H3ZMUN2019

World Health Organization
（WHO）

Topic: Mental Health Care of Children in Conflict and Post-Conflict Zones

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Letter from the Director

Dear delegates:

Welcome to H3Z-MUN Conference 2019.

For many of you, this conference will be your start point of Model UN. You may still have doubts and questions about the procedure of Model UN conference after several training sessions, and this is absolutely normal. This conference will help you understand how Model UN works, how to write fine documents and how to perform the best perspective of yourself.

This year is a brand-new start of H3Z-MUN. Dais members started the multi-committee for the first time, as well as hiring volunteers and writing Background Guide on our own. We are managing to let all of you have splendid experience in your first MUN conference.

Last year, in H3Z-MUN2018, I was a delegate in SPECPOL, representing the USA under the topic of controlling space debris. To be honest, this is not a relevantly fair topic for all the delegates, especially for those delegates representing undeveloped countries. Just imagine how delegate of Guatemala feels like when he heard about this topic. Therefore, this year we're introducing WHO to this specific conference, to let all of you own an equal chance to speak, to let your voice be heard in public, to have a stand on your country's position.

By the end of 2016, 2 out of 5 children are living in conflict zones. To fulfill the sustainable goal made by the UN, the mental healthcare of underage children is urgent to be solved. Childhood is supposed to be an essential part of the development of children's personality, it is vulnerable, thus, we ought to dedicate ourselves to the process of protecting them.

If you have any academic questions, please don't hesitate to ask for help from dais members on or offline.

Again, it’s my utmost honor to invite you to this year's MUN conference.

Sincerely,
Ronnie Hou

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Introduction of the Committee

Founded on 7 April 1948 – a date we now celebrate every year as World Health Day- the primary role of WHO is to direct and coordinate international health within the United Nations system. Governed by the World Health Assembly, WHO's core function is to direct and coordinate international health work through collaboration.

WHO staff are united in a shared commitment to achieve better health for everyone, everywhere. Together, WHO is reaching the fundamental goal of attaining health objectives by supporting national health policies and strategies.

WHO's main areas of work are health systems; health through the life-course; noncommunicable and communicable diseases; preparedness, surveillance and response; and corporate services. This committee will specifically focus on the mental health care problem. People living through humanitarian emergencies are particularly vulnerable to mental health problems; WHO helps ensure that the mental health and psychosocial support provided in humanitarian emergencies is coordinated and effective.

The work of the Organization is carried out by the World Health Assembly, the Executive Board, and the Secretariat. The functions of the World Health Assembly include making the policies of the Organization, appointing the Director-General, and approving the proposed program budget. The Executive Board consists of 34 members expert in their respective health field. The Secretariat is composed of the Director-General and technical and administrative staff (“Constitution”).

There are six regional organizations in the system: Africa, Americas, South-East Asia, Europe, Eastern Mediterranean, and Western Pacific. Each of them consists of a

regional committee and a regional office. The regional office is the administrative body of the regional committee.

Note: It's important for delegates to remember the functions of the committee at all times. Intervention in countries' domestic affairs is in any case forbidden during the conference. The regional committee (and also the World Health Assembly) has no right to apply coercive enforcement to any country.

Introduction of the Topic

The nature of war has changed dramatically. Today's conflicts happen where people live and they take a brutal toll on children. Heavy bombardment and destruction in war create a humanitarian crisis where there is a lack of adequate food, clean water, and medicine. The consequences of war can have a major impact on the health of children for years to come. Traumatic events can have a profound and lasting impact on the emotional, cognitive, behavioral and physiological functioning of an individual.

Depending on the circumstances, the psychosocial impacts of disasters can range from mild stress reactions to problems such as anxiety, depression, substance abuse, and post-traumatic stress disorders (PTSD).

Definition of Key Terms

Conflict and Post-conflict area

The term "conflict" is derived from the Latin "to clash or engage in a fight", and it indicates a confrontation between one or more parties aspiring towards incompatible or competitive means or ends. Conflicts, if controlled or managed constructively, do not lead to violence. Some conflicts are "mutually satisfactory while others end up frustrating one or all parties".

Peter Wallensteen (2002) recognizes three general forms of conflict: interstate, internal, and state-formation conflicts. Interstate conflicts are disputes between nation-states or violations of the state system. Examples of internal and state-formation conflicts include civil and ethnic wars, anti-colonial struggles, secessionist and autonomous movements, territorial conflicts, and battles over control of the government.

