPE)	Bayley Scales of Infant and Toddler Development III	Adolescent Self-Esteem Measure (ASEM)	African Youth Psychosocial Assessment (AYPA)	HOME Inventory	Adult Support Questionnaire
African Youth Psychosocial Assessment (AYPA)	General Health Questionnaire (GHQ)	Screen for Child Anxiety Related Emotional Disorders (SCARED)	Brief COPE	Beery Visual-Motor Integration Test (VMI)	Child Self-Rating Scale (CSRS)	Aggression Questionnaire (AQ)	Intention to Use Alcohol Scale (IUAS)	BarON EQ-I Emotional Intelligence – Youth Version
Beck Depression Inventory (BDI)	Global School-Based Health Survey (SBHS)	Strengths and Difficulties Questionnaire (SDQ)	Children's Coping Strategies Checklist (CCSC)	Cambodian Developmental Assessment Test (CDAT)	Children's Attribution and Perceptions Scale (CAPS)	Alabama Parenting Questionnaire (APQ)	Intl Society for the Prevention of Child Abuse and Neglect Screening Tool (ICAST-C)	Children's Coping Strategies Checklist (CCSC)
Beck Youth Inventories (BYI)	Grief Questionnaire	War Trauma Questionnaire (WTQ)	Children's Hope Scale (CHS)	Child Behaviour Checklist (CBCL) & Youth Self-Report (YSR)	Draw-and-talk	Beck Youth Inventories (BYI)	Measures developed in context	Family Ambiance Scale
Centre for Epidemiological Studies – Depression Scale (CES-D)	Grief Screening Scale (GSS)	World Health Organization Disability Assessment Scale (WHO-DAS)	Connor-David Resilience Scale (CD-RISC)	Child Diagnostic Interview Schedule	Draw-and-write	Child and Adolescent Strengths Assessment (CASA)	Multiple Aggression Questionnaire (MAQ)	Feeling of Acceptance Scale

continued on next page

Table 3 Tools used to assess key MHPSS domains among children affected by armed conflict *continued*

Disabling distress and MNS Disorder (1/3)	Disabling distress and MNS Disorder (2/3)	Disabling distress and MNS Disorder (3/3)	Coping	Functioning	Subjective wellbeing	Social behaviour (1/2)	Social behaviour (2/2)	Social connectedness
Child Behaviour Checklist (CBCL) and Youth Self-Report (YSR)	Hamilton Rating Scale for Depression (HRSD)		Child-Adolescent Measurement System (CAMS)	Clinician-Administered PTSD Scale (CAPS)	Rosenberg Self-Esteem Scale (RSE)	Child Behaviour Checklist (CBCL) & Youth Self-Report (YSR)	Multiple Indicator Cluster Survey (MICS)	Friendship Quality Scale
Child Posttraumatic Symptom Scale (CPSS)	Harvard Trauma Questionnaire (HTQ)		Measures developed in context	Denver II Test	Tennessee Self-Concept Scale	Child Behaviour Inventory (CBI)	Oxford Measure of Psychosocial Adjustment (OMPA)	Inventory of Socially Supportive Behaviours (ISSB)
Child Psychosocial Distress Screener (CPDS)	Hopkins Symptom Checklist (HSCL)		Therapeutic group photography (qualitative)	Difficulties in Emotional Regulation Scale (DERS)	WHO Disability Assessment Schedule (WHO-DAS)	Children's Aggression Scale for Parents (CASP)	Parent-Adolescent Communication Scale	Medical Outcome Study Social Support Survey (MOSS)
Children's Attributional Style Questionnaire (CASQ)	Impact of Event Scale (IES)		Perceived Control Over Future Scale	Human Figure Drawing Test		Classroom Performance Scale (CPS)	Parental Bonding Instrument (PBI)	Measures developed in context
Children's Revised Impact of Events Scale (CRIES)	Irritability Questionnaire (IQ)		Posttraumatic Growth Inventory for Children (PTGI-C-R)	Impact on School Performance Scale (ISPS)		Concern for Others Scale (CFS)	Parenting Stress Index (PSI)	Network of Relationships Inventory
Clinician-Administered PTSD Scale (CAPS)	Mental Health Inventory (MHI)		Youth Coping Inventory (YCI)	Measures developed in context		Conflict Tactics Scale (CTS)	Perceived Stigmatization Questionnaire (PSQ)	Parental Monitoring Questionnaire
Depression Self-Rating Scale for Children (DSRS)	Measures developed in context			Non-verbal scale of suffering (N-V SOS)		Coping with Children's Negative Emotions Scale (CCNES)	Pupil's Evaluation List (LPU)	Parental Support Scale (PSS)
Diagnostic Interview for Children & Adolescents – Revised (DICA-R)	Mini-International Neuropsychiatric Interview (MINI)			Strengths and Difficulties Questionnaire (SDQ)		Family Violence Checklist	Social Competence Scale (SCS)	Provision of Social Relations Scale (PSR)
Diagnostic Predictive Scales (DPS)	Multi-dimensional Anxiety Scale for Children (MDAS)			The MOS 36-Item Short-Form Health Survey (SF-36)			Strengths and Difficulties Questionnaire (SDQ)	SAHA Social Support Scale (SAHA)
Exposure to Violence Scale (EVS)	Oxford Measure of Psychosocial Adjustment (OMPA)			Vineland Adaptive Behavior Scales (VABS)			Vineland Adaptive Behavior Scale (VABS)	Stigma by Association Scale
Exposure to War Stressors Questionnaire (EWSQ)	Penn State Worry Questionnaire (PSWQ)			WHO Disability Assessment Schedule (WHO-DAS)				
Family Inventory of Political Stressors (FIPS)	Post-Traumatic Stress – Reaction Index (PTS-RI)							

