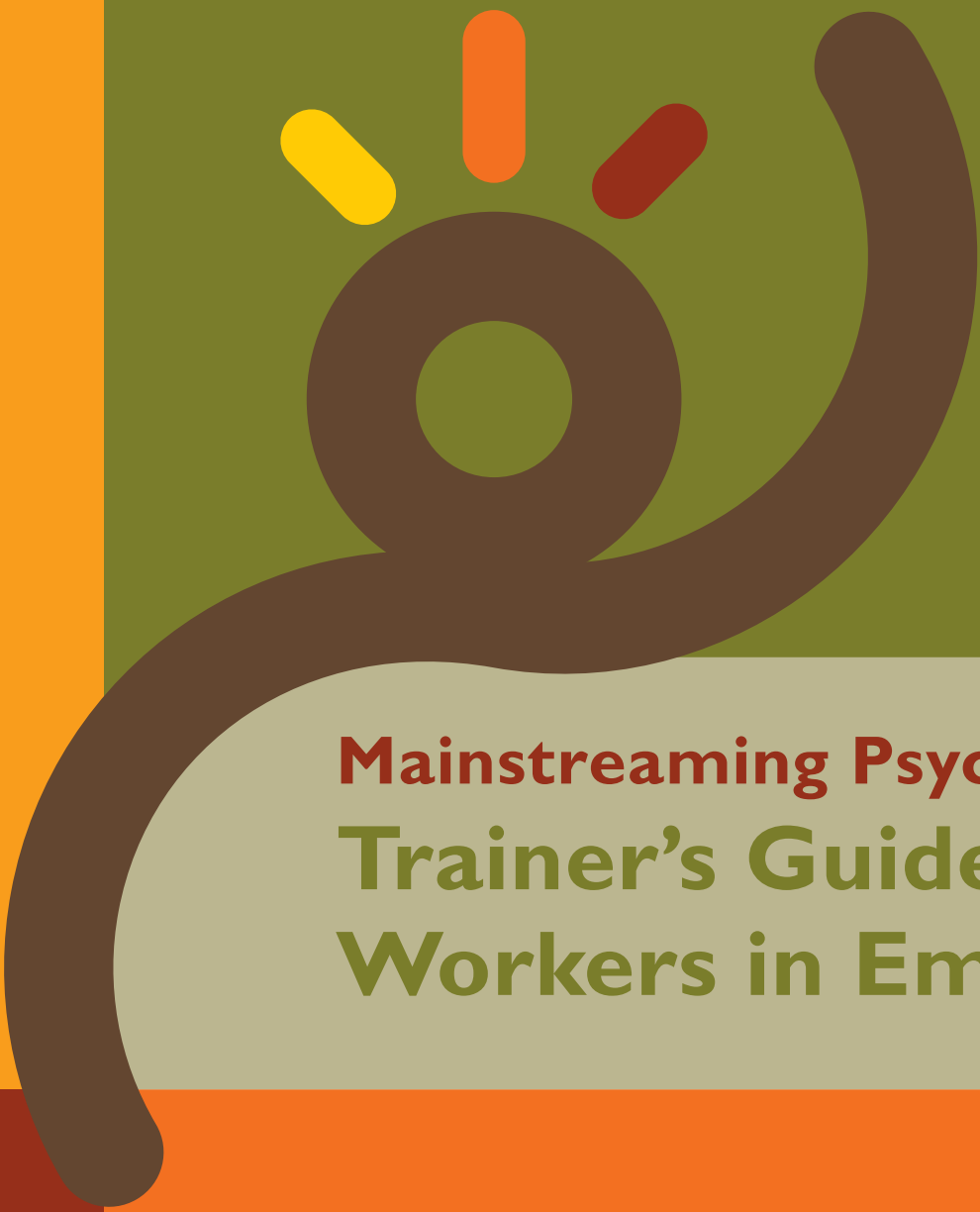


PSYCHOSOCIAL WELLBEING SERIES

A stylized human figure in a dark brown color, with a circular head and a long, curved neck. Above the head are three vertical bars in yellow, orange, and red, resembling a sun or light rays. The figure is positioned on the left side of the cover, partially overlapping a light green rectangular area.

*Guide to Recommended Training
Materials to Facilitate the Integration
of Mental Health and Psychosocial
Support into Health Care*

**Mainstreaming Psychosocial Care and Support
Trainer's Guide For Training Health
Workers in Emergency Settings**

First edition, January 2010





Psychosocial Wellbeing For All Children

REPSI is a regional non-governmental organisation working with partners to promote psychosocial care and support (PSS) for children affected by HIV and AIDS, poverty and conflict in East and Southern Africa.

THE REPSI PSYCHOSOCIAL WELLBEING SERIES

Through this series, REPSI strives to publish high quality, user-friendly, evidence-based manuals and guidelines, all characterised by subject matter that can be said to address the issue of psychosocial wellbeing. Within the series, different publications are aimed at different levels of audience or user. This audience includes: 1) community workers, 2) a variety of social actors whose work is not explicitly psychosocial in nature, but in which it is felt to be crucial to raise awareness around psychosocial issues, 3) caregivers, parents, youth and children, 4) specialised psychosocial and mental health practitioners. Apart from formal impact assessments, towards further developing the evidence base for our tools and approaches, we welcome user feedback around our materials. The standardised feedback form and a full list of all the titles in the series can be downloaded from www.repsi.org

Jonathan Morgan

Editor, REPSI Psychosocial Wellbeing Series



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Foreword

This guide represents an important contribution to the REPSSI mainstreaming series.

It provides trainers, working in emergencies, with a collection of strategically selected materials that they can use to guide them in designing training programs filled with knowledge and skills to prepare health workers to integrate psychosocial and mental health support into health care.

REPSSI (Regional Psychosocial Support Initiative) along with TPO Uganda (Transcultural Psychosocial Organisation) and GPSI (Global Psycho-Social Initiatives) joined together to produce this guide. As historical leaders in the field of psychosocial and mental health support in developing countries affected by violence, they decided to pool their resources to produce a series of materials that can be used by trainers in emergency situations.

REPSSI is a regional non-governmental organisation working with partners to promote psychosocial care and support for children affected by HIV and AIDS, poverty and conflict in East and Southern Africa.

TPO is a non-governmental organisation based in Uganda. Its interventions empower local communities, civil society organisations and governments to meet the psychosocial and mental health needs of communities especially in conflict, post-conflict and disaster-affected areas.

GPSI is a global initiative that facilitates training programmes from which its learners implement culturally relevant family and community interventions in developing countries affected by conflict and other emergencies.

The REPSSI mainstreaming series also includes:

Mainstreaming Psychosocial Care and Support: Facilitating Community Support Structures

Lessons Learned in Uganda About Community Based Psychosocial and Mental Health Interventions

Mainstreaming Psychosocial Care and Support Trainer's Guide for Training Teachers in Conflict and Emergency Settings:

An Edited Anthology of Global Teacher Training Materials to

Facilitate the Integration of Mental Health and Psychosocial Support into Education

Mainstreaming Psychosocial Care and Support Through Child Participation:

For Programmes Working with Children and Families Affected by HIV and AIDS, Poverty and Conflict

Mainstreaming Psychosocial Care and Support Within Early Childhood Development:

For ECD Practitioners Working with Children and Families Affected by HIV and AIDS, poverty and conflict

Mainstreaming Psychosocial Care and Support Into Economic Strengthening Programmes:

For Practitioners Working with Children and Families Affected by HIV and AIDS, Conflict and Poverty

Mainstreaming Psychosocial Care and Support Within the Education Sector:

For School Communities Working with Children and Families Affected by HIV and AIDS, Poverty and Conflict



**Mainstreaming Psychosocial Care and Support Within
Food and Nutrition Programmes:**

For Practitioners Working with Children and Families Affected
by HIV and AIDS, Poverty and Conflict

**Mainstreaming Psychosocial Care and Support Into
Home-Based Care Programmes:**

For Practitioners Working with Children and Families Affected
by HIV and AIDS

We trust that this guide will assist your efforts to support and
empower individuals, families and communities affected by
emergencies.



Noreen Masiwa Huni
Executive Director, REPSSI
January, 2010



Patrick Onyango-Mangen
Country Director, TPO Uganda
January, 2010



Dr Nancy Baron
Director / Global Psycho-Social Initiatives (GPSI)
January, 2010



Introduction

“Armed conflicts and natural disasters cause significant psychological and social suffering to affected populations. The psychological and social impacts of emergencies may be acute in the short term, but they can also undermine the long-term mental health and psychosocial well-being of the affected population. These impacts may threaten peace, human rights and development.” “One of the priorities in emergencies is thus to protect and improve people’s mental health and psychosocial wellbeing.” “Achieving this priority requires coordinated action among all government and non-government humanitarian actors.” (IASC MHPSS Guidelines 2007)

Health care is an essential element in the coordinated response to emergencies. Yet, “there is a gap in most emergencies between mental health and psychosocial support (MHPSS) and general health care.” (IASC MHPSS Guidelines 2007)

This trainer’s guide includes a collection of materials that are recommended for training health workers working in emergency settings on how to integrate psychosocial and mental health support into health facilities and communities. These 23 materials are recommended since they conform to the Inter Agency Standing Committee (IASC) guidelines on Mental Health and Psychosocial Support (MHPSS) in emergency settings.

Health workers need a lot of information and skills to adequately provide psychosocial and mental health support. Therefore, the materials recommended in this trainer’s guide include a wide range of materials selected from different sources and contexts. The trainer’s guide also includes commentary and guidance about how trainers can utilise these materials.

Acknowledgements

The guidelines were commissioned by REPSSI and TPO Uganda and written by Dr Nancy Baron of Global Psycho-Social Initiatives (GPSI), who has extensive experience in working with schools and communities affected by emergencies and conflict situations.

We would like to acknowledge the contributions of the persons below that were actively involved in developing the guidelines:

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- Kinyera Richard from TPO Somalia
- Margaret Opele from TPO Uganda
- Rose Mogga from TPO Uganda
- Sarah Akera from TPO Uganda
- Taban Edward from TPO Somalia

Who is this guide intended for?

The trainers who will most easily use this guide will already have experience as trainers. They will independently read the materials and integrate what they learn into their training of health workers and/or training of trainers of health workers.

Trainers can use the recommended materials:

- To inform them about key issues important in the training of health workers.
- To facilitate the design and content of their training curriculum.
- As handouts and reading for the trainees.

The health workers targeted for inclusion in the training to be done by trainers who use this guide will work in emergency affected settings in developing countries that have access to few medical professionals. The health workers can include nurses, nursing aides and trained health workers. They will most often work in community based primary health care facilities.

Conformance with Inter Agency Standing Committee (IASC) guidelines on Mental Health and Psychosocial Support (MPHSS)

The materials recommended in this guide conform to the (IASC) guidelines on Mental Health and Psychosocial Support (MPHSS). It is important that this trainer's guide conforms to these guidelines since they are the standards promoted internationally by organisations, universities and individuals working in emergency settings.

The Inter Agency Standing Committee (IASC) guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings are a “multi-sectoral, interagency framework that enables effective coordination, identifies useful practices and flags potentially harmful practices, and clarifies how different approaches to mental health and psychosocial support complement one another.”

“They reflect the insights of practitioners from different geographic regions, disciplines and sectors, and reflect an emerging consensus on good practice among practitioners.”

“The core idea behind them is that, in the early phase of an emergency, social supports are essential to protect and support mental health and psychosocial wellbeing. In addition, the guidelines recommend selected psychological and psychiatric interventions for specific problems.”

“The composite term mental health and psychosocial support is used in this document to describe any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder.”

Some of the recommended materials were written after the completion of the guidelines in 2007, and therefore clearly use their language and content. Others were written prior to 2007 and though the concepts are compliant with the overall concepts of the guidelines some do not use quite the same language.

Format of this guide

This guide is organised into three sections:

Section 1: Designing the Training Programme

Section 2: Essential Knowledge and Skills for Training Health Care Workers

Section 3: Recommended Materials

Overview of the content within the materials recommended in this trainer's guide

The materials selected for this guide provide trainers with:

1. Examples of global models of training, trainer's guides and manuals, and lessons learned in the training of health workers internationally.
2. Information about training methods that can be used in the training of health workers.
3. Essential information that can be included in the training of health workers about:
 - International guidelines.
 - Ethics.
 - Value of community-based care.
 - Importance of integration of psychosocial and mental health care within health care.
 - Knowledge about the effects of emergencies on adults, children, families and communities including the concepts of psychosocial wellbeing, human needs and development, resilience, coping, and how to differentiate normal responses from distress and/or mental disorders.
 - Psychosocial and mental health prevention.
 - Levels of psychosocial and mental health treatment.
 - Skills needed by health workers including skills for communication, psychosocial support, assessment, differential diagnosis, Psychological First Aid, awareness raising and psycho-education, effective medical treatment and referral.

4. Information that can be used to aid health workers in self-care and management of the stresses of their work.

Training Materials Recommended in this guide

This guide recommends 23 materials that are useful for trainers in their training of health care workers in emergency settings.