Some conflicts are country-wide (Rwanda), and others are localized in specific parts of a country (Sudan). Their origins, often multifaceted, ranging from ethnic and economic inequalities, social exclusion of sectors of the population, social injustice, competition for scarce resources, poverty, lack of democracy, ideological issues to religious

differences (Nigeria and Sudan), and political tensions. The conflicts in the Sudan, Burundi, and Rwanda are, in large measure, the result of historical discrepancies between the ethnic or tribal components of the population. As of November 2011, the number of counties listed as being involved in an on-going conflict stands at 56.[1]

On the other hand, post-conflict is a "conflict situation in which open warfare has come to an end. Such situations remain tense for years or decades and can easily relapse into large-scale violence".In post-conflict areas, there is an absence of war, but not essentially real peace. Lakhdar Brahimi states that "the end of fighting does propose an opportunity to work towards lasting peace, but that requires the establishment of sustainable institutions, capable of ensuring long-term security." Prolonged conflict can lead to terrible human loss and physical devastation; it can also lead to the breakdown of the systems and institutions that make a stable society work, and these are the very systems that need to be revived.

Refugee

A refugee, generally speaking, is a displaced person who has been forced to cross national boundaries and who cannot return home safely (for more detail see legal definition). Such a person may be called an asylum seeker until granted refugee status by the contracting state or the UNHCR if they formally claim asylum. The lead international agency coordinating refugee protection is the United Nations Office of the United Nations High Commissioner for Refugees (UNHCR).

More than half of the refugee population are children. They need special attention due to the duality of being both refugees and children. As being refugees, they are under the uncertainty of the unpredicted upheavals; as being children, they should be granted extra protection. The safety and well-being of refugee children are at far greater risk than that of children in general. The violent outbreaks of emergencies, the breakdown of families, community structures and the acute shortage of resources faced by most refugees have a profound impact on the physical and mental health of refugee children.

Mental Health

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

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[1] *Another way of defining conflicts relies solely on quantitative means. The UCDP divides armed conflicts into the following three subsets by level:*

- *Minor Armed Conflict: at least 25 battle-related deaths per year and fewer than 1,000 battle-related deaths during the conflict.*
- *Intermediate Armed Conflict: at least 25 battle-related deaths per year and an accumulated total of at least 1.000 deaths, but less than 1.000 in any given year.*
- *War: at least 1.000 battle-related deaths per year*

The positive dimension of mental health is stressed in WHO's definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Mental Disorder

Worldwide 10-20% of children and adolescents experience mental disorders. Half of all mental illnesses begin by the age of 14 and three-quarters by mid-20s. Neuropsychiatric conditions are the leading cause of disability in young people in all regions. If untreated, these conditions severely influence children's development, their educational attainments and their potential to live fulfilling and productive lives. Children with mental disorders face major challenges with stigma, isolation, and discrimination, as well as lack of access to health care and education facilities, in violation of their fundamental human rights.

Trauma

Trauma is an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives.
Trauma types may include:

Sexual maltreatment/abuse
Sexual assault/rape
Physical maltreatment/abuse
Physical assault
Emotional abuse/psychological maltreatment

Neglect
Domestic violence
War/terrorism/political violence
Illness/medical trauma
Serious injury/accident
Natural disaster
Kidnapping
Traumatic loss or bereavement
Forced displacement
Impaired caregiver
Extreme interpersonal violence
Community violence
School violence
Other trauma

Post-traumatic stress disorders

Posttraumatic stress disorder (PTSD), is a serious condition that can develop after a person has experienced or witnessed a traumatic or terrifying event in which serious physical harm occurred or was threatened. PTSD is a lasting consequence of traumatic ordeals that cause intense fear, helplessness, or horror, such as a sexual or physical assault, the unexpected death of a loved one, an accident, war, or natural disaster. Families of victims can also develop PTSD, as can emergency personnel and rescue workers.

Statement of the Problem

Under the peaceful appearance of the entire world, wars and conflicts happen silently but roaringly. War is the worst form of human-made violence. Since World War II, there have been approximately 140 wars, most of which took place in low-income countries. The militarization of these countries, with its combination of low-intensity warfare and high-intensity lethal weaponry, is the first major cause of displacement, especially of women and children. The consequences caused by unexpected wars contribute to an enormous psychological and socioeconomic burden at the cost of the individual, the family, and the community.

Children, who are considered as the future of the society, are suffering from desperation and pains in conflict and post-conflict zones. The violence in childhood impacts lifelong health and well-being and traumas, which often associated with medical and social problems including increased suicide risk, need great capital and a long course of treatment to cure if caused. World Health Organization has made great progress such as researches, studies, and the establishment of programs. For example, Target 16.2 of the 2030 Agenda for Sustainable Development is to “end abuse, exploitation, trafficking and all forms of violence against, and torture of, children”. Therefore, to make these actions more efficient, delegates are expected to develop reasonable solutions out of humanism, according to the current both economic and social situation. It will be up to the committee to decide the way to solve this crisis.

