

Practitioner perspectives on integrating mental health and psychosocial support (MHPSS) and peacebuilding: a qualitative study

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Abstract

Background

Major international agencies have recently called for the integration of mental health and psychosocial support (MHPSS) and peacebuilding, yet empirical evidence on how integration is understood and enacted by those who deliver it remains scarce. This study explored how practitioners understand and practise the relationship between the two fields, and what conditions, tensions, and barriers shape integration in practice.

Methods

We conducted a qualitative key informant interview study with 32 practitioners (24 women, 8 men) based in six countries and involved in the design or implementation of MHPSS and/or peacebuilding across United Nations agencies, government bodies, and NGOs. We recruited participants through snowball sampling until code saturation and interviewed them online using a semi-structured format. We analysed the data using reflexive thematic analysis.

Results

We generated five interrelated themes: (1) mental health problems as a driver of conflict; (2) the blind spot between the individual and the collective; (3) fear of failed containment and the question of competence; (4) gendered stigma of mental health problems; and (5) the mismatch between donors' short-term metrics and the long-term trajectory of mental health recovery. Practitioners identified mental health dynamics not only in conflict-affected communities but also within peace negotiations and mediation, and called for mental health to be embedded in conflict analysis and the design of peace processes. Rather than simply a merging of the two sectors, integration to them meant attending to interactions between the individual and the collective that neither field covers alone. Rather than focusing on whether or not to integrate, their accounts instead centred on how to do so safely, feasibly, and sustainably, pointing to interrelated conditions spanning knowledge translation, professional and organisational competence, social and cultural accessibility, and funding and evaluation systems.

Conclusions

The debate on integrating MHPSS and peacebuilding is shifting from normative justification to implementation. Because the conditions for integration are cumulative and interdependent, priorities include anchoring practical guidance in existing multi-level frameworks, building organisational capacity and care for practitioners, designing socially and culturally accessible entry points, and aligning funding and evaluation with the temporality of recovery.

Background

Armed conflict has severe and long-lasting effects on mental health. In conflict-affected settings, more than one in five people are estimated to experience a mental disorder [1]. Individual psychological burdens, including trauma, loss, chronic fear, and mistrust, can in turn erode social relationships and fuel community divisions and intergroup tensions [2, 3]. These interconnected effects have generated growing interest in linking mental health and psychosocial support (MHPSS) with peacebuilding [4]. According to the Inter Agency Standing Committee (IASC), MHPSS refers to "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder" [4].

International guidance increasingly recommends integrated approaches that address MHPSS and core areas of peacebuilding together, with the aim of generating synergies, and early practice and empirical research on integrated programming have begun to be reported [5–9]. Two guidance documents in particular have given this agenda its current shape. United Nations Development Programme (UNDP)'s 2022 guidance note argues that the psychological wounds of conflict, if left unaddressed, can trap communities in cycles of violence, yet observes that MHPSS has rarely been considered structurally in conflict prevention and peacebuilding. It calls for locally owned and participatory approaches, attention to stigma, and care for the wellbeing of staff [6]. The 2024 IASC guidance, developed through a global mapping of practice and consultations with practitioners, frames integration as bidirectional, since peace cannot take root where distress and grievance erode trust, and mental health cannot recover where the conditions of conflict persist [7].

Despite this progress, integration is not self-evident in practice. MHPSS and peacebuilding have developed through distinct professional communities, terminologies, intervention logics, and outcome measures, and a persistent divide remains between the two fields [3, 7, 10, 11]. Scholars have long argued that psychosocial practice must move beyond individual pathology to engage with social and political change [10, 12], and recent conceptual work proposes models of psychosocial peacebuilding that link individual and collective recovery [2, 11, 13]. A review of the literature nevertheless found that, while the theoretical case for integration is strong, the evidence base consists mainly of programme descriptions [3]. In particular, little attention has been paid to how the practitioners who actually carry out integration understand the relationship between the two fields, the conditions that facilitate or constrain it, and the tensions and barriers they encounter. Policies and frameworks take effect only through the discretionary judgements of those who implement them [14]. Without evidence on how integration is interpreted and operationalised, therefore, guidance risks remaining declaratory [6], donors lack criteria for what to fund and evaluate, and implementing organisations have little basis for determining the competencies and safeguards that integration requires [15].