The 23 recommended training materials are separated into five categories:

- I. Trainers Skills: Materials to enhance the training skills of the trainers.
- II. International guidelines about MHPSS in emergency settings: Materials related to the integration of psychosocial support in emergency affected settings.
- III. Mental health and psychosocial support information for training health workers: Materials about specific mental health issues that may be included in training programmes.
- IV. Information, skills, interventions and action steps to train health workers: Specific examples of mental health and psychosocial support as part of integrated health care.
- V. Care for the caregivers: Minimizing the stress of health workers: Materials about how to maximize working capacities and minimize the stress of health care workers.

I. Trainer Skills

1. On the road to peace of mind guidebook: An applied approach to training trainers who train teams to do psychosocial and mental health interventions in developing countries affected by catastrophes. Author: Nancy Baron of Global Psycho-Social Initiatives, Uganda, 2007.

2. Helping Health Workers Learn: A book of methods, aids, and ideas for instructors at the village level. Author: David Werner and Bill Bower for the Hesperian Foundation, USA, 2004.

3. Orientation Seminar: General Aid Workers. Author: Nancy Baron for the IASC MHPSS Reference Group, Geneva, 2009.

II. International guidelines and standards

4. Inter Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Author: IASC MHPSS Working Group, Geneva, 2007.

5. Mental Health and Psychosocial Support (MHPSS) In Humanitarian Emergencies: What Should General Health Coordinators Know? Author: IASC MHPSS Working Group, Geneva, 2008.

III. Mental health and psychosocial support information

Inter Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Author: IASC MHPSS Working Group, Geneva, 2007. (This document is repeated in this section because of the information it contains which is relevant to mental health and psychosocial support.)

Orientation Seminar: General Aid Workers. Author: Nancy Baron for the IASC MHPSS Reference Group, Geneva, 2009. (This document is repeated in this section because of the information it contains which is relevant to this section.)

6. Advances in Disaster Mental Health and Psychological Support. Edited by: Joseph O. Prewitt Diaz and Rashmi Lakshminarayana, India, 2008.

7. Mental Health Effects of Disaster and Trauma on Individuals and Communities: Understanding and Intervention. Author: Ben Weinstein, Department of Mental Health, Thailand, 2004.

8. Mental Health Module for Psychosocial Care Givers: Mental Health and Psychosocial Support in Emergency Operation (For Lady Health Workers). Author: World Health Organisation (WHO) and Ministry of Health, Pakistan, 2006.

9. Where There is No Psychiatrist. A Mental Health Care Manual. Author: Vicram Patel, The Royal College of Psychiatrists, India, 2003.

10 A. Training handbook: A trainer's guide: Psychiatric nursing care in general health facilities in Eritrea.

10 B. General manual: Psychiatric nursing care in general health facilities in Eritrea - About awareness and learning basic skills. Author: Ilse Verkaaik, Healthnet –TPO / Ministry of Health, Eritrea, 2006.

11. Disabilities among refugees and conflict-affected populations. Author: Women's Commission for Refugee Women and Children, Geneva, 2008.

12. Responding to the needs of children in crisis. Author: Lynne Jones, International Medical Corps (IMC), UK, 2008.

13. Mental health and psychosocial wellbeing among children in severe food shortage situations. Author: World Health Organisation (WHO), Geneva, 2006.

IV. Skills, interventions and action steps

14. Psychological First Aid (PFA): Field Operations Guide (Second edition). Author: National Child Traumatic Stress Network and National Center for PTSD, USA, 2006.

15. Clinical Management of Survivors of Rape: Developing protocols for use with refugees and internally displaced persons (revised edition). Author: WHO/ UNHCR/ UNFPA, Geneva, 2004.

16. After the Wave: A Pilot Project to Develop Mental Health Services in Ampara District, Sri Lanka Post-Tsunami. Authors: Budosan B., Jones, L., Wickramasinghe, W.A.L., Farook, A.L., Edirisooriya, V., Abeywardena, G. & Nowfel, M. J. Sri Lanka, 2007.

17. Cultural Challenges to Psychosocial Counselling in Nepal. Authors: Wietse Tol, Mark Jordans, Sushama Regmi and Bhodendra Sharma, Centre for Victims of Torture, Nepal Transcultural Psychosocial Organization (TPO), Netherlands, Nepal, 2005.

18. Psychological approaches to somatisation in developing countries. Author: Vikram Patel & Athula Sumathipala, India, 2006.

19. Custodial hospitals in conflict situations. Author: World Health Organisation (WHO), Geneva, 2003.

20A. Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care.

20B. "The Alcohol Use Disorders: Identification Test: Guidelines for Use in Primary Care". Author: Department of Mental Health and Substance Dependence, World Health Organisation (WHO), Geneva, 2001.

21. Self-help Strategies for Cutting Down or Stopping Substance Use: A Guide. Author: World Health Organisation (WHO), Geneva, 2003.

V. Care for the caregivers

22. Harmonizing personal, professional and familial life stress management workbook. Author: K. Sekar, S. Bhadra, C. Jayakumar, and K.V. Kishorekumar, National Institute of Mental Health and Neuro Sciences / CARE, Bangalore, India, 2005.

23. Managing stress in humanitarian workers: Guidelines for good practice. Author: Antares Foundation, Netherlands, 2006.

Section I Designing the Training Programme

This section provides trainers with ideas about how to design a training programme. Key information has been extracted from the IASC MHPSS Guidelines 2007 and other texts relating to curriculum development and training programme design.

The IASC MHPSS Guidelines 2007 recommends that a training programme for Health Workers “should accentuate practical instruction and focus on the essential skills, knowledge, ethics and guidelines needed for emergency response.” (IASC MHPSS Guidelines 2007 Action Sheet 4.3). This guide aims to assist trainers in selecting these essential elements from the wealth of information that is available in the sector.

The IASC also recommends that “seminars should be participatory, should be adapted to the local culture and context and should utilise learning models in which participants are both learners and educators.” (IASC MHPSS Guidelines 2007 Action Sheet 4.3). This guide therefore provides a framework for the design of a training programme but it is essential that trainers draw on the existing knowledge and strengths of their participants and ensure that each training operation is unique and specifically designed for the local culture and context .

IASC MHPSS Guidelines for the design of training programmes for health workers

The IASC MHPSS Guidelines recommend that these key actions are necessary for preparing a training programme for all emergency humanitarian workers including health workers:

1. Prepare a strategic, comprehensive, timely and realistic plan for training.

- Plans must be coordinated and integrated between partners and should follow the IASC MHPSS Guidelines.

2. Select competent, motivated trainers.

- Local trainers or co-trainers with prior experience and/or knowledge when they have the necessary knowledge and skills.

3. Utilise learning methodologies that facilitate the immediate and practical application of learning.

- Use participatory teaching style.
- Utilise learning models wherein participants are both learners and educators.
- Train participants in local languages or translation.

- Use audio/visual/reference materials adapted to local conditions.
- Use classrooms for theoretical learning and initial practice of skills.
- Use hands-on field-based training to practise skills in locations like emergency-affected area.
- Distribute written reference materials in accessible language.
- Complete immediate evaluations of training (by trainers, trainees and assisted populations).

(IASC MHPSS Guidelines 2007 Action Sheet 4.3)

Action Sheet 4.3 recommends matching trainees' learning needs with appropriate modes of learning. It recommends the use of:

Brief orientation seminars (half or full-day seminars) which should provide immediate basic, essential, functional knowledge and skills relating to psychosocial needs, problems and available resources to everyone working at each level of response.

Training seminars which provide more extensive knowledge and skills recommended for those working on focused and specialised MHPSS.

- The length and content of training must vary according to trainees' needs and capacities.
- The timing of seminars must not interfere with the provision of emergency response.
- Use of short, consecutive modules for cumulative learning is recommended.
- Training seminars should always be followed up with field-based support and/or supervision.

Action Sheet 4.3 further suggests that trainers “consider establishing Training of Trainers (ToT) programmes to prepare trainers prior to training.”

It also recommends to, “after any training, establish a follow-up system for monitoring, support, feedback and supervision of all trainees, as appropriate to the situation.”

Action Sheet 6.2 recommends that it is important to “avoid overburdening primary health care workers with multiple, different training sessions.” It suggests:

- Trainees should have time to integrate mental health training into their daily practice so that they can deliver mental health care.
- Trainees should not be trained in numerous different skill areas (e.g. mental health, TB, malaria, HIV counselling) without planning how these skills will be integrated and used.

- Theoretical training in short courses is insufficient and may result in harmful interventions. It must always be followed up with extensive on-the-job supervision.

Creating a curriculum for training health workers

Trainers need to decide based on their context, culture and capacities, and those of the health workers they will train, how to best utilise the content presented within the materials in this guide.

Trainers will use these materials differently for every group of health workers they train since all have unique needs. To determine which materials to use within their training, trainers are encouraged to complete an assessment in a timely way to determine the actual needs of each training group.

An assessment of training needs will be completed differently depending on the context. The findings of this assessment will determine the actual content that is necessary within the training curriculum.

The following excerpt on training skills comes from the first recommended materials set: *On the road to peace of mind guidebook: An applied approach to training trainers who train teams to do psychosocial and mental health interventions in developing countries affected by catastrophes.*

“Every training endeavor needs a PLAN including goals, objectives and a detailed curriculum. Training always begins with an assessment and analysis of the needs of a future training group and leads to trainers taking sufficient time to prepare a detailed training plan that fits together goals and objectives with a course structure and curriculum content.”

Assessment of a training group

A training plan begins with an assessment to collect information about the future trainees' existing capacities, strengths, skills, weaknesses, expectations, priorities and needs. Depending on the situation, trainers collect this information directly by asking the future trainees during group or individual meetings or by mail and/or through communication with the training sponsor and other people who know the future trainees.

Some assessment questions include:

- What are the goals and expectations of the training according to the person(s) who requested it and according to the trainees?
- What do the trainees “do” in their work and how will they use this learning?
- What do the trainees want and/or need to learn and why?
- What knowledge, skills and experiences do the trainees already have?
- How will the new learning be integrated into their existing knowledge and work?

- What are their limitations for using their new learning?
- How much time is available for training and using the new learning.

After collecting the information, trainers analyse it to first determine if the group needs training and then if the trainer has the capacity to do this training. If the answers are YES to both then the information collected in the assessment directs the trainers in the design of a plan and curriculum that can specifically respond to the needs of each training group.

Designing a curriculum

A curriculum provides the overall framework for a training course. The overall goals and objectives are tailor-made for each training group. In advance of the training, trainers put extensive time into the design of a curriculum. Once the overall design is made it is broken into sequential steps. Each step becomes a lesson that has its own plan with specific goals, objectives, teaching methodologies and timing. Each lesson teaches a small amount of knowledge or skills but when strategically placed with other lessons forms the steps to fulfil the overall goals of the curriculum.

A group of lessons strategically placed together into a curriculum creates a whole that is far greater than each of its parts.

An outline for a curriculum can be prepared like this:

Content of training (in sequential order)	Training Methodologies	Time Allotted
1.		
2.		
3		

Preparing a curriculum

The curriculum provides the overall framework of a training course. To prepare a curriculum:

- Establish overall purpose, goals and objectives of the training.
- Select content to be included in the curriculum.
- Organize the content and determine what can be taught together as one lesson.
- Order the lessons 1,2,3 etc, sequentially.
- Prepare written lesson plans with clear goals and objectives.
- Choose training methodologies that accord with what is taught in each lesson.
- Determine the time needed for each step in each lesson and fit into the overall time allotted.
- Build in ongoing assessment to verify student learning.

- End each lesson with prepared summary of important points and connect to next lesson.
- End full training with prepared summary of key points leading to goals.
- Ensure that all lessons include how the learning will be applied.
- Include methods for trainer and student evaluations.

Choosing the content of the curriculum

A major challenge for trainers is how they decide what content is essential and should be included in their curriculum. The IASC MHPSS Guidelines recommend that “in an emergency situation, it is most advantageous to only teach essential basic emergency response rather than overwhelm trainees with trying to learn skills that require more time and supervision than is available” (IASC MHPSS Guidelines 2007).

Wener and Bower (1995) add that “a common problem for new trainers is that they try to train every thing they know about a certain topic in the time allotted. There are many things that can be taught about any topic, learning to focus only on what is essential for trainees to learn is a challenge. Trainers learn to not waste time on things that are nice to know but have no purpose. A useful metaphor is that training must hit the center of the Bull’s Eye like in target practice with a gun or bow and arrow. Preparation and practice, teaches trainers how to hit the center or the Bull’s Eye with their training” (Werner & Bower 1995).

Training is not about what trainers want to teach but rather what is essential for their trainees to learn.

Monitoring learning

Building a monitoring system into training to verify that trainees actually learn what is taught is valuable. This can be done through written exercises or by observing the trainees using what is taught.