Mental Problems

Psychological Problems Children may display a wide range of emotional and physiological reactions following a disaster. Severe trauma during childhood can have a devastating effect on the development of the brain and all functions mediated by this complex organ. Posttraumatic stress responses have been documented in children who have suffered the traumatic loss of their parents, siblings, and peers. The more severe psychological reactions are associated with variables such as a higher degree of exposure (e.g., life threat, direct physical injury, witnessing a death or injury), closer proximity to the disaster, history of prior traumas, female gender, poor parental response, and parental psychopathology. Children who are directly affected by the conflict, including bombardment and home demolition, developed a greater incidence of post-traumatic stress disorders (PTSD) and fear. Research suggests that the majority of children do not suffer from long-term consequences of prolonged stress. Children living in refugee camps experienced more psychological problems than nonrefugee children. Children living in war zones can express acute distress from various traumatic events through emotional problems that may manifest as PTSD, dissociative disorders, anxiety, and substance abuse. Depending on the severity of exposure, the incidence rates of various psychiatric disorders in children may vary from 3% to 60% of the

exposed children.

Contributing Factors

Violence

Before being resettled, children often must spend long periods of time in refugee camps, where they often experience forms of violence like sexual assault, rape, and sexual exploitation. Children are raped as young as the age of seven and are, at times, offered money by the rapists creating a system of non-consensual prostitution. Child refugees in camps are often targets of sexual assault due to their vulnerability. However, sexual assault can also occur throughout the refugees' journeys, starting while being smuggled across borders and continuing in the refugee camps. Therefore, sexual assault in the camps often compounds the trauma already inflicted by refugee children's past experiences.

Sexual violence is not the only form of violence in refugee camps. The international nongovernmental organization Amnesty International conducted reports of police violence in the trauma they have endured and may feel further alienated when entering new communities refugee transit camps. An Amnesty International interview with a 16-year-old Syrian refugee in Greece found that several police officers hit her with their batons. After asking other police officers for medical treatment and showing her wounds, the officers laughed and asked her to leave. Therefore, violence still occurs once a child flees their home country and child refugees suffer physical, mental, and emotional harm while also not necessarily being given the resources to heal.

Detainment

The detainment of children refugees when migrating is also a serious problem. Child refugees will often be detained by police when migrating between countries and placed in facilities meant for adults. In Libya, a child refugee named Lovette was packed into a cell with women and other girls. She was fed only 3 times a week and reported police beating if people complained about anything. Detainment of children puts children at risk for serious harm to a child's health and well-being.

Education

A lack of access to education is an immense problem for child refugees. More than half of all refugee children do not have access to school. The education gap continues to

grow through child refugees' adolescence. Only 22% of child refugees attend secondary school compared to the global average of 84%, and only 1% of refugees attend university compared to the global average of 34%. These disparities pose an extreme problem because, without education, child refugees are likely to struggle to find work, much like their parents do. Therefore, refugee children are not provided the opportunity to transform their generation by breaking the cycle of poverty.

Other Relevant Problems

Street Children

Street Children born of war are commonly faced with stigma, discrimination, abandonment, and infanticide. This makes them vulnerable to trafficking and ending up on the streets. The closure of schools during conflict and war results in children being pushed onto the streets. These children are commonly seen as illegitimate and as "enemy" children. They may be subjected to rejection, abuse or neglect from family members and their communities. These children also suffer from a lack of access to resources and a denial of citizenship. These children are called 'street children'.

The problems of street children are many:
Street children are vulnerable to conscription, either forcibly or voluntary.
Street children play varied roles in conflicts ranging from fighting to roles such as wives, cooks, porters, and spies.
Street children are exposed to sexual abuse (rape, gang-rape and sodomy) and substance abuse (hard and soft drugs) during wars and conflict situations.
Street children not involved in wars, but seen on the streets, are vulnerable to victimization by law enforcers (police and military).
Street children coming out of combatant activity are faced with health issues and various other related factors including psycho-social trauma/mental instability, physical disability (loss of limbs, hearing, etc.), sexually transmitted diseases and HIV/AIDS.
Child soldiering disposes street children to increased aggressiveness and criminality.
Street children, apart from the risk of being trafficked, are pushed into prostitution especially during chaotic conflict situations and victims of rape are saddled with unwanted pregnancies resulting in low self-esteem.
In times of political, cultural, ethnic and/or religious unrest, street children are manipulated and used as political pawns (through propaganda, false promises, and bribery during election rallies), and as thugs (to participate in violence, looting, etc.).
Children in war zones have been deliberately killed or maimed by parties to conflicts, often in extremely brutal ways. Some of the children targeted had fled rural areas and gone into towns to avoid recruitment by government or rebel armies. Children are often abducted from their homes, schools and refugee camps. They are exploited for forced labor, sexual slavery, and forced recruitment and have been trafficked across borders.

Causes, Symptoms, Diagnosis, Treatment

Causes

Risk Factors

Traumatic events that were life-threatening or caused physical harm can be a risk factor that influences the development of PTSD. Events that involve interpersonal violence, such as a physical attack, sexual abuse, or rape, are more likely to influence someone experiencing PTSD after their trauma.

Research has shown that between 30 percent and 40 percent of children who experience physical or sexual abuse will end up developing PTSD.