To address this gap, we conducted semi-structured key informant interviews with practitioners working in MHPSS and/or peacebuilding, examining (1) how they understand and practise the relationship between the two fields, and (2) what conditions facilitate or constrain integration in practice. By focusing

on practitioners' experiences, this study aims to build a more empirically grounded understanding of how integration is interpreted and enacted on the ground.

Methods

Study design and reporting

We conducted a key informant interview study, analysed through reflexive thematic analysis [16]. We report the study in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) [17] (see Additional file 1).

Setting and sample

We conducted this study at King’s College London, United Kingdom, with participants joining interviews online from their respective locations. We recruited practitioners aged 18 years or older who had at least one year of experience designing and/or implementing MHPSS and/or peacebuilding interventions in conflict-affected settings as staff of organisations such as the United Nations, government bodies, or NGOs. We excluded practitioners working in specialised clinical mental health services, whether in conflict-affected settings or elsewhere, given the study's focus on community-oriented rather than clinical practice, and those unwilling or unable to provide informed consent (Table 1).

Table 1
Eligibility criteria

Inclusion criteria	Exclusion criteria
1. Aged 18 years or older	
2. At least one year of experience as staff of the United Nations, government bodies, or NGOs (local/international) in the design and/or implementation of MHPSS and/or peacebuilding in conflict-affected settings	1. Working in specialised clinical mental health services in conflict-affected settings (e.g. psychiatrists in clinical settings), rather than broader MHPSS interventions.
3. Able to provide informed consent	2. Unwilling or unable to provide informed consent

We used snowball sampling, beginning with an initial interview with a professional contact working for an NGO providing MHPSS services. We then expanded the participant pool through referrals from participants. We determined the sample size based on code saturation, defined as the point at which no substantive new codes emerged [18]. Of the practitioners invited, eight declined or did not respond, most commonly citing time constraints. The final sample comprised 32 practitioners (24 women, eight men) based in six countries (Germany, Indonesia, Japan, South Sudan, Switzerland, and the United Kingdom) (Table 2). Countries were not selected for geographic representativeness, and their distribution reflects the referral networks through which participants were recruited. We invited participants on the basis of

their professional relevance to the study and did not provide financial compensation. We will share a practitioner-oriented summary of the study findings with participants.

Table 2
Participant characteristics

Characteristic		N = 32
Gender	Female	24
	Male	8
Professional background	Clinical/mental health	5
	Peacebuilding/conflict resolution	8
	Both fields	19
Main region of practice	Eastern Europe/Caucasus	2
	South/Southeast Asia	3
	Middle East/North Africa	3
	Sub-Saharan Africa	6
	Multiple regions/global	18

Data collection: semi-structured key informant interviews

We conducted the interviews in English via Microsoft Teams or Zoom between May and August 2026. Interviews lasted 30–60 minutes. With participants’ consent, we audio-recorded all interviews and used Microsoft Teams or Zoom to produce verbatim transcripts, which we checked against the recordings and corrected as needed. No one other than the interviewer and the participant was present, and we conducted no repeat interviews. We did not return transcripts to participants for comment.

We used mainly open-ended questions to encourage participants to speak freely about their experiences and the meanings they attached to them. After an introductory exchange, we asked about their current roles and experience in MHPSS and peacebuilding. We then explored their understanding of the relationship between the two fields and asked them to describe specific situations in which MHPSS and peacebuilding interacted. In the latter part of the interview, we explored the factors that shaped integration and invited participants to reflect on how the two fields connect in practice (see Additional file 2).

Data analysis: reflexive thematic analysis

We analysed the data using reflexive thematic analysis [16]. Coding proceeded concurrently with data collection, allowing insights from earlier interviews to sharpen our attention to subsequent data. Two authors, including the first author who conducted the interviews, independently coded the transcripts line by line, staying close to participants' accounts while noting broader patterns relevant to the research questions, and iteratively grouped and refined codes into themes. We met regularly to compare interpretations and examine how our disciplinary perspectives shaped the coding. We iteratively refined codes, grouped them into candidate themes, and reviewed these against the coded extracts and full dataset, attending to disconfirming cases. We defined the final themes as patterns of shared meaning capturing how practitioners understood, negotiated, and experienced the integration of MHPSS and peacebuilding. We used NVivo 15 and Microsoft Word for coding.