Summarising learning

Summaries are useful after each major point, at the end of a lesson and at the conclusion of a course. A summary is not the time to add new information or repeat everything that was taught. Rather, summarising helps trainees to remember key

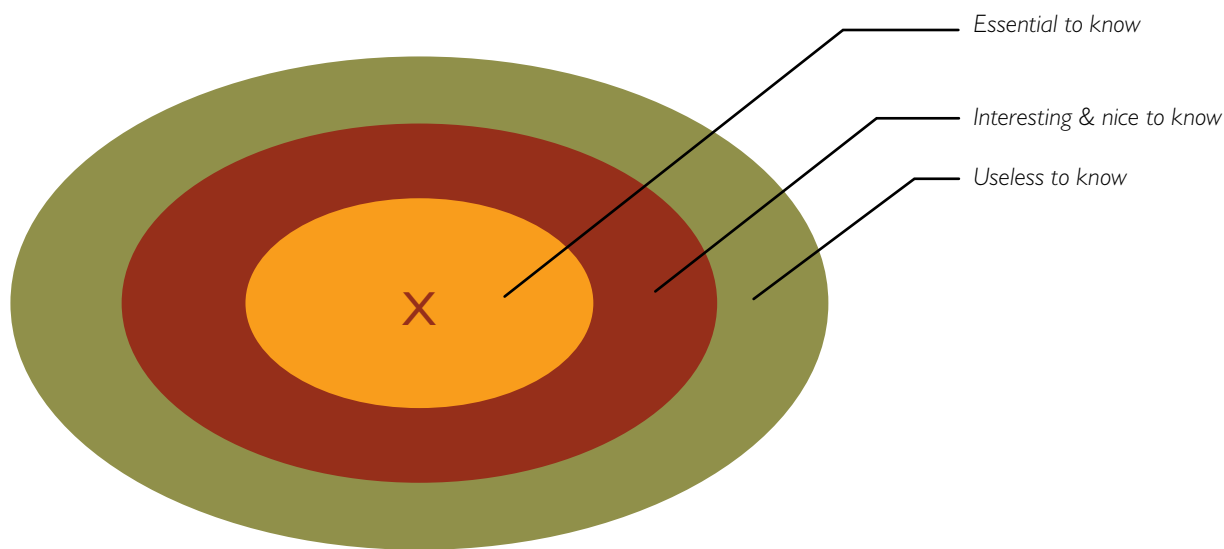
learning, combine knowledge and skills and integrate it into practice when it is continually summarized and tied together. Summaries can be done by the trainer or the trainees or both together. Asking the trainees to summarize provides an opportunity for the trainer to assess what they have learned.

With the information from the assessment, trainers will design their curriculum and decide the training goals, content, number of days and training methodology. Trainers can utilize the materials in this guide to assist them in the design and content of health worker training.

Training methodologies

Trainers can use different training methodologies in their training of health workers. Trainers may also change their methodologies depending who they are training and what is being taught.

Health workers are best trained via an adult learning model. In this model, the adult’s existing knowledge, experience and skills are respected and utilized thereby making the adult both a learner as well as a co-facilitator with the responsibility to educate him or herself and the others within the training programme. Training of adults builds on and enhances what the adult already knows. Adult learning is most effective when the content is practical and can be readily utilized immediately by the learner.



Participatory training methods are used in adult training since they actively engage learners in the process of their learning.

Training methodologies can include:

- Participatory presentations.
- Discussions.
- Experiential learning through the use of case examples, role play, drama, story telling, music, media, etc (Baron N., 2007).

Access to information for trainers

Section 3 includes Appendix I which provides Trainers with an overview of key sections of the IASC MHPSS Guidelines Action Sheets related to Health Workers. It also includes key points from Action Sheet 4.3: Organize orientation, training and supervision of aid workers in mental health and psychosocial support.

Section 3 also includes Table I which provides trainers with an overview of each set of materials recommended in the guide. The following topics, which are essential to the design of a training programme for health workers, are included with reference to relevant materials.

Training Methodologies

- *On the road to peace of mind guidebook: An applied approach to training trainers who train teams to do psychosocial and mental health interventions in developing countries affected by catastrophes.*

Nancy Baron / Global Psycho-Social Initiatives, Kenya (2007).

- *Helping Health Workers Learn: A book of methods, aids, and ideas for instructors at the village level.*
David Werner and Bill Bower / Hesperian Foundation, USA (2004).

Examples of Trainers' Guides

- *Orientation Seminar: General Aid Workers.*
Nancy Baron / IASC MHPSS Reference Group, Geneva (2009).
- *Mental Health and Psychosocial Support in Emergency Operation (For Lady Health Workers).*
WHO / Ministry of Health Pakistan (2006).
- *Mental Health Effects of Disaster and Trauma on Individuals and Communities: Understanding and Intervention.*
Ben Weinstein / Department of Mental Health Ministry of Public Health, Thailand (2004).
- *General manual: Psychiatric nursing care in general health facilities in Eritrea - About awareness and learning basic skills.*
- *Training handbook, A trainer's guide: Psychiatric nursing care in general health facilities in Eritrea - About awareness and learning basic skill.*
Ilse Verkaaik / Healthnet-TPO / Ministry of Health, Eritrea 2006.

Within the materials recommended in this section, trainers acquire ideas about how to design a training programme. Section 2 provides trainers with an overview of the recommended materials from which they can select the content including essential information, skills, interventions and action steps for their training.



Section 2 Essential Information, Skills, Interventions and Action Steps for Training Health Workers

This section provides trainers with a selection of recommended materials from which they can select the content for their training programme. It includes an overview of the essential information, skills, interventions and action steps that health workers need to learn so that they integrate psychosocial and mental health support into their work during emergencies.

In the IASC MHPSS Guidelines, “the composite term mental health and psychosocial support is used (in this document) to describe any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder.”

IASC MHPSS Guideline recommendations for content of training of health workers

The IASC MHPSS Guidelines 2007 recommends that the content for the training of health workers should be “directly related to the expected emergency response.”

The contents recommended in Action Sheet 4.3 for **brief orientation seminars** may include:

- Review of safety and security procedures.
- Methods for workers to cope with work-related problems.
- Codes of conduct and other ethical considerations.
- Human rights and rights-based approaches to humanitarian assistance.
- Importance of empowerment and of involving the local population in relief activities.
- Basic knowledge on impact of emergencies on mental health and psychosocial well-being.
- Techniques for psychological first aid.
- Methods to promote the dignity of the affected population, using lessons learned.
- Knowledge about local socio-cultural and historical context, including:
 - » Basic knowledge about crisis and world view(s) of affected populations.
 - » Basic information about cultural attitudes, practices and social organization.
 - » Basic information on workers' behaviours that might be offensive.

- Information about available sources of referral.
- Information on how and where to participate in relevant inter-agency coordination.

The content of **training seminars** may include:

- All information covered in the orientation seminars.
- Emergency individual, family and community psychosocial and mental health assessment.
- Emergency psychosocial and mental health response techniques that can be taught quickly, based on existing capacities, contexts and cultures of trainees and known to be effective in related contexts.
- Knowledge and skills necessary for implementing interventions that are:
 - (a) part of minimum response and
 - (b) identified as necessary through assessment.

The content that is further recommended for national and international health staff in Action Sheet 6.1 within half-day or, preferably, one-day orientation seminars is:

I. “Psycho-education and general information, including:

- The importance of treating disaster survivors with respect to protect their dignity.
- Basic information on what is known about the mental health and psychosocial impact of emergencies.
- (See Chapter 1), including understanding of local psychosocial responses to an emergency.
- Key conclusions drawn from local mental health and psychosocial support assessments (See Action Sheet 2.1).
- Avoiding inappropriate pathologising/ medicalisation (i.e. distinguishing non-pathological distress from mental disorders requiring clinical treatment and/or referral).
- Knowledge of any available mental health care in the region to enable appropriate referral for people with severe mental disorders (See Action Sheet 6.2).
- Knowledge of locally available social supports and protection mechanisms in the community to enable appropriate referrals (See Action Sheets 5.2 and 3.2).

2. Communicating to patients, giving clear and accurate information on their health status and on relevant services such as family tracing. A refresher on communicating in a supportive manner could include:

- Active listening.
- Basic knowledge on how to deliver bad news in a supportive manner.
- Basic knowledge on how to deal with angry, very anxious, suicidal, psychotic or withdrawn patients.
- Basic knowledge on how to respond to the sharing of extremely private and emotional events, such as sexual violence.

3. How to support problem management and empowerment by helping people to clarify their problems.

4. Brainstorming together on ways of coping, identifying choices and evaluating the value and consequences of choices.

5. Basic stress management techniques, including local (traditional) relaxation techniques.

6. Non-pharmacological management and referral of medically unexplained somatic complaints, after exclusion of physical causes.

7. All aid workers, and especially health workers, should be able to provide very basic Psychological First Aid (PFA).”

According to Action Sheet 6.2 training of health workers should also include:

- “Treating all service users and their caregivers with dignity and respect”.
- The mental status examination.
- Recognition and frontline management of all the severe disorders.

The severe disorders may be *pre-existing or emergency-induced* and include the following conditions:

- » Psychoses of all kinds.
- » Severely disabling presentations of mood and anxiety disorders (including severely disabling presentations of PTSD).
- » Severe mental disorders due to the use of alcohol or other psychoactive substances (see Action Sheet 6.5 for guidance on problems related to substance use).
- » Severe behavioural and emotional disorders among children and youth.
- » Severe pre-existing developmental disabilities.
- » Neuropsychiatric disorders including epilepsy, delirium and dementia and mental disorders resulting from brain injury or other underlying medical conditions (e.g. toxic substances, infection, metabolic disease, tumour, degenerative disease).

- » Any other severe mental health problem, including (a) locally defined severe disorders that do not readily fit established international classification systems (see Action Sheet 6.4) and (b) risk behaviours commonly associated with mental disorder (e.g. suicidal feelings, self-harm behaviour).
- The provision of guidelines and protocols for the above.
- Time management skills, focusing on how to integrate mental health work into normal clinical work.
- Simple practical psychological interventions, as covered in *Where There is No Psychiatrist*.
- Keeping proper clinical records. Give copies to caregivers if possible, as the population may be mobile.
- Maintaining confidentiality. When confidentiality must be broken for protection reasons, address guardianship and medico-legal issues and inform service users and caregivers.
- Setting up appropriate lines of referral to supports in the community (see Action Sheets 5.2 and 6.4) and to secondary and tertiary services if they exist and are accessible.
- For personnel authorised to use medication in the affected country, good prescribing practices include:
 - » Rational use of essential psychiatric drugs in emergency kits, according to the guidelines in *Essential Drugs in Psychiatry* and consistent with *Where There is No Psychiatrist*.
 - » How to facilitate continuing access and adherence to prescribed medication for people with chronic disorders (e.g. chronic psychosis, epilepsy.)
- » How to avoid prescribing psychotropics to people with disaster-induced, non-pathological distress (see Action sheet 6.1) by developing non-pharmacological strategies for stress management.
- » How to avoid prescribing placebo medications for medically unexplained somatic complaints.
- » Understanding both the risks and benefits of benzodiazepines, particularly the risk of dependence from long-term prescribing.
- » How to minimise the unnecessary prescription of multiple medications.
- The management of and support for persons with severe mental disorders who have been chained or physically restrained by caregivers involves the following steps:
 - » First, facilitate very basic means of psychiatric and social care e.g. the provision of appropriate medication, family education and support. Promote humane living conditions.
 - » Second, consider untying the person. However, in those rare instances where the person has a history of violent behaviour, ensure basic security for others before doing so.

Access to information for trainers

The knowledge and skills recommended within the IASC MHPSS Guidelines for inclusion within a training programme for Health Programmes can be found within the following recommended materials.

Appendix 1 within Section 3 includes an overview of IASC MHPSS Guidelines (2007):

- Chapter 1
- Action Sheet 4.3: Organise orientation, training and supervision of aid workers in mental health and psychosocial support.
- Action Sheet 5.4: Facilitate support for young children (0-8 years) and their caregivers.
- Action Sheet 6.1: Include specific psychological and social considerations in provision of general health care.
- Action Sheet 6.2: Provide access to care for people with severe mental disorders.
- Action Sheet 6.3: Protect and care for people with severe mental disorders and other mental and neurological disabilities living in institutions.
- Action Sheet 6.4: Learn about and, where appropriate, collaborate with local, indigenous and traditional healing systems.
- Action Sheet 6.5: Minimise harm related to alcohol and other substance use.

Section 3 Table 1 provides trainers with an overview of the materials included within the guide. The following is an outline of the information, skills, interventions and action steps that trainers will find within the recommended materials.

Information

The following information can be found within the recommended materials.

Mental health and psychosocial consequences of emergencies

- *Inter Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings (Chapter 1)* IASC MHPSS Working Group, Geneva (2007).
- *Advances in Disaster Mental Health and Psychological Support* Edited by Joseph O. Prewitt Diaz and Rashmi Lakshminarayana.

Response to the stress of emergencies

- *Mental Health Effects of Disaster and Trauma on Individuals and Communities: Understanding and Intervention* Ben Weinstein / Department of Mental Health Ministry of Public Health, Thailand (2004).
- *Mental Health Module for Psychosocial Care Givers: Mental Health and Psychosocial Support in Emergency Operation (For Lady Health Workers)* WHO / Ministry of Health, Pakistan (2006).

Overview of mental disorders

- *Where There is No Psychiatrist. A Mental Health Care Manual* Vicram Patel / The Royal College of Psychiatrists, India (2003).
- *Training handbook, A trainer's guide: Psychiatric nursing care in general health facilities in Eritrea - About awareness and learning basic skills.*
- *General manual: Psychiatric nursing care in general health facilities in Eritrea – About awareness and learning basic skills* Ilse Verkaaik / Healthnet –TPO / Ministry of Health, Eritrea (2006).
- *Mental Health Module for Psychosocial Care Givers: Mental Health and Psychosocial Support in Emergency Operation (For Lady Health Workers)* WHO / Ministry of Health, Pakistan (2006).