10. Evidence gaps

Despite significant progress in the past decade to define the key issues facing CAAFAG and illustrate their MHPSS needs and lived experiences during and after armed conflict, some major gaps persist in the evidence for MHPSS among CAAFAG during and beyond the reintegration period. Some of the major gaps identified in the literature review are discussed below.

The effects of age and gender on MHPSS interventions are not well understood. Most MHPSS interventions are not gender- or age-sensitive, although some studies have focused on female CAAFAG without considering their age, or to the exclusion of children of all genders. Female CAAFAG are largely ignored in the literature and programming and, despite the positive outcomes of many MHPSS interventions, little attention has been paid to gender differences (Tonheim, 2017).

More evidence is needed to better understand the experiences of female CAAFAG. This includes patterns relating to whether they were recruited or abducted, their roles during the war and their reintegration process. Similarly, the experiences of boys who suffer sexual violence due to their CAAFAG status is poorly understood. As a result, these children may not be adequately attended to and may be particularly at risk for poor mental health outcomes (see All Survivors project). More evidence on these topics would make it possible to plan more gender-sensitive CAAFAG programmes and effective gender-informed MHPPS interventions for both female and male CAAFAG and across a range of ages.

Understanding a community's culture and the importance of religion and other social phenomena in narratives of wellbeing is of particular importance in the delivery of appropriate interventions that are accessible and non-stigmatizing. This underscores a need for systematic approaches to ensure that evidence-based MHPSS interventions for CAAFAG are adapted to be culturally responsive.

Another area lacking rigorous evidence is in the planning and cross-sectoral collaboration for short- and long-term interventions that can contribute to mental health and social service systems that are sustainable beyond the period of acute emergency. For example, short-term interventions without follow-up are common, making it difficult to link outcomes to interventions. Similarly, although many interventions have addressed the MHPSS needs of individuals and war-affected communities, little to no evidence has examined implementation of MHPSS embedded in formal CAAFAG responses and programming. There is also an evidence gap on prevention of psychosocial distress and mental health conditions among CAFAAG, including limited research on risk and protective factors.

Research on barriers to and facilitators of such integration, as well as testing strategies for ensuring ethical, culturally and gender-sensitive and effective MHPSS in these settings, are needed.

Finally, and importantly, beyond the lack of evidence on quality and process in MHPSS provision, evidence from our technical consultation emphasizes high levels of burnout and mental distress among those implementing CAAFAG programmes and MHPSS. Implementation scientists and CAAFAG practitioners alike must develop better understandings of how best to support those who care for children affected by armed conflict.

Annex I. MHPSS and CAAFAG questions for technical consultations

Sample questions: semi-structured questions for research, practice, advocacy and other experts

1. What are the profiles and experiences of different groups of CAAFAG and what are their diverse needs, considering girls and boys of all ages and abilities? For example,
   a. Children who have been trained and used for combat will have different needs from those who have experienced sexual violence (or more generally: perpetrators of violence, victims of violence, and both perpetrators and victims of violence);
   b. Those who are very young and born into an armed group will need different interventions from those who were formerly abducted or recruited as teenagers;
   c. Children who have been injured and disabled by explosive ordnance and unaccompanied children will have specific needs for rehabilitation and reintegration;
   d. Children who returned from captivity and were well received by parents and those whose parents died while they were away and whose parents were there but did not receive them well.

2. Armed forces and armed groups use a variety of methods for recruitment in different contexts, including physical abduction, face-to-face and online recruitment, and financial and protection incentives. How should MHPSS be considered the prevention of recruitment and use of girls and boys?

3. Tell us about your knowledge and experience with context-specific MHPSS in CAAFAG programming approaches.
   a. Incorporation of MHPSS in release processes, formal and informal?
   b. MHPSS considerations in transit centres, interim care centres, interim care placements for CAAFAG?
   c. Multisectoral, community-based and/or case management approaches to MHPSS in reintegration processes?
   d. MHPSS Interventions across the four layers of the IASC pyramid
      i. Basic services (food, health and shelter) and security for everyone in the community.
      ii. Community and family support for a smaller number of people who are able to maintain their mental health and psychosocial wellbeing if they receive help in accessing key community and family supports.
         – Any difficulties with CAAFAG getting support from the communities they once harmed?
      iii. Focused, non-specialised support is necessary for the still smaller number of people who additionally require more focused individual, family or group interventions by trained and supervised workers (but who may not have had years of training in specialised care).
      iv. Specialised services required for the small percentage of the population whose suffering, despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning.