Research team and reflexivity

The first author (MA), a female postdoctoral researcher with prior field experience in MHPSS in conflict-affected settings, conducted all interviews. She had known a minority of participants professionally before the study and approached the remainder through referral. Before obtaining consent, she informed participants of her professional background and the aims of the study. Her background gave her familiarity with the field's vocabulary and practical constraints but may also have predisposed her towards accounts framing integration as desirable. To address this, she kept a reflexive journal throughout the study and drew on it, together with team discussions, to interrogate her assumptions during coding and theme development.

Ethics

The King's College London Research Ethics Committee approved the study (LRS/RGO-25/26-55913). All participants gave written informed consent, including consent for the use of anonymised verbatim quotations. We pseudonymised all transcripts and removed identifying details of organisations, countries, and programmes from the quotations. We implemented a distress protocol under which the interviewer would pause or stop the interview if a participant showed signs of distress. We recorded no adverse events.

Results

We generated five interrelated themes regarding participants' experiences of integrating MHPSS and peacebuilding, presented in turn below.

Theme 1: Mental health problems as a driver of conflict

Most participants spoke of mental health problems not only as an aftermath of conflict, but also as a driving force for further violence. They shared varied theories about the psychological mechanisms

involved, including individuals with conflict-related psychosocial issues dehumanising the opposing party, holding expectations of the other side so rigid that even conciliatory moves are read as hostile, and being in a constant state of bodily alertness. Intrusive thoughts and bodily reactions were the most frequently heard accounts, and one participant gave a vivid example from a negotiation setting.

"Something would happen at the table. Perhaps a word, a gesture, even a tone of voice ... and suddenly it would bring back what had happened during the conflict. You could see the person's whole reaction change. At that point, they were no longer responding only to what was happening in the room." (Male, UN staff member)

Participants articulated a chain reaction in which mental health problems, through such mechanisms, undermine dialogue, negotiation, and reconciliation, compounding and sustaining conflict. From a clinical angle, one participant linked common mental health problems to a heightened willingness to retaliate and take risks. What participants sought was therefore "not producing a good agreement document ... but building into the design of the peace process itself the psychological foundation" (Female, INGO worker). In practice, this includes emotional support for negotiators, emotion-regulation skills, facilitation grounded in psychological safety, and environments that do not trigger flashbacks.

"I've never seen how you can do peacebuilding without an understanding of this, at least psychology and understanding how the human psyche works and yes, mental health and trauma." (Female, INGO worker)

Yet despite its central role, participants noted that mental health problems are often insufficiently recognised within peacebuilding practice and are treated "far too often as a consequence [of conflict]" rather than "as a factor that may also shape or sustain conflict dynamics" (Male, UN staff member). Participants therefore argued that mental health problems should be incorporated into conflict analysis as a contributing factor, and that this should be reflected in theories of change with input from relevant specialists.

"Peacebuilding specialists know about conflict analysis and the design of dialogue, but they are not sufficiently trained in how trauma affects people's cognition and behaviour. ... Psychosocial support and trauma specialists need to be involved from the analysis and design stage, not in the latter half of the project." (Male, local government worker)

Theme 2: The blind spot between the individual and the collective

When asked how the two fields relate, participants located the central difficulty in a discrepancy between the medical model of mental health, rooted in the individualism of Western psychology, and the social and collective level at which peacebuilding actually occurs. This creates a blind spot in policy and guidance where the two meet. Conflict-related distress arises not only in those directly exposed to violence, but in the space between the individual and the collective. Memories, narratives, emotions and hostile perceptions are transmitted through families and shape the narratives and identities of entire

communities, even taking root in those not directly exposed to conflict. Such distress is difficult to trace through an individual clinical lens and commonly goes unregistered by contemporary peacebuilding's focus on the collective.