Needs of children in emergency settings

- *Responding to the needs of children in crisis* Lynne Jones / International Medical Corps (IMC), UK (2008).
- *Mental health and psychosocial wellbeing among children in severe food shortage situations.* WHO, Geneva (2006).

Understanding disabilities in emergency settings

- *Disabilities among refugees and conflict-affected populations* Women's Commission for Refugee Women and Children, Geneva (2008).

Skills, interventions and action steps

The following skills, interventions and actions steps can be found in these recommended materials.

Overview of levels of intervention for mental health and psychosocial support during emergencies

- *Inter Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings* IASC MHPSS Working Group, Geneva (2007).

Psychological First Aid for emergency settings

- *Psychological First Aid (PFA): Field Operations Guide (Second edition).* National Child Traumatic Stress Network and National Center for PTSD, USA (2006).

Examples of psychosocial and psychological support in emergency settings;

Community model of psychosocial support; Monitoring and evaluation tools

- *Advances in Disaster Mental Health and Psychological Support* Edited by Joseph O. Prewitt Diaz and Rashmi Lakshminarayana.

Example of comprehensive emergency mental health response

- *After the Wave: A Pilot Project to Develop Mental Health Services in Ampara District, Sri Lanka Post-Tsunami* Budosan B., Jones,L., Wickramasinghe,W.A.L., Farook, A.L., Edirisooriya, V., Abeywardena, G. & Nowfel, M. J., Sri Lanka (2007).

Managing somatic complaints in developing countries

- *Psychological approaches to somatisation in developing countries* Vikram Patel & Athula Sumathipala, India (2006).

Psychiatric hospital care in emergency settings

- *Custodial hospitals in conflict situations* WHO, Geneva (2003).

Collaboration with local, indigenous and traditional healing systems

- *IASC MHPSS Guidelines Action Sheet 6.4 (2004).*

Treating substance abuse in primary health care

- *Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care.*
- *The Alcohol Use Disorders: Identification Test: Guidelines for Use in Primary Care* WHO, Geneva (2001).
- *Self-help Strategies for Cutting Down or Stopping Substance Use: A Guide* WHO, Geneva (2003).

Management of rape in emergency settings

- *Clinical Management of Survivors of Rape: Developing protocols for use with refugees and internally displaced persons (revised edition).* WHO/ UNHCR/ UNFPA, Geneva (2004).

Skills, roles and responsibilities of mental health

professionals after a disaster;

Basic interventions for early phases of disaster recovery;

Creating effective public education programmes;

Community interventions - promoting community self help;

Helping the helpers

- *Mental Health Effects of Disaster and Trauma on Individuals and Communities: Understanding and Intervention* Ben Weinstein / Department of Mental Health Ministry of Public Health, Thailand (2004).

Individual interventions (relaxation, problem solving, grief counseling and non-pharmacological interventions for pain and sleep disturbances);

Care of special groups (children, adolescents, women, older people, amputees and relief workers)

- *Mental Health and Psychosocial Support in Emergency Operation (For Lady Health Workers)* WHO, Pakistan (2006).

Cultural challenges to psychosocial counselling

- *Cultural Challenges to Psychosocial Counselling in Nepal* Wietse Tol, Mar Jordans, Sushama Regmi, Bhodendra Sharma / Centre for Victims of Torture, Nepal / Transcultural Psychosocial Organization (TPO), Netherlands (2005).

Managing work related stress for individual workers

- *Harmonizing personal, professional and familial life stress management workbook* K. Sekar., Subhasis Bhadra, C. Jayakumar, and K.V. Kishorekumar / National Institute of Mental Health / Neuro Sciences with CARE, India (2005).
- *Mental Health Effects of Disaster and Trauma on Individuals and Communities: Understanding and Intervention* Ben Weinstein / Department of Mental Health Ministry of Public Health, Thailand (2004).

Managing work related stress via organisational practices

- *Managing stress in humanitarian workers: Guidelines for good practice* Antares Foundation, Netherlands (2006).

Trainers can select the content for their training of health workers from the information, skills, interventions and action steps that are presented in the recommended materials reviewed in this section. Section 3 includes a complete overview of all 23 sets of recommended materials.

Section **3** Overview of Materials

This section provides trainers with a table which includes an overview of each of the 23 sets of materials recommended in this guide. By reading the overview, trainers can determine which of the materials are most pertinent to their training and then select which of the materials to utilize in their training. The table includes information about how the trainer can easily access each recommended material set.

The table has been structured with the following headings:

Title Author Date Inclusion in this Guide Accessibility	Goals and purpose of the material How trainers can use the material in the training of health workers	Key learning for trainers and health workers
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The recommended materials are divided into 5 sections:

I. Trainer's skills

The materials in this section can be used by trainers to enhance their skills.

II. International guidelines about MHPSS in emergency settings

The IASC MHPSS Guidelines (2007) provide trainers with essential information that they can use in their training of health workers. APPENDIX I includes an overview of the specific sections of the IASC MHPSS Guidelines that are most useful for training health workers. The 2nd material set in this section highlights the information within the IASC MHPSS Guidelines needed to train "Health Coordinators".

III. Mental health and psychosocial support information for training health workers

The materials in this section complement the information provided in the IASC MHPSS Guidelines 2007. They provide more information about key MHPSS issues that trainers can include in their training of health workers.

IV. Skills, intervention and action steps to train health workers

In this section, the materials provide examples of skills, interventions and action steps that health workers can learn to use to enable them to provide mental health and psychosocial support as an integrated part of health care.

V. Care for the caregivers: Minimizing the stress of health workers

This section's materials provide trainers with information and tools that they can use in their training of health workers about the stress of working in emergency settings and tools that can be used to “care for the caregivers” and minimize this stress.

TABLE I: Overview of the materials recommended to facilitate trainers training health workers to integrate psychosocial and mental health support into health care in emergency settings.

Title Author Date Inclusion in this Guide Accessibility	Goals and purpose of the material How trainers can use the material in the training of health workers	Key Learning
<p>A. Trainer’s Skills</p>	<p>The materials in this section can be used by trainers to enhance their skills.</p>	<p>Trainers can learn about: How to design training seminars and combine content, timing and training methodologies. Participatory training methodologies.</p>
<p style="text-align: center;">I.</p> <p style="text-align: center;">On the road to peace of mind guidebook: An applied approach to training trainers who train teams to do psychosocial and mental health interventions in developing countries affected by catastrophes</p> <p>Nancy Baron Global Psycho-Social Initiatives, Uganda, 2007</p> <p>In this Trainer’s Guide: Overview included in Introduction</p> <p>Available for purchase online at: http://www.microtraining.com/product_info.php?products_id=352</p> <p>Available in 2010 from www.intervention.com</p>	<p>Trainers can enhance their training skills through reviewing this material.</p> <p>“The film ON THE ROAD TO PEACE OF MIND together with the guidebook presents an applied Training of Trainers (TOT) approach. They are designed to educate Trainers about how they can prepare teams to provide psycho-social and mental health assistance for populations in developing countries affected by catastrophes like wars, conflicts, health epidemics and disasters.”</p> <p>Watching the film and reading the guide provides a practical framework for how to train trainers. By modifying it for culture and context, the framework can be applied by trainers for use in training programs around the world.</p> <p>These materials were prepared by a trainer for international groups being trained as trainers.</p>	<ul style="list-style-type: none"> • A 14-step framework for training trainers. • Examples of international training of trainers (TOT) courses • 11 stages for the development of psychosocial and mental health programs in developing countries. • Outline for how to facilitate an applied Training of Trainers including: beginning the TOT; facilitating a cooperative, supportive group process; promoting personal growth and self-confidence; encouraging self-care and management of trainer anxiety; ending the TOT. • Skills to train trainers about how to train including: presentation skills; framework for participatory presentations; framework for discussion; trainers’ tools; preparation of a training plan; preparing a curriculum; skills development in the classroom; practicing skills in the field. • Reading list for further reading about training trainers.

<p style="text-align: center;">2. Helping Health Workers Learn: A book of methods, aids, and ideas for instructors at the village level</p> <p>David Werner and Bill Bower Hesperian Foundation USA, 2004</p> <p>Available for purchase online at: http://www.talcuk.org/books/training-and-education-b.htm</p>	<p>Though not written for emergency settings, this book is an excellent resource for Trainers about training methods that can be used to educate Health Workers in developing countries.</p> <p>It was written as an international tool for health educators.</p>	<p>This illustrated book shows trainers how to make health education engaging and effective, while emphasizing a people-centered community based approach.</p> <p>It presents strategies for how to gain effective community involvement through participatory training.</p>
<p style="text-align: center;">3. Orientation Seminar: General Aid Workers</p> <p>Nancy Baron IASC MHPSS Reference Group Geneva, 2009</p> <p>Available online at: www.psychosocialnetwork.net</p>	<p>This 6 ½ hour IASC MHPSS Orientation Seminar (which can be taught in 1 full day or two half days) provides trainers with an example of how to design a seminar.</p> <p>This seminar was prepared by a consultant and reviewed and accepted for use by the IASC MHPSS Reference Group.</p>	<p>Trainers can learn about how to organise a seminar through this example which includes a clear 6 part structure including:</p> <ol style="list-style-type: none"> 1. Assessment. 2. Establish goals. 3. Seminar Step-by-step: Content that follows goals/ Training methodologies/ Timing/ Practical application/ Way forward/ Summary/ Plan for follow-up. 4. Monitoring of learning during seminar. 5. Reading. 6. Evaluation.

<p>B. International Guidelines About MHPSS in Emergency Settings</p>	<p>The IASC MHPSS Guidelines (2007) provide trainers with much of the essential information that they can use in their training of health workers. Appendix I includes an overview of the specific sections of the IASC MHPSS Guidelines that are most useful for training health workers.</p> <p>Material #5 in this section highlights the information within the IASC MHPSS Guidelines needed to train “Health Coordinators”.</p>	<p>The information provided in the IASC MHPSS Guidelines includes</p> <ul style="list-style-type: none"> • Content and methodology necessary for comprehensive training. • Global research and evidence-supported information about the MHPSS consequences of emergencies. • Internationally accepted concepts about the design and implementation of multiple levels of MHPSS intervention.
<p style="text-align: center;">4. Inter Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings</p> <p>IASC MHPSS Working Group Geneva, 2007</p> <p>In this Trainer’s Guide: APPENDIX I: Overview of:</p> <ul style="list-style-type: none"> • Chapter I • Action Sheet 4.3 • Action Sheet 5.4 • Action Sheet 6.1 • Action Sheet 6.2 • Action Sheet 6.3 • Action Sheet 6.4 • Action Sheet 6.5 <p>Available in multiple languages online at: http://www.who.int/mental_health/emergencies/en/</p>	<p>The IASC MHPSS Guidelines are an essential component in the training of health workers. Trainers should become knowledgeable on the full text and utilise essential sections in their training.</p> <p>The guidelines are important since they provide: A “multi-sectoral, interagency framework that enables effective coordination, identifies useful practices and flags potentially harmful practices, and clarifies how different approaches to mental health and psychosocial support complement one another.”</p> <p>“The core idea behind them is that, in the early phase of an emergency, social supports are essential to protect and support mental health and psychosocial well-being. In addition, the guidelines recommend selected psychological and psychiatric interventions for specific problems.”</p> <p>These guidelines were prepared by the IASC MHPSS Working Group and reviewed and accepted by a wide range of international organizations, experts, educational institutions, governments, etc.</p> <p>The synopsis of the guidelines presented in this trainer’s guide was prepared by the author.</p>	<p>Trainers are directed to utilize Appendix I to find the specific parts of the guidelines most important to training Health Workers from:</p> <ul style="list-style-type: none"> • Chapter I • Action Sheet 4.3: Organize orientation, training and supervision of aid workers in mental health and psychosocial support. • Action Sheet 5.4: Facilitate support for young children (0-8 years) and their caregivers. • Action Sheet 6.1: Include specific psychological and social considerations in provision of general health care. • Action Sheet 6.2: Provide access to care for people with severe mental disorders. • Action Sheet 6.3: Protect and care for people with severe mental disorders and other mental and neurological disabilities living in institutions. • Action Sheet 6.4: Learn about and, where appropriate, collaborate with, local, indigenous and traditional healing systems. • Action Sheet 6.5: Minimise harm related to alcohol and other substance use.

**5.
Mental Health and Psychosocial Support
(MHPSS) In Humanitarian Emergencies:
What Should General Health
Coordinators Know?**

IASC MHPSS Working Group
Geneva, 2008

Available online at:
IASC mhps@who.int

Or

[http://www.reliefweb.int/rw/lib.nsf/db900SID/
EVOD-7EPDYC?OpenDocument](http://www.reliefweb.int/rw/lib.nsf/db900SID/EVOD-7EPDYC?OpenDocument)

Trainers can use the information in this draft document in their training of health coordinators/planners and health workers to inform them about key concepts in mental health and psychosocial support and provide recommendations for best practices during emergency response.

This document was written collaboratively by members of the IASC MHPSS Working Group.