4. Which MHPSS programming initiatives or interventions would you recommend in which kinds of CAAFAG settings?

5. What kinds of factors most influence the implementation, monitoring and evaluation of MHPSS programming in the field?
   a. Severity of mental and behavioural health problems?
   b. Cultural factors?
   c. Vulnerabilities among the communities involved in the same conflict?

6. How can practitioners adequately measure the impact of MHPSS in CAAFAG programming and adjust programming during implementation?

7. What kinds of remote management tools are needed for MHPSS in CAAFAG programming, especially to deliver them in hard-to-reach locations hampered by security risks and difficult travel?

8. Which factors are most important to consider for contextualisation of global MHPSS tools and approaches for local CAAFAG programming?

9. To what extent were the communities involved in programming to alleviate their distress?

10. What success and challenges have you encountered in deploying the IASC MHPSS multi-layered framework in CAAFAG programming?
    a. How could it have been done better?

11. During reintegration processes, CAAFAG individual needs might not align with family and community MHPSS needs, for instance in contexts affected by violent extremism. How can this dynamic be restored to align with the social-ecological model?

12. Do you have any comments or any questions regarding this consultation?

Annex II. Considerations for consultations with youth with lived CAAFAG experiences

Define Settings

- **Conflict-affected Zone; Active combat Zones; …** While a considerable number of children are active in direct combat, many are affected by armed conflict through support roles such as cleaners, cooks, messengers, etc. Children are also affected by armed conflict through sexual violation, abduction or kidnapping by armed forces or armed groups.

Define Profile

- **Age** (what is the definitive age group).
- **Gender** (Experiences are different for boys and girls, with specific vulnerabilities for both. Girls can experience sexual abuse, unwanted pregnancy, and unsafe and unwanted abortion, and can suffer from health problems during pregnancy and childbirth. They may also face difficulties reintegrating with their families and communities if they return with children born during their association with armed forces or armed groups).
- **Recruitment**: Consider methodology of recruitment and on the other hand people born into it (many of them have never been in their country of origin before and can face stigma from family and community members on their return).
- **Experiences**
  - Direct and indirect: While a considerable number of children are active in direct combat, many are affected by armed conflict through support roles such as cleaners, cooks, messengers, etc. Children are also affected by armed conflict through sexual violation, abduction or kidnapping by armed forces or armed groups, and
  - These children have faced considerable suffering including loss of family members, exposure to violence, surviving sexual violation and witnessing conflict, and many of them have never been in their country of origin before, and can face stigma from family and community members on their return.
- **Reintegration difficulties**
  - Many also face difficulties reintegrating with their families and communities if they return with children born during their association with armed forces and armed groups.
- **Need**
  - "Children associated with armed forces and armed groups (CAAFAG) experience heightened risk for mental health problems following their association such as anxiety, depression, and severe stress disorders, with notable increases in aggression and hostility." And … children with persistent mental health and psychosocial problems may face a more difficult pathway to social reintegration. A small percentage of children will struggle to function on a day-to-day basis, including children who may have had pre-existing mental health conditions or those who have endured particularly traumatic or severely distressing experiences.
  - One of the most devastating outcomes for CAAFAG is the years of lost educational and economic opportunity. This can result in difficulties in attaining key lifecycle milestones. Many formerly associated children reported these challenges to be more problematic than the actual experiences of the war.
- **Use of MHPSS services and access to other services**:
  - Without a comprehensive multi-layered approach which includes specialised mental health care, these children may be vulnerable to violence, abuse and exploitation of all kinds, including re-recruitment by armed forces or armed groups.
  - UNICEF's approach to addressing the varying and complex needs of these children is to ensure access to integrated and specialised psychological and psychiatric services, established within a multisectoral and multi-layered system of support (in accordance with the Interagency (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency) for children who are likely to have different reactions to war and their alleged association with armed forces and armed groups, and different coping resources, social supports and needs.

Define Consultation Process

- **Questions**:
  - Look up similar work done, and questions used
  - Consult with an ex-CAFAAG to support development of questions in alignment with the expected objective for project
  - Workshop process to co-design and finalise questions to be used.
- **Networks**: Get support from networks (from advisory group, other networks) connected to the defined settings.
- **Safety**: Consider safe engagement processes by engaging with existing CAAFAG networks that work with young people to co-facilitate/directly engage with young people from their network during these consultations.
- **Facilitation**:
  - Facilitators should be able to speak local language (otherwise we need to provide translation)
  - Research officer to synthesize consultation content
- **Platform**:
  - Virtual – survey and zoom
  - Consider limitations and allowances for both
- **Engagement**: This is going to be a one-to-one consultation
- **Target number vs Minimum required number**: 15
- **Context Considerations**: Perspectives will differ even with similar experiences; the consultations must account for context differences across regions and experiences. If we end up with too many interests, we will go through a prioritization process (using the person profile above) to determine those that cover as much of the varying contexts as possible.

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