"You can have a young person who was born after the war, but they know exactly who they are supposed to fear or hate. Nobody sat down and diagnosed that as trauma. It comes from what they hear at home, how people talk in the community, what stories are repeated. So where do we put that? It is psychological, but it is also social." (Female, local NGO worker)

This understanding shaped what integration meant to participants. For them, integration meant addressing interactions between the individual and the collective that neither field covers alone. Participants repeatedly emphasised that the two cannot be treated separately in practice, and saw individual and collective experiences as continuously shaping one another. As one participant put it, "ultimately, it is individual human beings who build peace, and each of those individuals carries psychological experiences of war and violence" (Male, INGO worker). They therefore envisaged a psychosocial approach to peacebuilding that treats the individual, family, community and societal levels as interconnected, rather than proceeding from individual recovery to collective peace in a linear fashion.

"For me, you cannot say, 'First we fix the individual, and then we fix the community.' It doesn't work like that. The person is affected by the family and the community, and at the same time what happens with that person affects the people around them. Everything is connected." (Female, local NGO worker)

However, participants identified a structural barrier to such practice: the knowledge base supporting work across levels has not kept pace. Conventional psychology has taken the individual as its main unit of analysis, accumulating systematic knowledge of diagnosis and treatment, while peacebuilding has built a substantial body of knowledge around institutions, intergroup relations, reconciliation and social change. Yet neither field offers a similarly systematic understanding of what occurs between these levels.

"I've always found the best, the most effective peace builders to be people trained in psychology, but maybe not classical psychology because there does seem to be a bit of a blinker. There's a limit between the individual and the collective... Collective trauma was mentioned, but nothing was written about how to work with it." (Female, INGO worker)

Theme 3: Fear of failed containment and the question of competence

Participants identified "containment" as a core competency for safely integrating mental health into peacebuilding. By containment, they meant the ability to receive and hold another person's intense emotions and help make those emotions more manageable [19]. Participants often described a lack of confidence in this capacity, and that uncertainty was closely bound up with their fear of what might be released.

"There's a worry that if you ask, 'Has anyone here experienced trauma?', they will share horrible stories, it will get out of control, and people will feel a lot worse afterwards... How do you catch it? How do you ground people so that they can leave afterwards?... it's not therapy, right?" (Female, INGO worker)

Participants stressed that mental-health-sensitive practice is not simply a matter of giving people an opportunity to speak. Encouraging deep self-disclosure before sufficient safety and trust have been established can itself constitute a risk: some participants recalled settings that became emotionally unstable, in which people re-experienced past trauma or displayed defensive reactions. Good intentions alone are not enough. As one participant put it, "if you are not trained, you do not know what to ask and when, or conversely when not to ask" (Male, local NGO worker). Participants therefore emphasised the need to clarify the boundaries between the roles of MHPSS and peacebuilding practitioners and those of psychological professionals.

"Participants may be experiencing mental health difficulties, but facilitators without clinical training should not be expected to diagnose or treat them. Their role is to create a supportive environment and connect them to appropriate professional support if needed." (Female, UN staff member)

Moreover, even highly skilled practitioners need organisational support to assist communities effectively. One participant, a trained psychotherapist, noted that clinical practice is only possible when supported by ethical frameworks, supervision, personal therapy, and clear boundaries, none of which they saw in peacebuilding practice. Without such organisational support, burnout and impaired judgement can occur. Individual skills such as containment were thus described as inseparable from the support available to practitioners themselves.

"In psychology we are taught that in order to face clients you have to maintain your own mental health... otherwise you cannot do the work ethically. ... But in peacebuilding practice this kind of care is absent." (Female, INGO worker)

Theme 4: Gendered stigma of mental health problems

Stigma attached to mental health problems was the most frequently cited barrier to bringing mental health into peacebuilding spaces. It operated at two distinct levels, the individual level of help-seeking and the institutional level at which policy priorities are determined. At both levels, this stigma was understood and perpetuated through a gendered lens. At the individual level, seeking help or showing vulnerability was regarded as feminine, *"a sign of weakness or lack of resilience"* (Female, local NGO worker), a norm at times clothed in religious vocabulary, with distress attributed to insufficient faith rather than recognised as a health problem. At the institutional level, hierarchical structures reproduced gender bias and mental health stigma and the intersection between the two. The higher the decision-making level, participants noted, the greater the resistance to acknowledging mental health as important, because it was dismissed as an individual-level matter primarily affecting women.