This document provides trainers with the specific information health coordinators/planners should know from the IASC MHPSS Guidelines 2007.

<p>C. Mental Health and Psychosocial Support Information for Training Health Workers</p>	<p>The following materials complement the information provided in the IASC MHPSS Guidelines 2007. They provide information about key MHPSS issues that trainers can include in their training of health workers.</p>	<p>KEY LEARNING</p> <ul style="list-style-type: none"> • Enhance trainers understanding of MHPSS consequences of emergencies for adults and children. • Provide trainers with essential information about key MHPSS issues that they can include in their training. • Provide trainers with examples of how content can be organized in a training seminar to best educate health workers on needed information.
<p style="text-align: center;">4. Repeated: Inter Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings</p> <p>IASC MHPSS Working Group Geneva, 2007</p> <p>In this Trainer's Guide: Appendix I: Overview of: Chapter I</p> <p>Available in multiple languages online at:http://www.who.int/mental_health/emergencies/en/</p>		<p>Trainers are provided with an overview about the consequences of emergencies and recommended levels of intervention within Chapter I. They can use this concise and well organized information in their training of health workers.</p> <p>The information in Chapter I includes:</p> <p>“Armed conflicts and natural disasters cause significant psychological and social suffering to affected populations. The psychological and social impacts of emergencies may be acute in the short term, but they can also undermine the long-term mental health and psychosocial wellbeing of the affected population. These impacts may threaten peace, human rights and development.”</p> <p>“One of the priorities in emergencies is thus to protect and improve people's mental health and psychosocial well-being.”</p> <p>“Achieving this priority requires coordinated action among all government and non-government humanitarian actors.”</p> <p>“Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies erode normally protective supports, increase the risks of diverse problems and tend to amplify pre-existing problems of social injustice and inequality.”</p>

		<p>“In emergencies, not everyone has or develops significant psychological problems. Many people show resilience, that is the ability to cope relatively well in situations of adversity.”</p> <p>“There are numerous interacting social, psychological and biological factors that influence whether people develop psychological problems or exhibit resilience in the face of adversity.”</p> <p>“Affected groups have assets or resources that support mental health and psychosocial well-being. The nature and extent of the resources available and accessible may vary with age, gender, the socio-cultural context and the emergency environment. A common error in work on mental health and psychosocial wellbeing is to ignore these resources and to focus solely on deficits – the weaknesses, suffering and pathology – of the affected group.”</p> <p>“Affected individuals have resources such as skills in problem-solving, communication, negotiation and earning a living. Examples of potentially supportive social resources include families, local government officers, community leaders, traditional healers (in many societies), community health workers, teachers, women’s groups, youth clubs and community planning groups, among many others. Affected communities may have economic resources such as savings, land, crops and animals; educational resources such as schools and teachers; and health resources such as health posts and staff. Significant religious and spiritual resources include religious leaders, local healers, practices of prayer and worship, and cultural practices such as burial rites.”</p> <p>“To plan an appropriate emergency response, it is important to know the nature of local resources, whether they are helpful or harmful, and the extent to which affected people can access them.”</p>
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		<p>IASC MHPSS Guidelines Core Principles:</p> <ol style="list-style-type: none"> 1. Human rights and equity. 2. Participation. 3. Do no harm. 4. Building on available resources and capacities. 5. Integrated support systems: “Activities and programming should be integrated as far as possible. Activities that are integrated into wider systems (e.g. existing community support mechanisms, formal/ non-formal school systems, general health services, mental health services, social services, etc.) tend to reach more people, often are more sustainable, and tend to carry less stigma.” 6. Multi-layered supports: “In emergencies, people are affected in different ways and require different kinds of supports. A key to organising mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups. <p>The interventions recommended at each layer include:</p> <ol style="list-style-type: none"> i. Basic services and security. “The well-being of all people should be protected through the (re)establishment of security, adequate governance and services that address basic physical needs (food, shelter, water, basic health care, control of communicable diseases). These basic services should be established in participatory, safe and socially appropriate ways that protect local people’s dignity, strengthen local social supports and mobilise community networks.” ii. Community and family supports. iii. Focused, non-specialised supports. iv. Specialised services.
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<p style="text-align: center;">3. Repeated: Orientation Seminar: General Aid Workers</p> <p>Nancy Baron IASC MHPSS Reference Group Geneva, 2009</p> <p>Available online at: www.psychosocialnetwork.net</p>	<p>This is an IASC MHPSS Orientation Seminar for General Aid Workers including those working in nutrition and food security, shelter, health workers (not medical staff), protection, and welfare in an emergency settings.</p> <p>Though trainers will determine the specific goals for any Orientation Seminar from an assessment of their specific context, this Seminar provides trainers with an example of a seminar that provides aid workers in an emergency setting with basic knowledge about MHPSS so that they can protect and support people's well-being. This seminar was prepared by a consultant and reviewed and accepted for use by the IASC MHPSS Reference Group.</p>	<p>Trainers can modify this seminar for their context and use it in their training of health workers. It boosts participants' awareness of:</p> <ul style="list-style-type: none"> • The impact of their humanitarian operations on the mental health and psychosocial wellbeing of the people. • How emergencies affect the mental health and psychosocial well-being of a population. • How they can support mental health and psychosocial well-being through their operations. • How to effectively involve an affected population in humanitarian operations. • The importance of collaboration between all partners in bolstering operations that facilitate mental health and psychosocial well-being.
<p style="text-align: center;">6. Advances in Disaster Mental Health and Psychological Support</p> <p>Edited by Joseph O. Prewitt Diaz and Rashmi Lakshminarayana</p> <p>India, 2008</p> <p>Available at: VHAI -- Voluntary Health Association of India Press S-79 Okhla Industrial Area, Phase II New Delhi, India 110020</p> <p>Available online at: http://ocha-gwapps1.unog.ch/rw/RWFiles2006.nsf/FilesByRWDocUnidFilename/KH11-6WD85U-full_report.pdf/\$File/full_report.pdf</p>	<p>Trainers are provided with an excellent guide from theory to practice about mental health and psychological support in disasters within this book.</p> <p>This comprehensive book was written and edited by numerous experts in the field.</p>	<p>The content is divided into four sections.</p> <p>"Section I presents the theoretical bases for mental health and psychosocial support activities following a major disaster.</p> <p>Section II provides the reader with six specific examples of how mental health and psychosocial needs of affected populations have been addressed in Sri Lanka, Lebanon, Iraq, the Philippines, Afghanistan, and Palestine.</p> <p>Section III moves from mental health and psychiatry into a community model of psychosocial support. These sections present a transition from psychiatry to psychosocial support in India and are followed by two case studies; one from Kumbakonam, Tamil Nadu, India, and the other addressing the tsunami response during the acute to early reconstruction phases of the disaster cycle in the south and western provinces of Sri Lanka.</p> <p>Section IV proposes tools for monitoring and evaluation of community-based psychosocial support needs and interventions."</p>

<p style="text-align: center;">7.</p> <p style="text-align: center;">Mental Health Effects of Disaster and Trauma on Individuals and Communities: Understanding and Intervention</p> <p>Ben Weinstein Department of Mental Health Thailand, 2004</p> <p>Available online at: drbweinstein@yahoo.com</p>	<p>This trainer's manual includes the content of a training course that was used to train mental health professionals "to assist effectively in disaster relief efforts" in Thailand in the affected areas in the aftermath of the tsunami.</p> <p>It combines information from a variety of sources "to provide a basic introduction to a variety of mental health concerns that develop following traumatic incidents, with a focus on disaster."</p> <p>It provides trainers with useful, concise and well-organized content for training about mental health consequences and intervention in emergency settings. It does not provide actual lesson plans. Trainers with similar training goals can modify the content in this manual,</p> <p>It was written by a consultant for the Department of Mental Health in Thailand.</p> <p>It was written to conform to the international standards.</p>	<p>Trainers can modify the content in this manual and utilise it in their training of health workers.</p> <p>The content includes:</p> <p>Section 1: Disaster, Extreme Stress and Response Patterns. Section 2: Skills, Roles and Responsibilities of Mental Health Professionals After a Disaster. Section 3: Self Care for Mental Health Professionals. Section 4: Basic Interventions for Early Phases of Disaster Recovery. Section 5: Creating Effective Public Education Programmes. Section 6: Community Interventions- Promoting Community Self Help. Section 7: Helping the Helpers.</p> <p>After completion of the workshop outlined in the manual, participants will be able to:</p> <ol style="list-style-type: none"> 1. Understand the basic mental health effects of disaster and traumatic stress. 2. Understand the importance of supporting natural resiliency in individual and community recovery. 3. Identify the roles and responsibilities of mental health professionals as part of disaster response. 4. Identify normal and pathological responses to traumatic stress. Provide direct assistance to survivors, workers, and volunteers during the emergency and post-impact phases of the disaster recovery. 5. Provide direct assistance and interventions at the community level. 6. Use public education methods to transfer their knowledge about coping with traumatic stress to other groups in the community, including educators, healthcare personnel, community mental health workers, indigenous healers, and community members.
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**8.
Mental Health Module for
Psychosocial Care Givers:
Mental Health and Psychosocial Support in
Emergency Operation
(For Lady Health Workers)**

WHO / Ministry of Health
Pakistan, 2006

Available online at:
[http://www.who.org/pdf/mental_health/
For_lady_health_workers.pdf](http://www.who.org/pdf/mental_health/For_lady_health_workers.pdf)

This training module was designed for use in the aftermath of a major earthquake in North West Pakistan.

The Ministry of Health in Pakistan saw this training as the “first step towards realization of the goal of providing mental health and psychosocial care in an integrated manner within the primary care services.”

Trainers can learn from the design and content in this module which was used to specifically train health workers in an emergency setting in a developing country.

Trainers can modify the content in this manual and utilise it in their training of health workers.

Upon completion the participants are expected to:

- Understand stress responses to earthquakes and the process of grief following the human and material losses sustained by the survivors.
- Be able to differentiate between distress and mental disorders.
- Be able to provide basic psychosocial support.
- Be able to identify common mental disorders seen amongst the survivors.
- Be able to identify those people who require referral for specialist assistance.
- Be able to educate the community about mental health and psychosocial issues commonly encountered by the surviving community members.

The training module content includes:

1. Introduction.
2. Normal Stress Response.
3. Differentiation between Stress and Distress.
4. Differentiation between Distress and Disorder.
5. Grief and Bereavement.
6. Individual Interventions
(*Relaxation , problem solving, .Grief counseling and non-pharmacological interventions for pain and sleep disturbances*).
7. Identification, and referral of common mental disorders
(*Post Traumatic Stress Disorder, Anxiety disorders, depressive illness, psychosis, substance abuse disorders And epilepsy*).
8. Care of Special Groups
(*children, adolescents, women, the elderly, amputees and relief workers*).

9.
Where There is No Psychiatrist.
A Mental Health Care Manual

Vicram Patel
The Royal College of Psychiatrists
India, 2003

Available at:
www.globalmentalhealth.org

<http://www.rcpsych.ac.uk/publications/gaskellbooks/gaskell/1901242757.aspx>

This is a comprehensive manual about mental health care and is highly recommended.

Even though mental illnesses are common and cause great suffering in every part of the world, many health workers have a limited understanding about mental health and are less comfortable dealing with mental illness. This book is a practical manual for mental health care for the community health worker, the primary care nurse, the social worker and the primary care doctor, particularly in developing countries.

The following is an abbreviated overview of some of the content that trainers will find in this manual.

Part I. An overview of mental illness

1. An introduction to mental illness

- Mental health and mental illness.
- Common mental disorders.
- 'Bad habits'.
- Severe mental disorders (psychoses).
- Mental retardation.
- Mental health problems in the elderly.
- Mental health problems in children.
- Culture and mental illness.

2. Assessing someone with a mental illness

3. The treatment of mental illness

- Drug treatments.
- Talking treatments and counselling.
- Relaxation and breathing exercises.
- Problem-solving.
- Counselling in a crisis.
- The importance of follow-up treatment.
- Referring to a mental health specialist.

Part II. Clinical problems

4. Behaviours that cause concern

- The person who is aggressive or violent.
- What are the causes of confusion and agitation?
- The person who is suspicious, has odd beliefs or is hearing voices.
- The person who is thinking of suicide or has attempted suicide.
- Loneliness and isolation.
- Someone with seizures or fits.
- The mother who becomes disturbed after childbirth.