Characteristics of the Child

As with adults, it is more common for someone to develop PTSD after a traumatic event when they have already been through a previous traumatic event. The emotional impact of trauma can have a cumulative effect, so even if a child didn't demonstrate PTSD symptoms after a previous traumatic experience, it is more likely that they will experience PTSD with each subsequent trauma.

Girls are two to three times more likely than boys to develop PTSD after trauma. Some researchers suggest that this difference is due to the likelihood of girls being exposed to a traumatic event—such as sexual abuse—earlier and more often than boys. Other elements to explain this difference in the rate of PTSD between girls and boys is still being researched.

Children and teens who have a previous diagnosis of a mood or anxiety related disorder are more likely to develop PTSD after a traumatic event than those with no prior mental health diagnosis.

Family Dynamics

There are some characteristics within the family that can be influential factors in a child or teen developing PTSD. For example, parent reactions to trauma can be a risk factor for children. There are times when the entire family has experienced the traumatic event together and the children witness their parents demonstrating symptoms of PTSD. Alternatively, there are times when only the child has experienced the traumatic event but the parent still develops symptoms of PTSD.

Children and teens with greater social support have been shown to be less likely to develop PTSD after a traumatic event. Although social support primarily involves parents and caregivers, the benefits of social support can include teachers and peers as well. Since many people who struggle with PTSD tend to do so in isolation, the secure and safe connections with others can help minimize the lonely feelings and the opportunities to isolate.

Responses to the Event

The following cognitive and emotional responses to the traumatic event have been shown to influence the development of PTSD in children and teens:
Anger about the event
Repetitive thinking about the event (ruminating)
Avoidance and suppression of the trauma related thoughts
Dissociation during or after the event
Higher heart rate at time of hospitalization if required due to injury during the event

Symptoms

Posttraumatic stress disorder, or PTSD, is diagnosed after a person experiences symptom for at least one month following a traumatic event. The disorder is characterized by three main types of symptoms:
Re-experiencing the trauma through intrusive distressing recollections of the event, flashbacks, and nightmares.
Avoidance of places, people, and activities that are reminders of the trauma, and emotional numbness.
Increased arousal such as difficulty sleeping and concentrating, feeling jumpy, and being easily irritated and angered.

Diagnosis

DSM-5 Criteria for PTSD

Criterion A: Stressor

Exposure or threat of death, serious injury, or sexual violence in one or more of the following ways:

Directly experienced the event.

Witnessed the event happen to someone else, in person.
Learned of a close relative or close friend who experienced an actual or threatened accidental or violent death.
Repeated indirect exposure to distressing details of the event(s). This could occur in the course of professional duties (first responders, collecting body parts, or professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

Criterion B: Intrusion Symptoms

The traumatic event is persistently re-experienced in one or more of the following ways:
Recurrent, involuntary, and intrusive memories. Children older than six may express this symptom through repetitive play in which aspects of the trauma are expressed.
Traumatic nightmares or upsetting dreams with content related to the event. Children may have frightening dreams without content related to the trauma.
Dissociative reactions, such as flashbacks, in which it feels like the experience is happening again. These may occur on a continuum ranging from brief episodes to complete loss of consciousness. Children may re-enact the events in play.
Intense or prolonged distress after exposure to traumatic reminders.
Marked physiological reactivity, such as increased heart rate, after exposure to traumatic reminders.

Criterion C: Avoidance

Persistent effortful avoidance of distressing trauma-related reminders after the event as evidenced by one or both of the following:
Avoidance of trauma-related thoughts or feelings.
Avoidance of trauma-related external reminders, such as people, places, conversations, activities, objects, or situations.

Criterion D: Negative Alterations in Mood

Negative alterations in cognition and mood that began or worsened after the traumatic event as evidenced by two or more of the following:
Inability to recall key features of the traumatic event. This is usually dissociative amnesia, not due to head injury, alcohol, or drugs.
Persistent, and often distorted negative beliefs and expectations about oneself or the world, such as "I am bad," or "The world is completely dangerous."
Persistent distorted blame of self or others for causing the traumatic event or for the resulting consequences.
Persistent negative emotions, including fear, horror, anger, guilt, or shame.
Markedly diminished interest in activities that used to be enjoyable.
Feeling alienated, detached or estranged from others.
Persistent inability to experience positive emotions, such as happiness, love, and joy.

Criterion E: Alterations in Arousal and Reactivity

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event, including two or more of the following:
Irritable or aggressive behavior
Self-destructive or reckless behavior
Feeling constantly "on guard" or like danger is lurking around every corner (hypervigilance)
Exaggerated startle response
Problems in concentration
Sleep disturbance

Criterion F: Duration

Persistence of symptoms in Criteria B, C, D, and E for more than one month.

Criterion G: Functional Significance

Significant symptom-related distress or impairment of different areas of life, such as social or occupational.