"[In political discussions, the topic of mental health] is often seen as a soft side. The attitude that 'this is about women, this is a women's and children's issue, this is not a matter for political analysts or important

people' is still deeply entrenched." (Female, INGO worker)

Notably, this gendering of mental health issues also has an exclusionary effect on men. Participants described how engaging men in the topic of mental health is often considered more taboo than it is for women, with one male local NGO worker describing the field as "*feminised*" and one female government worker noting that men frequently require "*a particular approach or framing*" to engage with the topic. In contexts where MHPSS was perceived as primarily intended for women, men who sought support faced a heightened risk of stigma, and some were discouraged from accessing services despite ongoing distress.

In response, the strategy participants described was itself a form of integration. Rather than presenting mental health and psychological support as discrete, individual-level issues using medical vocabulary, they embedded these topics within peacebuilding discourse, situating them in broader, more locally relevant concerns such as community well-being, social cohesion and community development. To complement this reframing, practitioners also collaborated with trusted community leaders and actors to deliver mental health messaging in ways that were socially acceptable and relevant to the community.

"In many conflict-affected areas stigma still follows you, so you have to use different wording for it ... This is a very traditional community, so it is strongly top-down, and the leaders are usually middle-aged men who will not listen ... A religious leader would be better placed to handle it than a psychologist." (Female, local NGO worker)

Theme 5: The mismatch between donors' short-term metrics and the long-term trajectory of mental health recovery

Participants highlighted a discrepancy between the short-term outcomes prioritised by donors and the long-term, non-linear nature of recovery from complex mental health problems. Peacebuilding programmes are required to demonstrate concrete change within limited funding cycles. However, recovery from mental health problems and changes in perceptions can take place over long periods and may be accompanied by stagnation and regression. Therefore, a funding structure that demands short-term results can itself be an obstacle to substantive integration.

"Everyone still wants quick results ... an agreement, a change in the law, and so on." (Female, INGO worker)

The problem lay not only in the limited time available, but also in donors prioritising measurable and visible results. Outcomes that are comparatively easy to measure using existing standardised instruments, such as post-traumatic stress disorder (PTSD), are emphasised. However, broader psychosocial changes, such as psychological stability, a sense of safety, trust, reduction of everyday and larger-scale violence, social connection, the restoration of relationships, and ultimately peace itself may not be adequately captured. This narrows what counts as a result, undervaluing both changes that are difficult to quantify and outcomes that consist of things that did not happen, such as prevented violence.

Participants therefore problematised the logic of evaluation itself, rather than a shortage of evaluation methods.

"Outcomes that are hard to see such as having prevented conflict by addressing mental health problems are ignored. ... What matters in funding is measurable results." (Male, INGO worker)

Participants also warned that growing donor attention to MHPSS risks creating visibility without substance. Integration may increasingly be reduced to a formal requirement in grant applications and reporting, rather than a substantive change in practice. Programmes must align with donor discourse to secure funding, and shifting fashions can drive superficial adoption. Attention has grown faster than expertise, which may leave the field staffed by people without adequate qualifications.

"As a sector, we have to be careful that mental health does not become a mere 'box-ticking exercise'. ... The same thing happened with gender [when it was integrated into peacebuilding]." (Female, INGO worker)

Discussion

In this study, we explored how practitioners understand and practise the relationship between MHPSS and peacebuilding, and what facilitates or hinders their integration, through key informant interviews with 32 practitioners. While a degree of consensus on the need for integration is emerging in both policy and theory [6, 7], participants' accounts revealed that the focus of the question has shifted from whether to integrate to how to integrate safely, feasibly, and sustainably. The principal contribution of this study therefore lies not in reaffirming the need for integration, but in documenting the challenges practitioners encounter in the field and in identifying the priorities and opportunities essential for effective implementation. Taken together, the five themes describe a chain of interrelated conditions. Integration depends on recognising psychosocial processes as relevant to conflict, on translating that recognition into actionable knowledge, on building the competence to engage safely, on ensuring that support is socially and culturally appropriate, and on sustaining practice through funding and evaluation systems.