		<p>5. Symptoms that are medically unexplained</p> <ul style="list-style-type: none"> • The person with multiple physical complaints. • The person who worries, gets scared or panics. • The person with sleep problems (insomnia). • The person who is tired all the time. • The person who complains of sexual problems. <p>6. Habits that cause problems</p> <ul style="list-style-type: none"> • The person who drinks too much alcohol. • The person who is abusing drugs. <p>7. Problems arising from loss and violence</p> <ul style="list-style-type: none"> • The person who has experienced a traumatic event. • Why do some victims of violence develop mental illness? • How do women suffering domestic violence present to health workers? • The woman who has been raped or sexually assaulted. • When men get raped. • The person who has been bereaved. <p>8. Problems in childhood and adolescence</p> <p>Part III. Integrating mental health</p> <p>9. Mental health in other contexts</p> <ul style="list-style-type: none"> • Primary and general health care. • Mental disorders in primary care. • Primary mental health care. • Maternal health and mental health. • The mental health of refugees. • Children involved in war. • Disasters. • Disasters and mental health. • Integrating mental health with disaster relief. • HIV/AIDS. • Promoting the mental health of carers. • The mental health of health workers. <p>10. Mental health promotion and advocacy</p> <p>Part IV. Localising this manual for your area</p> <p>Appendix. Flow charts for clinical problem-solving</p>
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**I0A.
Training handbook:
A trainer's guide: Psychiatric nursing care
in general health facilities in Eritrea - About
awareness and learning basic skills -**

**I0B.
General manual:
Psychiatric nursing care in general health
facilities in Eritrea - About awareness and
learning basic skills -**

Ilse Verkaaik
Healthnet –TPO / Ministry of Health
Eritrea, 2006

Available online at:
[http://www.healthnettpo.nl/HealthnetTPO\(EN\)/
CORE/00/03/F0.HTML](http://www.healthnettpo.nl/HealthnetTPO(EN)/CORE/00/03/F0.HTML)

Although this training programme was not designed for an emergency setting, trainers will find the information about mental disorders and the methods with which they are taught useful. Trainers with similar training goals could modify the content and add emergency setting information.

This handbook and manual were written by a consultant working with an NGO and collaborating with the Ministry of Health in Eritrea.

Eritrea is a developing country with limited psychiatric treatment and general hospitals provided no psychiatric care.

The purpose of the NGO's programme, for which the the handbook and manual were designed, was "to provide a continuous education programme for general nurses in mental health" to make them "aware that care for psychiatric patients is a part of their job, in order to contribute to the primary and secondary prevention of mental illness among the Eritrean population."

The goal of training general nurses was to "provide them with basic knowledge about the most prevalent mental health disorders, symptoms and treatment in order to have early recognition of mental health problems" and "some basic nursing skills, knowledge and attitudes that they can apply to prevent worsening of psychiatric symptoms and problems."

The training course included general nurses, senior nurses, head nurses, administrators, matrons, and other staff of general hospitals and other health facilities divided in groups of about 20-25 persons per training. Each group was trained for 2-3 days.

The training handbook includes lesson plans with lectures, handouts, and overhead presentations about each topic. The training used a participatory style "since the aim is to change attitudes towards psychiatric patients. It included "participatory lectures, some group work or individual assignments."

Trainers will find useful information in this training course via the trainer's guide and general manual

The training covers:

- Introduction to mental health.
- Stress and relaxation.
- Anxiety responses and anxiety disorders.
- Depression and suicide.
- Psychosis.
- Post-partum mental disorders.
- Alcohol and addiction.
- Somatoform disorders and sleeping problems.
- Epilepsy.

II. Disabilities among refugees and conflict-affected populations

Women's Commission for Refugee Women
and Children
Geneva, 2008

Available online at:
<http://reliefweb.int/rw/lib.nsf/db900SID/FBUO-7MPHPX?OpenDocument>

This report presents the special issues of persons with disabilities and need for special consideration for their health care in emergency settings globally.

Trainers can utilise the information in this report about disabilities in emergency settings in their training of health workers.

Highlighted by the report:

'The World Health Organization (WHO) estimates that between 7 and 10 percent of the world's population live with disabilities. As such, it can be assumed that between 2.5 and 3.5 million of the world's 35 million displaced persons also live with disabilities. Among displaced persons who have fled civil conflict, war or natural disasters, the number with disabilities may be even higher.

Yet, persons with disabilities "remain among the most hidden, neglected and socially excluded of all displaced people today. People with disabilities are often literally and programmatically "invisible" in refugee and internally displaced persons (IDP) assistance programmes."

They are not identified or counted in refugee registration and data collection exercises; they are excluded from or unable to access mainstream assistance programmes as a result of attitudinal, physical and social barriers; they are forgotten in the establishment of specialized and targeted services; and they are ignored in the appointment of camp leadership and community management structures.

Disabled persons' potential to contribute and participate is seldom recognized: they are more often seen as a problem than a resource.

Moreover, traditional community coping mechanisms, including extended families, neighbors and other caregivers, often break down during displacement. The loss of caregivers can leave persons with disabilities extremely vulnerable and exposed to protection risks.

All the field surveys cited in this report show a lack of specialised health care, psychosocial support and counseling services for persons with disabilities. There were no specialized doctors, no specialist therapy and a lack of specialized medicines and treatments. Moreover, there were generally no referrals to specialist services outside the camps.

Nearly all the refugees surveyed said that health clinics were often physically inaccessible for persons with disabilities and that they had to line up for long periods and were not given priority treatment.

		<p>Many disabled people and their families said that they were suffering from increased levels of isolation, depression and mental health problems since becoming refugees, but there were no or very limited psychosocial services available.</p> <p>One positive finding in all the countries' situations surveyed was that women with disabilities had access to reproductive health care. There were also positive examples of community health care and outreach programmes (especially in refugee camps).'</p>
<p style="text-align: center;">12. Responding to the needs of children in crisis</p> <p>Lynne Jones International Medical Corps (IMC) UK, 2008</p> <p>Available at: International Review of Psychiatry, 20:3, 291 — 303</p> <p>Available online at: http://dx.doi.org/10.1080/09540260801996081</p>	<p>Trainers can learn about the needs and problems of children affected by emergencies and effective forms of intervention.</p> <p>"This paper explores the issues confronting service providers setting up child and family mental health programmes in conflict, post-conflict and disaster areas."</p> <p>It presents an "approach recommended by the Inter Agency Standing Committee Guidelines for Mental health and Psychosocial Support in Emergency Settings."</p>	<p>This paper presents trainers with the needs and problems of children affected by emergencies.</p> <p>"Drawing on clinical experience and research in humanitarian settings, it (this paper) calls for greater attention to the child's perspective, their individuality and the cultural, social and political context in which they live."</p> <p>"It argues that those concerned with the psychopathology of children in crises should widen their frame of reference beyond narrowly defined traumatic reactions to include other mental health and psychosocial issues, including the current problems of daily life and the needs of children with pre-existing psychiatric disorders."</p> <p>"It recommends culturally valid means of assessment, the creation of age-appropriate services and training for primary healthcare workers."</p> <p>"Children's mental health needs in crises are varied, complex and intimately connected with their needs for security, food, shelter, education and family connection."</p> <p>"This requires holistic, rights-based approaches that can access resources to address basic needs, advocate for security and protection, and recognize and address the needs of the more vulnerable children."</p>

**13.
Mental health and psychosocial
well-being among children in severe
food shortage situations**

WHO
Geneva, 2006

Available online at:
[http://www.who.int/nmh/publications/msd_](http://www.who.int/nmh/publications/msd_MHChildFSS9.pdf)
[MHChildFSS9.pdf](http://www.who.int/nmh/publications/msd_MHChildFSS9.pdf)

A severe food shortage, which is common during emergencies, can “threaten the nutritional status of communities. This can cause malnutrition among affected populations including micronutrient deficiencies. Such deficiencies can inhibit intellectual and physical potential and cause lifelong disability.”

In emergencies, “many caregivers are unavailable or unable to provide psychosocial stimulation to their children during food crises due to their own poor physical or mental health. A lack of psychosocial stimulation has adverse consequences for children’s development (cognitive, motor, language) and mental health.

This paper provides trainers with easy to understand information about the importance of nutrition and stimulation to children and action steps that health workers can take in emergency settings.

Action steps in this article that trainers can recommend to health workers include:

- Attempts should be made to ensure that all households have an adequate quantity and quality of food.
- Information on appropriate feeding practices and the importance of psychosocial stimulation should be disseminated.
- Psychosocial support and education regarding appropriate feeding practices should be provided to caregivers.
- Breast milk is an ideal food for healthy growth and development. Breastfeeding women may need care, encouragement, and psychological support to continue breastfeeding.
- Children who are moderately or severely malnourished should be referred for combination nutrition/stimulation programmes.

Combination nutrition/stimulation programmes that emphasize appropriate feeding practices and responsive parenting (e.g., proactive stimulation and appropriate responses) have a greater impact than either intervention alone.

<p>D. Skills, Interventions and Action Steps to Train Health Workers</p>	<p>The following materials provide examples of specific skills, interventions and action steps that health workers can learn to use to enable them to provide mental health and psychosocial support as an integrated part of health care.</p>	<ul style="list-style-type: none"> • Enhances trainers’ knowledge about various skills, interventions and action steps that can be used by health workers to provide mental health and psychosocial support in emergency settings. • Addresses: Psychological First Aid (PFA), Clinical Management of Rape, Psychosocial Counseling, Dealing with somatisation, Protecting patients in a custodial hospital, Informing people how to manage alcohol and substance abuse.
<p>14. Psychological First Aid (PFA): Field Operations Guide (Second edition)</p> <p>National Child Traumatic Stress Network and National Center for PTSD USA, 2006</p> <p>Available online at: http://ncptsd.va.gov/ncmain/ncdocs/manuals/nc_manual_psyfirstaid.html</p>	<p>The IASC MHPSS Guidelines recommend that “All aid workers, and especially health workers, should be able to provide very basic psychological first aid (PFA).” “Some forms of psychological support (i.e. very basic psychological first aid) for people in acute psychological distress do not require advanced knowledge and can easily be taught to workers who have no previous training in mental health.”</p> <p>This guide provides trainers with detailed information about how to do Psychological First Aid (PFA) using a modular approach to help children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism.</p> <p>“PFA is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping. It does not assume that all survivors will develop severe mental health problems or long-term difficulties in recovery. Instead, it is based on an understanding that disaster survivors and others affected by such events will experience a broad range of early reactions (for example, physical, psychological, behavioral, spiritual). Some of these reactions will cause enough distress to interfere with adaptive coping, and recovery may be helped by support from compassionate and caring disaster responders.”</p> <p>A revision of this material is presently underway and should be available via www.who.int in 2010.</p>	<p>The Guide provides Trainers with detailed information about PFA.</p> <p>Basic Objectives of Psychological First Aid</p> <ul style="list-style-type: none"> • Establish a human connection in a non-intrusive, compassionate manner. • Enhance immediate and ongoing safety, and provide physical and emotional comfort. • Calm and orient emotionally-overwhelmed or distraught survivors. • Help survivors to tell you specifically what their immediate needs and concerns are, and gather additional information as appropriate. • Offer practical assistance and information to help survivors address their immediate needs and concerns. • Connect survivors as soon as possible to social support networks, including family members, friends, neighbors, and community helping resources. • Support adaptive coping, acknowledge coping efforts and strengths, and empower survivors; encourage adults, children and families to take an active role in their recovery. • Provide information that may help survivors cope effectively with the psychological impact of disasters. • Be clear about your availability, and (when appropriate) link the survivor to another member of a disaster response team or to local recovery systems, mental health services, public sector services, and organisations. <p>How to do Psychological First Aid (PFA) / Guidelines for Delivering Psychological First Aid</p> <ul style="list-style-type: none"> • Politely observe first, don’t intrude. Then ask simple respectful questions to determine how you may help.

- Often, the best way to make contact is to provide practical assistance (food, water, blankets).
- Initiate contact only after you have observed the situation and the person or family, and have determined that contact is not likely to be intrusive or disruptive.
- Be prepared that survivors will either avoid you or flood you with contact.
- Speak calmly. Be patient, responsive, and sensitive.
- Speak slowly, in simple concrete terms; don't use acronyms or jargon.
- If survivors want to talk, be prepared to listen. When you listen, focus on hearing what they want to tell you, and how you can be of help.
- Acknowledge the positive features of what the survivor has done to keep safe. Give information that directly addresses the survivor's immediate goals and clarify answers repeatedly as needed.
- Give information that is accurate and age-appropriate for your audience.
- When communicating through a translator or interpreter, look at, and talk to, the person you are addressing, not at the translator or interpreter.
- Remember that the goal of Psychological First Aid is to reduce distress, assist with current needs, and promote adaptive functioning, not to elicit details of traumatic experiences and losses.

Some Behaviors to Avoid

- Do not make assumptions about what survivors are experiencing or what they have been through.
- Do not assume that everyone exposed to a disaster will be traumatized.
- Do not pathologize. Most acute reactions are to be expected given what people exposed to the disaster have experienced.
- Do not label reactions as "symptoms," or speak in terms of "diagnoses," "conditions," pathologies," or "disorders."

**15.
Clinical Management of Survivors of Rape:
Developing protocols for use with refugees
and internally displaced persons
(revised edition)**

WHO/ UNHCR/ UNFPA
Geneva, 2004

Available online at:
<http://www.preventgbv africa.org/content/ revised-and-updated-clinical-management-rape- survivors-developing-protocols-use-refugees-and>

Sexual and gender-based violence, including rape, is a problem throughout the world, occurring in every society, country and region. Refugees and internally displaced people are particularly at risk of this violation of their human rights during every phase of an emergency situation. The systematic use of sexual violence as a method of warfare is well documented and constitutes a grave breach of international humanitarian law.

“This guide is intended for use by qualified health care providers (health coordinators, medical doctors, clinical officers, midwives and nurses) in developing protocols for the management of rape survivors in emergencies, taking into account available resources, materials, and drugs, and national policies and procedures. It can also be used in planning care services and in training health care providers. This guide provides trainers with “best practices in the clinical management of people who have been raped in emergency situations. It is intended for adaptation to each situation, taking into account national policies and practices, and availability of materials and drugs.”