Criterion H: Exclusion

The disturbance is not due to medication, substance use, or other illness.

DSM-5 PTSD Diagnosis

In order to be diagnosed with PTSD according to the DSM-5, one needs to meet the following:
Criterion A
One symptom or more from Criterion B
One symptom or more from Criterion C
Two symptoms or more from Criterion D
Two symptoms or more from Criterion E
Criterion F
Criterion G
Criterion H

Other Diagnostic Tools

In addition to using the DSM-5 manual to assess for PTSD criteria, a medical professional will likely want to complete a physical examination to check for medical

problems that could be contributing to or causing symptoms.

A psychological evaluation is likely to be recommended, which allows for you to openly discuss with your provider some of the events that have led to you experiencing these symptoms. During this evaluation, you would share with a provider signs and symptoms you're experiencing, as well as the duration and level of intensity of those signs.

This collective information can help medical providers and mental health professionals gain an understanding of your treatment needs and provide you with an appropriate level of care.

Children under six

The general criteria for diagnosing PTSD applies to adults and any person over the age of six years old. The following are the new specific criteria outlined in the DSM-5 for the preschool specifier, or for those six years or younger.

Criterion A
Children under the age 6 have been exposed to an event involving real or threatened death, serious injury, or sexual violence in at least one of the following ways:
The child directly experienced the event.
The child witnessed the event, but this does not include events that were seen on television, in movies, or some other form of media.
The child learned about a traumatic event that happened to a caregiver.

Criterion B

The presence of **at least one of the following intrusive symptoms** that are associated with the traumatic event and began after the event occurred:
Recurring, spontaneous, and intrusive upsetting memories of the traumatic event, which can be expressed through play
Recurring and upsetting dreams about the event
Flashbacks or some other dissociative response where the child feels or acts as if the event were happening again, which can be expressed through play
Strong and long-lasting emotional distress after being reminded of the event or after encountering trauma-related cues
Strong physical reactions, like increased heart rate or sweating, to trauma-related reminders

Criterion C

The child exhibits **at least one of the following avoidance symptoms or changes in his or her thoughts and mood**. These symptoms must begin or worsen after the

experience of the traumatic event.
Avoidance of or the attempted avoidance of activities, places, or reminders that bring up thoughts about the traumatic event.
Avoidance of or the attempted avoidance of people, conversations, or interpersonal situations that serve as reminders of the traumatic event.
More frequent negative emotional states, such as fear, shame, or sadness
Increased lack of interest in activities that used to be meaningful or fun.
Social withdrawal
Reduced expression of positive emotions

Criterion D

The child experiences **at least one of the below changes in his or her arousal or reactivity**, and these changes began or worsened after the traumatic event:
Increased irritable behavior or angry outbursts. This may include extreme temper tantrums.
Hypervigilance, which consists of being on guard all the time and unable to relax
Exaggerated startle response
Difficulties concentrating
Problems with sleeping
In addition to the above criteria, these symptoms need to have lasted at least one month and result in considerable distress or difficulties in relationships or with school behavior. The symptoms also cannot be better attributed to ingestion of a substance or to some other medical condition.

Treatment

When people are seeking out treatment for post-traumatic stress disorder (PTSD), many wonders if treatment will provide a cure. There are a number of effective treatments for PTSD, such as various therapy techniques, as well as evidence that medication may be useful for people struggling with symptoms of PTSD. These treatment methods are used to help minimize, or even eliminate, distressing symptoms that people with PTSD often experience.

Medications

Although there are no medications that have been specifically designed to treat PTSD, there are a variety of well-established medications currently used to treat other psychiatric conditions such as mood and anxiety disorders that have been found to be helpful in managing PTSD symptoms.

SSRIs

Selective serotonin reuptake inhibitors, commonly referred to as SSRIs, are a type of medication usually prescribed to help with symptoms of depression and anxiety. Examples of common SSRIs that may be used in the treatment of PTSD include:

Sertraline (Zoloft)

Paroxetine (Paxil)

Fluoxetine (Prozac)

The two currently approved by the Federal Drug Administration (FDA) for the treatment of PTSD are Zoloft and Paxil. The other medications have been shown effective as well but are considered to be used off-label if used for the treatment of PTSD.

SNRIs

It is noted that SSRIs are usually the common category of medications to turn to in the treatment of PTSD. However, an SNRI can be used as well. SNRI stands for serotonin-noripinephrine reuptake inhibitor and they are often used for the treatment of depression.

Up to 50 percent of those diagnosed with PTSD also meet criteria for the diagnosis of major depressive disorder.

One SNRI, venlaxafine (Effexor), has been found to be particularly effective in the treatment of PTSD.

Other Agents

Not uncommonly, other categories of medications such as the atypical antipsychotics and the anti-hypertensive alpha blocker prazosin may be used to decrease PTSD symptoms.