Integration begins with recognising mental health problems not only as an individual-level consequence of conflict but as a force that can drive and sustain it. This understanding (theme 1) aligns with psychosocial peacebuilding theory [2, 13], with empirical research linking post-conflict psychological states to attitudes towards peacebuilding [20–22], and with intervention research [23]. This study extends the previous literature by showing that practitioners observed these dynamics not only within communities but also in negotiation and mediation settings, where memories of past violence can resurface in immediate and tangible ways. These accounts complement research showing that emotions shape negotiation processes [24, 25]. Framing mental health as a factor in conflict nevertheless carries the risk of reducing political, economic, and institutional conditions to psychological problems [26]. This is precisely why participants' emphasis on design rather than therapy matters. What they sought was not psychotherapy for negotiators but the incorporation of mental health into conflict analysis and theories of change, and the building of a "psychological foundation" into the design of

peace processes themselves. This reframing allows practitioners to address trauma as a condition of process design rather than as pathology located within individuals.

When practitioners attempt to translate this recognition into decisions about assessment and intervention, however, they encounter the blind spot that policy and guidance leave between the individual and the collective (theme 2). Participants' accounts resonate with long-standing critiques of the individualisation and pathologisation of mental health support [12, 26, 27], and with scholarship that conceptualises collective trauma as a process shaping collective memory and social identity [28]. Notably, participants identified the integration of peacebuilding and MHPSS as aligning precisely with this blind spot, since it engages with the reciprocal relationship between trauma and conflict at the individual and collective level in a manner neither field could address alone. Their concern was not that these concepts do not exist at the theoretical level, but that practical frameworks for applying them in the field are lacking. In their words, the knowledge base has not kept pace with cross-level practice. Given that multi-level frameworks capable of supporting this translation already exist [29–31], anchoring the guidelines, decision-making tools, and training that participants called for in these frameworks appears more feasible than developing them anew.

As practitioners move from knowledge to practice, a further condition they emphasised was the development of concrete competencies, including the capacity for containment (theme 3). Their concerns align with trauma-informed practice and the principle of do no harm [2, 32]. Rather than reflecting practitioners' resistance to integration, these concerns reflect their awareness of the limits of their own expertise, and of the potential harms of engaging with trauma without clear boundaries or adequate support. As this self-awareness indicates, promoting integration cannot be reduced to raising awareness of mental health, nor to a matter of individual skill. Instead, participants called for systematising implementation structures. Indeed, research in both peacebuilding and mental health has demonstrated the importance of embedding such principles in organisational policies and procedures rather than in the skills of individual practitioners alone [15, 33]. Overall, competence means not only the training received by individual practitioners, but also an organisational capacity encompassing appropriate training, supervision, referral systems, and ethical governance.

Furthermore, whether integration reaches the people it should serve depends on whether support is socially and culturally appropriate and relevant (theme 4). Participants' accounts showed that stigma operates at two levels, individual help-seeking and institutional priority-setting, and that it is gendered at both. Research has long documented how masculinity norms suppress help-seeking at the individual level [34]. What this study reveals is the institutional face of stigma. Participants described how policy discussions dismissed mental health as a "women's and children's issue" or a "soft" topic, a pattern we can read as a form of structural stigma, in which social norms and institutional practices themselves constrain access [35]. Because of this dual stigma, anti-stigma efforts cannot end at changing individual attitudes. Participants' strategies targeted precisely this point. They rephrased mental health vocabulary to avoid terms that may be stigmatised, worked through religious leaders and other trusted messengers, and chose entry points into conversations about mental health according to context. Consistent with the

recognised need to incorporate cultural idioms of distress into assessment and intervention [36, 37], these strategies redesign access to support through existing social relations and cultural systems of meaning. They constitute, in themselves, a form of integration.