This is an easy to use guide with clear information and action steps. Trainers can use it to learn information about sexual and gender-based violence in emergencies that they can train to Health Workers. They can also learn action steps that Health Workers can use to assist survivors of rape, their families and communities.

This guide details the following protocol steps:
STEP 1 - Making preparations to offer medical care to rape survivors.
STEP 2 – Preparing the survivor for the examination.
STEP 3 – Taking the history.
STEP 4 – Collecting forensic evidence.
STEP 5 – Performing the physical and genital examination.
STEP 6 – Prescribing treatment.
STEP 7 – Counselling the survivor.
STEP 8 – Follow-up care of the survivor.
STEP 9 - Care for child survivors.
ANNEX 1 – Additional resource materials.
ANNEX 2 – Information needed to develop a local protocol.
ANNEX 3 – Minimum care for rape survivors in low-resource settings.
ANNEX 4 – Sample consent form.
ANNEX 5 – Sample history and examination form.
ANNEX 6 – Pictograms.
ANNEX 7 – Forensic evidence collection.
ANNEX 8 - Medical certificates.
ANNEX 9 – Protocols for prevention and treatment of STIs.
ANNEX 10- Protocols for post-exposure prophylaxis of HIV infection.
ANNEX 11– Protocols for emergency contraception.

The guide details essential components of medical care after a rape, and covers:

- Documentation of injuries.
- Collection of forensic evidence.
- Treatment of injuries.
- Evaluation for sexually transmitted infections (STIs) and preventive care.
- Evaluation for risk of pregnancy and prevention.
- Psychosocial support, counselling and follow-up.

The guide suggests these actions towards developing a protocol for medical care of rape survivors (not necessarily in this order):

- Identify a team of professionals and community members who are involved or should be involved in caring for people who have been raped.
- Convene meetings with health staff and community members.

		<ul style="list-style-type: none"> • Create a referral network between the different sectors involved in caring for rape survivors (community, health, security, protection). • Identify the available resources (drugs, materials, laboratory facilities) and the relevant national laws, policies and procedures relating to rape. (standard treatment protocols, legal procedures, laws relating to abortion, etc.) • Develop a situation-specific health care protocol, using this guide as a reference document. • Train providers to use the protocol, including what must be documented during an examination for legal purposes.
<p style="text-align: center;">16. After the Wave: A Pilot Project to Develop Mental Health Services in Ampara District, Sri Lanka Post-Tsunami</p> <p>Budosan B., Jones,L., Wickramasinghe,W.A.L., Farook, A.L., Edirisooriya, V., Abeywardena, G. & Nowfel, M. J. Sri Lanka, 2007</p> <p>Available online at: http://jha.ac/2007/09/16/after-the-wave-a-pilot-project-to-develop-mental-health-services-in-ampara-district-sri-lanka-post-tsunami/</p>	<p>Trainers can learn here how a programme for training primary health care professionals in mental health care service delivery in Sri Lanka was designed, implemented and evaluated. Sri Lanka is a developing country and was one of the locations most severely affected by the tsunami. This paper documents the successes and failures of this programme.</p> <p>The overall goal of this mental health training programme described in this paper was “to improve the emotional and psychological health status of tsunami-affected communities” in Sri Lanka.</p> <p>The objective was to increase the mental health capacity of Divisional Medical Officers of Health and to enable them to become trainers of their mid-level PHC health care staff (public health midwives and public health inspectors), so that all were able to deliver clinical services.”</p> <p>“The model focused on partnerships with key local and international health players, and was developed in line with Inter-Agency Standing Committee (IASC) guidelines on mental health and psychosocial support in emergency settings.”</p> <p>“It was designed to have a long lasting effect by initiating a long-term, comprehensive training programme conducted in a primary care setting.”</p>	<p>The training programme reviewed in this paper included the following core elements:</p> <ul style="list-style-type: none"> • competence in listening and other communication skills. • training in properly recognising mental health problems in a community. • teaching established mental health interventions. • providing strategies for problem-solving. • training in the treatment of medically unexplained somatic pain. • learning to collaborate with existing local resources, e.g. indigenous healers. <p>“In the observation of the practical performance of the field of trainees who completed the course it was found that they had good communication skills, respect for the patients, and a good working knowledge of referral procedures. The majority provided clear instructions and explanations to the patient, were able to make correct psychiatric diagnosis, and took appropriate decisions regarding medication and treatment.”</p> <p>“Trainees proved only partially satisfactory and needed further training in their performance regarding taking relevant medical history, performing appropriate mental health examinations, and keeping complete mental health records. Time constraints and patient workload were the main reasons why trainees usually did not have sufficient time to spend with each patient.”</p> <p>“Another challenge was the cultural style of “Western” NGOs. Patience, endurance, and self-control are highly appreciated personal qualities in Sri Lanka. The goal-orientation of international NGOs with tight deadlines and funding constraints sometimes led to clashes and frustration in implementation.”</p>

17.
**Cultural Challenges to Psychosocial
Counselling in Nepal**
**Wietse Tol, Mar Jordans, Sushama Regmi,
Bhodendra Sharma**

Centre for Victims of Torture, Nepal
Transcultural Psychosocial Organization (TPO),
Netherlands
Nepal, 2005

Available online at:
[http://tps.sagepub.com/cgi/content/
abstract/42/2/317](http://tps.sagepub.com/cgi/content/abstract/42/2/317)

Available journal at:
Transcultural Psychiatry 2005; 42; 317

This article describes the way in which “the practice of psychosocial counselling was adapted culturally to the context of Nepal”. Nepal is a developing country which has been riddled by emergencies for many years. The article describes methods of dealing with psychosocial problems and the cultural challenges of implementing psychosocial counseling.

The IASC MHPSS Guidelines state:
“The way in which health care is provided often affects the psychosocial wellbeing of people living through an emergency. Compassionate, emotionally supportive care protects the wellbeing of survivors, whereas disrespectful treatment or poor communication threatens dignity, deters people from seeking health care and undermines adherence to treatment regimes, including for life-threatening diseases such as HIV/AIDS.”

It highlights the importance of:
“Communicating to patients, giving clear and accurate information on their health status and on relevant services such as family tracing”.

A refresher on communicating in a supportive manner could include:

- Active listening.
- Basic knowledge on how to deliver bad news in a supportive manner.
- Basic knowledge on how to deal with angry, very anxious, suicidal, psychotic or withdrawn patients.
- Basic knowledge on how to respond to the sharing of extremely private and emotional events, such as sexual violence.

This article describes the difficulties of implementing “psychosocial counseling”. Trainers can, in particular, learn from one programme’s experience summarized as follows:

“In the very beginning of implementing training programmes in a country with extremely few mental health resources, CVICT opted for short-term training programmes with a training-of-trainers (TOT) structure. These training programmes were deemed ineffective, as psychosocial counselling skills (which usually only meant basic communication skills) were only superficially learned (and not practiced), and students were required to teach their barely learned skills to new students. Moreover, training was performed by expatriates, flown in for the purpose, with a minimal knowledge of cultural issues and who were thus insensitive to important issues hampering effective implementation in Nepal.”

“In our opinion, 10-day training programmes in psychosocial counselling taught by someone who does not know the cultural context of Nepal and which are designed to train trainers are not effective. ‘Trainers’ resulting from these programmes do not learn sufficient skills themselves and can thus not impart them to others. ‘Counsellors’ are confronted with clients’ problems that are too difficult for them to deal with and there is a significant danger of harm being done to both the ‘counsellor’ and the help-seeker.

After determining that the short-term training programmes were ineffective, a different approach was chosen. A longer term 5-month training programme was offered, in which students could practice their skills with real clients, under clinical supervision.

Problem solving (Egan, 1998), emotional support in a therapeutic relationship offering trust and hope, and a focus on skills (Ivey & Ivey, 1999) were chosen as the main components, because these seemed most culturally compatible and concrete.”

	<p>How to support problem management and empowerment by helping people to clarify their problems, brainstorming together on ways of coping, identifying choices and evaluating the value and consequences of choices;</p> <p>Basic stress management techniques, including local (traditional) relaxation techniques;"</p> <p>It is important to note that it does not recommend that health workers should become "counselors". This article describes the ineffectiveness of workers trained in short term "counseling" courses. This article describes what is necessary to train workers to be effective "psychosocial counselors".</p>	<p>In this model, "psychosocial counselling starts with the complaints that a client brings into the session, and is aimed at decreasing disability. The client is assisted in dealing with problems himself/herself within a counselling process, or is sometimes referred to traditional healers or other existing resources if the counsellor feels that to be more appropriate. Specifically, the counseling process consists of: (i) introduction, explanation and rapport building; (ii) assessment of and understanding of the problem (including looking for positive assets); (iii) goal setting (asking the client what outcomes are preferred); (iv) problem management (exploring and identifying solutions, brainstorming, working with existing coping strategies, using social and cultural resources, and additional techniques such as relaxation and psycho-education); (v) implementation (making a plan of action and transition); and, finally, (vi) termination of counselling (including closing and follow-up)."</p> <p>Throughout this article, case vignettes illustrate the counselling model.</p>
<p style="text-align: center;">18. Psychological approaches to somatisation in developing countries</p> <p>Vikram Patel & Athula Sumathipala India, 2006</p> <p>Available in: <i>Advances In Psychiatric Treatment</i>, 2006, vol. 12, pp. 54–62</p>	<p>This article presents trainers with a possible model that can be modified for clinical use in primary health care settings in developing countries globally with patients with somatic complaints.</p> <p>It presents a cognitive-behavioural intervention used in Sri Lanka, and delivered by primary care physicians to patients with somatic complaints.</p> <p>This article is not written about emergencies, but since somatization is a common occurrence in emergencies, the information can be modified by trainers and utilized.</p>	<p>Trainers can learn here about causes, consequences and treatment for somatization.</p> <p>This article notes that "medically unexplained somatic complaints are among the most common clinical presentations in primary care in developing countries and result in a considerable burden for patients and the healthcare system.(...) Prominent among these complaints are: fatigue and tiredness; aches and pains, notably headaches and generalised body pains; and abdominal discomfort.(...) Some complaints appear to occur within specific cultural contexts. Cultural factors may influence the way a somatic complaint is described."</p>

		<p>The article makes the point that somatization has often been assumed to be “a characteristic of mental disorder in non-Western societies and that this was because non-Western cultures were less accepting of psychological symptoms and mental illness. However, it is now acknowledged that somatic presentations are characteristic of all cultures and, furthermore, that the psychological symptoms of common mental disorders can often be elicited on enquiry (Patel et al, 1998; Araya et al, 2001). Thus, somatization is a universal phenomenon...”</p> <p>The article “identified trials using problem-solving therapy, cognitive therapy, cognitive-behavioural therapy, reattribution training and brief dynamic psychotherapy for the management of functional somatic symptoms; the most frequently used for this purpose is cognitive-behavioural therapy.”</p> <p>“There is evidence suggesting that cognitive-behavioural therapy, which has proven efficacy for somatoform disorders in the developed world, can be used in developing countries with some adaptations (e.g. by simplifying the content so that it can be applied in primary care by non-specialist health practitioners; using culturally appropriate analogies; and delivering the intervention over fewer and shorter sessions). The main components of such an intervention are presented in this article.”</p>
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19.
**Custodial hospitals in
conflict situations**

WHO
Geneva, 2003

Available online at:
[http://www.who.int/mediacentre/
background/2003/back4/en/print.html](http://www.who.int/mediacentre/background/2003/back4/en/print.html)

This paper provides trainers with essential information for health workers about the necessity of protection and treatment of patients in custodial hospital settings during conflict and how they can best assist.

It states: "during emergencies - such as wars - children, women, the elderly, the disabled and persons with severe physical or mental disorders are all rightly considered as belonging to vulnerable groups. Persons in custodial psychiatric hospitals may be among the most vulnerable for at least three reasons. First, they tend to live in physical isolation from their families. Second, they are less likely to receive help from community members because of misplaced public fear of people with mental disorders and because of social stigmas. Third, some persons in custodial psychiatric hospitals may have become too dependent on custodial care to feasibly move and settle elsewhere if necessary during conflict."

Trainers can draw from this resource an outline of the responsibilities of public health officials during emergencies with respect to custodial hospitals

- 'all health facilities, staff and patients should receive special protection. The public health official must ensure that custodial psychiatric hospitals are not excluded from such protection.
- Hospitals should have in place a crisis contingency plan. Such a plan should outline assignment of responsibility and mechanisms to carry out care during emergencies and evacuation if needed. If the institution contains locked facilities or cells, contingency plans should describe a hierarchy of responsibility for keys to ensure that doors can be unlocked at any given time.
- The public health official must ensure that the basic physical needs of patients are met.
- During emergencies the public health official should implement or strengthen human rights surveillance in institutions.
- The public health official should ensure at least basic mental health care to patients throughout the emergency.

"After the emergency: In the aftermath of an acute emergency, there is frequently impetus to develop and implement new mental health programmes. This may be an opportune time to make a paradigm shift towards gradually phasing out existing custodial psychiatric hospitals and to developing community services for people with severe mental disorders."