Remember that each person will respond differently in their tolerance and the perceived effectiveness of the medications used. The medication part of treatment will need to be monitored closely and managed by a trained medical professional.

Psychotherapy

There are a variety of psychotherapy techniques that can be used in the treatment of post-traumatic stress disorder. However, there are a few that are growing in researched-based evidence to show their effectiveness in the treatment of PTSD.

Cognitive Processing Therapy

Cognitive processing therapy is a specific type of cognitive behavioral therapy that focuses on how the patient's traumatic event is perceived and how the patient tend to cope with the emotional and mental part of the patient's experience. This process

includes educating the patient on the elements of cognitive behavioral therapy and emphasizes that the patient and his or her therapist work together as a team.
The patient collaborates in processing the traumatic event and work through "stuck points." Stuck points are certain thoughts related to the trauma that are preventing recovery. This method of counseling can be conducted in an individual or group format.

EMDR

Eye movement desensitization and reprocessing is more commonly referred to as EMDR. This is a type of psychotherapy often used with survivors of trauma, particularly those experiencing symptoms of PTSD. This technique utilizes bilateral sensory input such as side-to-side eye movements to help the patient process difficult memories, thoughts, and emotions related to the patient's trauma.

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is a style of talk-therapy that focuses on the relationship between thoughts, feelings, and behaviors. CBT targets current symptoms and problems, usually lasting 12-16 sessions and can be done in an individual or group format.

The goal of CBT is to help the patient return to a place where he or she regain hope, feel a greater sense of control in his or her thoughts and behaviors, as well as help he or she to reduce escape or avoidance behaviors.

Complementary and Alternative Therapies

Trauma-Sensitive Yoga

Yoga has been shown to offer wonderful healing benefit to a variety of populations, including those with mental health conditions, and is widely known for the benefit of stress relief. For people with PTSD, trauma-sensitive yoga can be of great benefit.

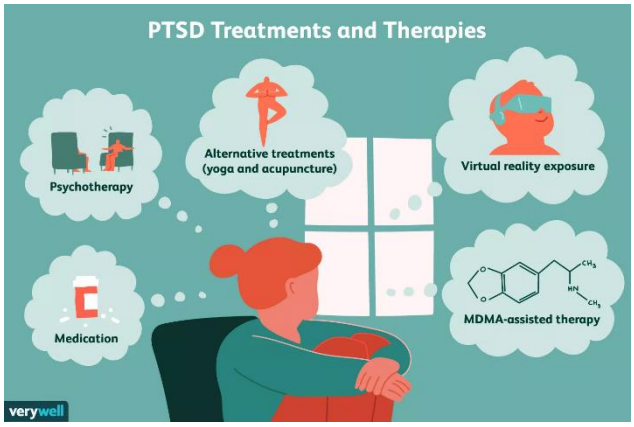
Acupuncture

This method of healing is a Chinese medicine energy practice that involves inserting thin needles into certain areas of the body to help prevent or relieve health issues. Approved by the Department of Veterans Affairs as an approved complementary and alternative medicine treatment for PTSD, studies have shown acupuncture to be safe and cost-effective. Common reports by patients include a significant reduction in feelings of stress and anxiety.

Innovative Treatments

Virtual Reality Exposure

Exposure therapy has been shown effective in the treatment of many anxiety-related disorders, as it helps the patient approach aspects of his or her trauma with less fear, working to become desensitized to the impact of his or her experience. Virtual reality exposure therapy (VRET) offers the technology for the patient to be gradually exposed to his or her traumatic situation while working closely with a trained clinician.



The visual situations are manipulated by the clinician and talked through together, continuing to expose you to the traumatic event and, over time, helping the event to have less and less emotional impact.

Relevant UN Actions

UNICEF, 'Save the children',

The United Nations Children's Fund (UNICEF) works in more than 190 countries and territories to put children first. UNICEF has helped save more children's lives than any other humanitarian organization by providing health care and immunizations, safe water and sanitation, nutrition, education, emergency relief and more.

UNICEF USA supports UNICEF's work through fundraising, advocacy and education in the United States. Together, UNICEF is working toward the day when no children die from preventable causes, and every child has a safe and healthy childhood.

UNHCR, 'Syria Emergency'

Over 5.6 million people have fled Syria since 2011, seeking safety in Lebanon, Turkey, Jordan and beyond. Millions more are displaced inside Syria and, as war continues,

hope is fading fast.

UNHCR works hard to help, leading a coordinated effort across the region. Together with our partners, NGOs and host governments, we offer a lifeline to those in need.

The "Convention on the Rights of the Child" (entered into force in 1990) is the first legally binding international instrument to incorporate the full range of human rights—civil, cultural, economic, political and social rights. It spells out the basic human rights that children everywhere have: the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life.

The 'International Labour Organization Convention' No. 182 (1999), declares child soldiering to be one of the worst forms of child labour and prohibits forced or compulsory recruitment of children under the age of 18 in armed conflict.