These strategies nevertheless carry a tension that participants themselves implied. Embedding psychological support without naming it makes support socially acceptable, yet it can also hide that support from the institutions that set priorities and allocate resources, notably funders (theme 5). In participants' accounts, funding and evaluation systems were not external conditions of integration but forces that shape its very substance, and their effects appeared in two directions. In one direction, substantive change goes unrecognised. Funding cycles are too short for the non-linear temporality of recovery, and donors prioritise readily measurable outcomes [38]. Policy documents already acknowledge this mismatch and propose longer funding cycles and multidimensional evaluation frameworks [39, 40]. The challenge lies instead in building institutional incentives that can value, and allocate funding to, long-term, uncertain, and context-dependent change. In the other direction, integration risks becoming tokenised, as projects superficially adopting integrative practices with limited expertise often attract donor attention, a trajectory that participants likened to how gender disparities had become a “checklist” item in grant proposals or project reports. In both directions the core problem is the same. What funding and evaluation systems count as results determines which forms of integrated practice become possible, who comes to practise them, and whether integration retains its substance.

Viewed as a whole, these findings suggest that the conditions for integration are cumulative and interdependent rather than discrete. Recognising psychosocial dimensions has limited practical value without mechanisms for translating that knowledge into intervention design, and such guidance has limited reach without the competence and organisational support needed to act on it appropriately. Even sound practice is difficult to sustain when social, cultural, funding, and evaluation systems work against it. Integration therefore depends less on any single intervention or professional skill than on alignment across multiple levels of practice. Because policies and frameworks take effect only through the discretionary judgements of those who implement them [14], practitioners stand at the centre of that alignment.

Study limitations

First, snowball sampling may have over-represented practitioners already interested in integrating MHPSS and peacebuilding. However, by including participants with diverse professional backgrounds and levels of practice, from community-level support to international peacebuilding, we captured implementation challenges across different contexts. Future research should deliberately include practitioners who may view integration less favourably, as well as stakeholders in different organisational positions, to examine a wider range of views.

Second, we focused on practitioners' experiences and perceptions and did not examine those of residents of conflict-affected areas, service users, donors, or policymakers. While the focus of this study allowed us to capture in depth practitioners' practice-based knowledge, an area that existing research has insufficiently addressed, future studies comparing perspectives across stakeholder groups and examining how each group understands the identified implementation conditions would further enrich this examination.

Finally, as a qualitative study, this research cannot establish whether integrating MHPSS and peacebuilding causally improves mental health or peacebuilding outcomes. Instead, our findings suggest hypotheses and implementation conditions for future testing. Longitudinal, mixed-methods, and implementation research should examine these relationships further.

Conclusions

Practitioners are not merely the recipients of guidance but the point at which integration succeeds or fails, and the conditions this study identified describe what that point of practice requires. These conditions include recognising trauma as a factor shaping conflict and embedding it in the design of peace processes, translating psychosocial concepts into practical frameworks for assessment and intervention, building the competencies and organisational structures needed for safe engagement, designing socially and culturally appropriate support, and aligning funding and evaluation with the temporality of recovery. Because these conditions are cumulative and interdependent, integrating MHPSS and peacebuilding is not simply a matter of adding mental health components to existing programmes but a task of redesigning conceptualisation, analysis, practice, organisation, and funding themselves. Next steps include specifying these conditions by building on existing frameworks, aligning funding and evaluation systems with them, and testing them across diverse conflict contexts in co-creation with practitioners and affected communities.

Abbreviations

COREQ

Consolidated Criteria for Reporting Qualitative Research

INGO

International non-governmental organisation

MHPSS

Mental health and psychosocial support

NGO

Non-governmental organisation

PTSD

Post-traumatic stress disorder

UN

United Nations

Declarations

Ethics approval and consent to participate:

Ethical approval was obtained from the King's College London Research Ethics Committee (reference: LRS/RGO-25/26-55913). All participants provided written informed consent prior to participation.

Consent for publication:

Not applicable.

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Author Contribution

MA: Conceptualisation, Methodology, Investigation, Formal analysis, Writing – original draft, Supervision, Project administration. MF: Methodology, Supervision, Writing – review & editing. SK: Formal analysis, Writing – review & editing. HM: Formal analysis, Writing – review & editing. AR: Formal analysis, Writing – review & editing. AH: Conceptualisation, Writing – review & editing. MS: Methodology, Supervision, Writing – review & editing. All authors read and approved the final manuscript.

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Availability of data and materials:

The datasets generated during the current study are not publicly available due to the confidentiality of participants but are available from the corresponding author on reasonable request, subject to ethical approval.

Competing interests: The authors declare that they have no competing interests.

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