The "Anti-war Agenda" (UNICEF, 1996) rests on the proposition that much of the tragedy befalling children is preventable. Recent years have seen the most barbaric acts of violence against children and other civilians. International war crimes tribunals must have both the support and the resources to bring perpetrators to justice. To prevent continued cycles of conflict, education must seek to promote peace and tolerance, not fuel hatred and suspicion. In the words of Graça Machel, "Despite the inherent brutality of conflict, no one can possibly believe it is ever permissible to murder, rape, torture or enslave children. Nor is it permissible to stand by and allow it to happen".

'Disarmament, demobilization and reintegration' (UNSC report 2003) programmes are now an integral part of peacekeeping operations, and the specific needs of child soldiers have been sufficiently addressed.

WHO's comprehensive mental health action plan 2013- 2020 was adopted by the 66th World Health Assembly. Dr Margaret Chan, the WHO Director-General, described the new Comprehensive Mental Health Action Plan 2013–2020 as a landmark achievement: it focuses international attention on a long-neglected problem and is firmly rooted in the principles of human rights. The action plan calls for changes. It calls for a change in the attitudes that perpetuate stigma and discrimination that have isolated people since ancient times, and it calls for an expansion of services in order to promote greater efficiency in the use of resources.

The four major objectives of the action plan are to:

strengthen effective leadership and governance for mental health.
provide comprehensive integrated and responsive mental health and social care services in community-based settings.
implement strategies for promotion and prevention in mental health.

strengthen information systems, evidence and research for mental health.

Each of the four objectives is accompanied by one or two specific targets, which provide the basis for measurable collective action and achievement by Member States towards global goals. A set of core indicators relating to these targets as well as other actions have been developed and are being collected via the Mental Health Atlas project on a periodic basis.

Questions Must be Answered

How to prevent children's mental illnesses or ease the symptoms if possible?

How to diagnose the children's mental disorders if the child doesn't will to express his or her symptoms?

Parents and caregivers play a significant part in curing children's mental disorders. What's the role of parents and caregivers in the process of treating the children's mental health disease? In detail, how certain things can parents and caregivers do to help the child find the support and resources they need to experience healing?

What organizations can the committee cooperate with when resettling the refugee children? Who is responsible for the migration?

Concerning the treatment of street children, what different measures shall be taken? The distinction between refugee children and street children is notable.

Wars are unpredictable. How do governments ensure the health of children? What methods governments should take to avoid panic?

The healthcare is necessary for children who have problems in mental health, but where the funds come from?

Possible Solutions

Those in conflict zones have been living a miserable life. With no doubt that these homes have no capability to afford any healthcare. In the process of solving these dilemmas, delegates shall consider establishing certain welfare programs to make funds. Cooperating with NGOs will be an effective measure as well. Besides, delegates may find microfinance loans or other financial supports effective.

To combat sexual and physical violence, delegates may want to consider implementing

more trained police authorities in camps or develop a neighborhood-watch based-system using trained refugees. This system could also provide a stipend to refugees who choose to serve as a guardian for the camp community which, along with being subjected to review, can prevent them from being corrupted by refugees or camp staff that may seek to exploit children.

Given the vulnerability of child refugees, the committee may want to consider how to prioritize refugees for mental health care treatment. Should children be prioritized for mental health care treatment over individual refugees? When thinking about this question, the committee should consider the role of parents as care-providers of children and the support parents need to effectively provide care and support for children.

The effects of racism and xenophobia on child refugees can be extremely damaging. It can lead to manipulation, loss of job and educational opportunities, and abuse. Therefore, governments may want to consider how to best thwart such discrimination and racist sentiments. Possible solutions include developing or enhancing laws and potential punishments for those who are found to adopt and practice such ideologies. Given the extreme lack of funding for increased resources for refugees, the committee may want to discuss how to best utilize funds.

Bloc Position

European countries

Europe is the birthplace of the modern mentally healthcare as well as agglomeration of developed states. European Mental Health Action Plan carried out by the WHO European Region has three core objectives which include but not limited to protection and promotion to people with mental health, and affordable as well as accessible mental health services. To some certain degrees, European countries with abundant mental healthcare experience do have the capability to assist the children in conflict zones.

The United States

The military opposition between the U.S. and Iran is always a sticky problem in the middle-east region. After Trump unilaterally tore up the Iranian Nuclear Agreement, it stimulated the conflicts and grudges to erupt. As the leading nation of the world, the balance between the sanctions and the consideration of mental healthcare should be attached significance.

Middle-east countries

The situation in middle-east is unpredictable. Undifferentiated attack injures all citizens including disadvantaged groups like women, children, and the old seriously.

Governments are supposed to take responsibility and grab chances to establish mental healthcare sites and promote the standard positively. Appealing to reduce the conflicts which may cause casualties properly is an urgent task.

Note to the delegates

The background guide is based on the academic research of the dais to help delegates understand the academic background of the committee's crisis. Due to the actual time limit on the conference's schedule, the committee will specifically focus on the content the dais provided in the background guide. However, the dais encourages further research based on the main topic as well as the country which the delegate represents for.

The research may include:
The measure took by the governments, NGOs, or organizations relevant to the topic.
History of the committee crisis
Other types of mental disorder (This will NOT be fully discussed during the conference. Delegates may research to fully present your Draft Resolution.)

PP Requirements

The position paper should be in **12 points, leave para-space, Times New Roman font**. You should submit your document via email to **h3zmun2019@126.com** before 23:59, September xx, 2019. Any late submission will result in consequences. All documents should be in forms of .doc, or .docx. Make sure your document is not damaged before submitting it.

You must cite any information or ideas borrowed from someone else's work (when in doubt, just cite). Please include a work cited page at the end of your document.

If you need any feedback, please contact the dais.

Work Cited

World Health Organization. (2000). Mental health and psychosocial care in conflict and post-conflict situations: from crisis through reconstruction. World Health Organization. https://apps.who.int/iris/handle/10665/66754

https://www.who.int/news-room/fact-sheets/detail/violence-against-children

“ About WHO.” World Health Organization, World Health Organization, www.who.int/about.

American Psychological Association, American Psychological Association, www.apa.org/topics/trauma/.

https://www.verywellmind.com/ptsd

“Posttraumatic Stress Disorder (PTSD): Symptoms, Diagnosis, Treatment.” WebMD, WebMD, www.webmd.com/mental-health/post-traumatic-stress-disorder#1.

“ PTSD Symptoms in Children Age Six and Younger.” Anxiety and Depression Association of America, ADAA, adaa.org/living-with-anxiety/children/posttraumatic-stress-disorder-ptsd/symptoms.

Junne, G. & Verokren, W. (Ed). Post-conflict development: meeting new challenges. 2005, Boulder, CO

Trauma History and Psychopathology in War-Affected Refugee Children Referred for Trauma-Related Mental Health Services in the United States

[10]Lakhdar Brahimi, Former Special Adviser of the Secretary-General of the United Nations, State building in crisis and post-conflict countries, June 2007, Available at http://unpan1.un.org/intradoc/groups/public/documents/un/unpan026305.pdf

“ Refugee.” Wikipedia, Wikimedia Foundation, 10 Aug. 2019, en.wikipedia.org/wiki/Refugee.

“Our Mission.” UNICEF USA, www.unicefusa.org/mission.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4921424/pdf/main.pdf(https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4921424/)

“Mental Health: a State of Well-Being.” World Health Organization, World Health Organization, 15 Aug. 2014, www.who.int/features/factfiles/mental_health/en/.

Murthy RS, Bertolote JM, Epping-Jordan JA, Funk M, Prentice T, Saraceno B, Saxena S. The World Health Report Mental Health: New Understanding New Hope. Geneva: WHO 2001; 36–45.

United Nations Security Council (UNSC) report, 2003. Agenda item 113: Promotion and protection of the rights of children.

A report from “A Civil Society Forum for Anglophone West Africa on Promoting and

Protecting the Rights of Street Children", 2003; 21- 24 in Accra, Ghana.

Kay Seong Ngoo. Children in war zones at high risk of suffering emotional disorders. BMJ 2002; 10: 215-58.

Davidhizar R, Shearer R. Helping children cope with public disasters: Support given immediately after a traumatic event can counteract or even negate long-term adverse effects. American Journal of Nursing 2002; 102: 26-33.

Thabet AA, Abed Y, Vostanis P. Emotional problems in Palestinian children living in a war zone: a cross-sectional study. Lancet 2002; 359: 1801-4.

Clark J. Threat of war in affecting mental health of Iraqi children. BMJ 2003; 326: 56. 11. De Jong J, Komproe I, Van Ommeren M, et al. Lifetime events and posttraumatic stress disorder in 4 post-conflict settings. JAMA 2001; 286: 555-62.

Emotional and Behavioral Disorders of Children and Adolescents. A Global Mental Health Education Program. World Federation for Mental Health, Baltimore, MD 2003;1-16.

Pynoos R, Nader K. Issues in the treatment of posttraumatic stress in children and adolescents. In: Wilson J P, Rapheal B, editors. International handbook of traumatic stress syndromes. New York: Plenum 2000; 535-49.

Terr LC. Childhood traumas: An outline and overview. American Journal of Psychiatry 1991; 148: 10-20.

Tener Goodwin Veenema, Kathryn Schroeder-Bruce RN. The Aftermath of Violence: Children, Disaster and Posttraumatic Stress Disorder. Journal Of Pediatric Health Care 2003; 16 : 235-44

"Comprehensive Mental Health Action Plan 2013–2020." World Health Organization, World Health Organization, 25 Sept. 2015, www.who.int/mental_health/action_plan_2013/en/.