<p style="text-align: center;">20A. Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care</p> <p style="text-align: center;">20B. “The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care”</p> <p>Department of Mental Health and Substance Dependence WHO Geneva, 2001</p> <p>Available online at: http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf</p>	<p>Trainers can use these manuals to develop a comprehensive approach to alcohol screening and brief intervention in primary health care.</p> <p>Though the manuals were not designed for emergency settings, trainers can modify them since alcohol and substance abuse are reported to be serious problems in many emergency settings.</p> <p>The manuals were written “to help primary care workers - physicians, nurses, community health workers, and others – to deal with persons whose alcohol consumption has become hazardous or harmful to their health. Its aim is to link scientific research to clinical practice by describing how to conduct brief interventions for patients with alcohol use disorders and those at risk of developing them. The manuals may also be useful for social service providers, people in the criminal justice system, mental health workers, and anyone else who may be called on to intervene with a person who has alcohol-related problems.”</p> <p>The supplementary manual entitled “The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care”. describes how to screen for alcohol-related problems in primary health care.</p>	<p>These manuals provide trainers with information about the identification and treatment of alcohol abuse, including:</p> <ul style="list-style-type: none"> • Roles and Responsibilities of Primary Health Care. • SBI: A Risk Management and Case Finding Approach. • Alcohol Education for Low-Risk Drinkers. • Abstainers and Others. • Simple Advice for Risk Zone II Drinkers. • Brief Counselling for Risk Zone III Drinkers. • Referral for Risk Zone IV Drinkers with Probable Alcohol Dependence. • Appendix. <p>A. Patient Education Brochure. A Guide to Low-Risk Drinking. B. Self-Help Booklet. C. Training Resources.</p>
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**21.
Self-help Strategies for Cutting Down or
Stopping Substance Use: A Guide**

WHO
Geneva, 2003

Available online at:
[http://www.who.int/substance_abuse/activities/
en/Draft_Substance_Use_Guide.pdf](http://www.who.int/substance_abuse/activities/en/Draft_Substance_Use_Guide.pdf)

This self-help guide is “designed for people who are at moderate risk of substance related problems and who do not have severe substance related problems or dependence.” It provides clear, easy to understand information and strategies for self-help.

Trainers can share this guide with health workers as a tool assist people with moderate substance abuse issues.

Trainers can learn about self-help strategies for reducing or stopping substance. The guide covers the following topics:

1. Introduction.
2. How do you know if you are at risk.
3. What is a substance use problem.
4. Getting Started.
5. Getting Support.
6. Do I need to do something about my substance use.
7. Which substances are you concerned about.
8. Measuring your substance use.
9. How much is too much.
10. Choosing your goal.
11. Changing the way you use.
12. My contract with myself.
13. Getting on with it.
14. Keeping your “Substance Use Diary”.
15. High Risk Situations.
16. Setting Substance Use Guidelines.
17. Helpful tips.
18. Handling High Risk Situations.
19. The problem solving approach.
20. How to say NO.
21. Sticking to your guidelines.
22. These tips will help you.
23. When things go wrong.
24. Alternatives to Substance Use.
25. Guidelines for Supporters.

<p>E. Care for the Caregivers: Minimising the Stress of Health Workers</p>	<p>These materials provide trainers with information and tools about the stress of working in emergency settings and tools that can be used to “care for the caregivers” and minimize this stress.</p>	<ul style="list-style-type: none"> • Understanding the stresses that affect humanitarian workers including health workers. • Self-care and stress management. • Principles and practices that organizations can use to minimize the stress caused to humanitarian workers including health workers.
<p style="text-align: center;">22.</p> <p style="text-align: center;">Harmonizing personal, professional and familial life stress management workbook</p> <p>K. Sekar,, Subhasis Bhadra, C. Jayakumar, and K.V. Kishorekumar</p> <p>National Institute of Mental Health and Neuro Sciences / CARE Bangalore, India, 2005</p> <p>Available online at: www.nimhans.kar.nic.in</p>	<p>This Stress Management Workbook is easy for trainers to read and use. It provides health workers with “simple self care and stress management techniques at personal, family and organizational levels”.</p> <p>This workbook was designed by an international NGO in India to assist humanitarian workers who assisted people affected by the tsunami to ‘harmonize their personal, professional and familial life.’</p> <p>It states that “dealing with the trauma, sorrow and pain of the people affect the workers emotionally, physically and socially. Many of the workers being survivors of the same disaster have taken up the role as care givers. All over the world in various disaster interventions and rehabilitation work it is seen that stress and burnout among the rehabilitation workers is an added complication whenever the organizations failed to take care of the fellow workers. Therefore, harmonizing personal, professional and familial life of the rehabilitation workers has been considered as one of the prime focuses in the Tsunami rehabilitation project. The need is to empower the workers to handle the stress in their professional and personal life and establish a harmonious living within self. This includes self care, dealing with stress and caring for fellow workers. This process also ensures the organizational development in the long run.”</p>	<p>Topics of interest to trainers:</p> <ul style="list-style-type: none"> • Understanding stress. • Physical reactions of stress. • Psychological reactions of stress. • Our response to stress. • Tips to manage yourself. • Stress in family life cycle. • The life events. • Stress among the women workers. • The family members I am living with. • Simple tips to manage stress in family life. • Presumptive stressful life events scale. • Stress in disaster related work. • Occupational stress test. • Burnout experience. • Job stress. • Writing letters. • Coping with stress. • Device for assessment of coping strategies. • Sleep hygiene techniques and anger control. • Time chart analysis. • Competitiveness. • Assertiveness to manage stress Personal assertiveness scale. • Working together-personal resources. • Multi tasking or multiple roles. • Holistic living Tree of sustenance. • Debriefing session and co-counseling. • Relaxation exercise. • Physiological exercise.

		<ul style="list-style-type: none"> • Emotional thermometer. • Use of stress management techniques. • Stress busters. • Strategies to handle your stress in disaster intervention work • Checklist of staff friendly organization. • Ethical issues.
<p style="text-align: center;">23. Managing stress in humanitarian workers: Guidelines for good practice</p> <p>Antares Foundation Netherlands, 2006</p> <p>Available at: Antares Foundation W.G. Plein 269 1054 se Amsterdam The Netherlands</p> <p>Available online at www.antaresfoundation.org</p>	<p>Trainers can utilise these guidelines on how organisations can mitigate the stress that affects humanitarian workers</p> <p>“The objective of these Guidelines for Good Practice is to facilitate the NGOs in defining their own needs in relation to stress management in their organization. This will be different for every NGO, whether national or international, big or small. And although the principles should be universal, the implementation and indicators will depend on the context and culture of the organization. The guidelines are meant as an orientation for organizations that are interested in developing their own staff care system.”</p>	<p>Trainers can utilize the follow 9 principles :</p> <p>Principle 1: Policy The agency has a written and active policy to prevent or mitigate the effects of stress.</p> <p>Principle 2: Screening and assessment The agency systematically screens and/or assesses the current capacity of staff members to respond to and cope with the anticipated stressors of an assignment.</p> <p>Principle 3: Preparation and training The agency ensures that all employees have appropriate pre-assignment preparation and training in managing stress.</p> <p>Principle 4: Monitoring The agency ensures the monitoring of the response to stress of its staff on an ongoing basis.</p> <p>Principle 5: Ongoing support The agency is providing training and support, on an ongoing basis, to help its staff deal with the daily stresses of humanitarian aid work.</p> <p>Principle 6: Crisis support The agency provides staff with specific and culturally appropriate support in the wake of critical or traumatic incidents and other unusual and unexpected sources of severe stress.</p> <p>Principle 7: End of assignment support The agency provides practical, emotional and culturally appropriate support for staff at the end of an assignment or contract. This includes a personal stress review and an operational debriefing.</p> <p>Principle 8: Post assignment support The agency has clear written policies with respect to the ongoing support they will provide to staff members who have been adversely impacted by exposure to stress and trauma during their assignment.</p>

Appendix I

Overview of Selected Sections from Inter Agency Standing Committee (IASC) Mental Health and Psychosocial Support (MHPSS) guidelines in Emergency Settings

The Inter Agency Standing Committee (IASC) guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings are a “multi-sectoral, interagency framework that enables effective coordination, identifies useful practices and flags potentially harmful practices, and clarifies how different approaches to mental health and psychosocial support complement one another.”

“They reflect the insights of practitioners from different geographic regions, disciplines and sectors, and reflect an emerging consensus on good practice among practitioners.”

“The core idea behind them is that, in the early phase of an emergency, social supports are essential to protect and support mental health and psychosocial well-being. In addition, the guidelines recommend selected psychological and psychiatric interventions for specific problems.”

The full text of these **Guidelines** is available online at http://www.who.int/mental_health/emergencies/en/

The following is an overview of key points from selected sections of these international guidelines and standards that have been chosen since they are useful in the training of health workers. The selected sections are:

- **Chapter I.**
- **Action Sheet 4.3: Organise orientation, training and supervision of aid workers in mental health and psychosocial support.**
- **Action Sheet 5.4: Facilitate support for young children (0-8 years) and their caregivers.**
- **Action Sheet 6.1: Include specific psychological and social considerations in provision of general health care.**
- **Action Sheet 6.2: Provide access to care for people with severe mental disorders.**
- **Action Sheet 6.3: Protect and care for people with severe mental disorders and other mental and neurological disabilities living in institutions.**
- **Action Sheet 6.4: Learn about and, where appropriate, collaborate with local, indigenous and traditional healing systems.**

- **Action Sheet 6.5: Minimise harm related to alcohol and other substance use.**

The following key points are quoted directly from the guidelines for these selected sections of the IASC MHPSS.

IASC MHPSS Guidelines Chapter I:

“Armed conflicts and natural disasters cause significant psychological and social suffering to affected populations. The psychological and social impacts of emergencies may be acute in the short term, but they can also undermine the long-term mental health and psychosocial well-being of the affected population. These impacts may threaten peace, human rights and development.”

“One of the priorities in emergencies is thus to protect and improve people’s mental health and psychosocial well-being.”

“Achieving this priority requires coordinated action among all government and non-government humanitarian actors.”

“The composite term mental health and psychosocial support is used in this document to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder.”

“Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies erode normally protective supports, increase the risks of diverse problems and tend to amplify pre-existing problems of social injustice and inequality.”

“Thus, mental health and psychosocial problems in emergencies encompass far more than the experience of PTSD.”

“In emergencies, not everyone has or develops significant psychological problems. Many people show resilience, that is the ability to cope relatively well in situations of adversity.”

“There are numerous interacting social, psychological and biological factors that influence whether people develop psychological problems or exhibit resilience in the face of adversity.”

“Affected groups have assets or resources that support mental health and psychosocial well-being. The nature and extent of the resources available and accessible may vary with age, gender, the socio-cultural context and the emergency environment. A common error in work on mental health and psychosocial well-being is

to ignore these resources and to focus solely on deficits – the weaknesses, suffering and pathology – of the affected group.”

“Affected individuals have resources such as skills in problem-solving, communication, negotiation and earning a living. Examples of potentially supportive social resources include families, local government officers, community leaders, traditional healers (in many societies), community health workers, teachers, women’s groups, youth clubs and community planning groups, among many others. Affected communities may have economic resources such as savings, land, crops and animals; educational resources such as schools and teachers; and health resources such as health posts and staff. Significant religious and spiritual resources include religious leaders, local healers, practices of prayer and worship, and cultural practices such as burial rites.”

“To plan an appropriate emergency response, it is important to know the nature of local resources, whether they are helpful or harmful, and the extent to which affected people can access them.”

IASC MHPSS Guidelines Core Principles:

1. Human rights and equity.

2. Participation: “Humanitarian action should maximise the participation of local affected populations in the humanitarian response. In most emergency situations, significant numbers of people exhibit sufficient resilience to participate in relief and reconstruction efforts. Many key mental health and psychosocial supports come from affected communities themselves rather than from outside agencies.”

3. Do no harm.

4. Building on available resources and capacities

5. Integrated support systems: “Activities and programming should be integrated as far as possible. Activities that are integrated into wider systems (e.g. existing community support mechanisms, formal/non-formal school systems, general health services, general mental health services, social services, etc.) tend to reach more people, often are more sustainable, and tend to carry less stigma.”

6. Multi-layered supports: “In emergencies, people are affected in different ways and require different kinds of supports. A key to organising mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups. This may be illustrated by a pyramid (see Figure 1). All layers of the pyramid are important and should ideally be implemented concurrently.

The interventions recommended at each layer include:

i. Basic services and security. “The well-being of all people should be protected through the (re)establishment of security, adequate governance and services that address basic physical needs (food, shelter; water; basic health care, control of communicable diseases). These basic services should be established in participatory, safe and socially appropriate ways that protect local people's dignity, strengthen local social supports and mobilise community networks.”

ii. Community and family supports. The second layer represents the emergency response for a smaller number of people who are able to maintain their mental health and psychosocial well-being if they receive help in accessing key community and family supports. Useful responses in this layer include family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women's groups and youth clubs.

iii. Focused, non-specialised supports. The third layer represents the supports 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. The top layer of the pyramid represents the additional support 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. This assistance should include psychological or psychiatric supports for people with severe mental disorders.

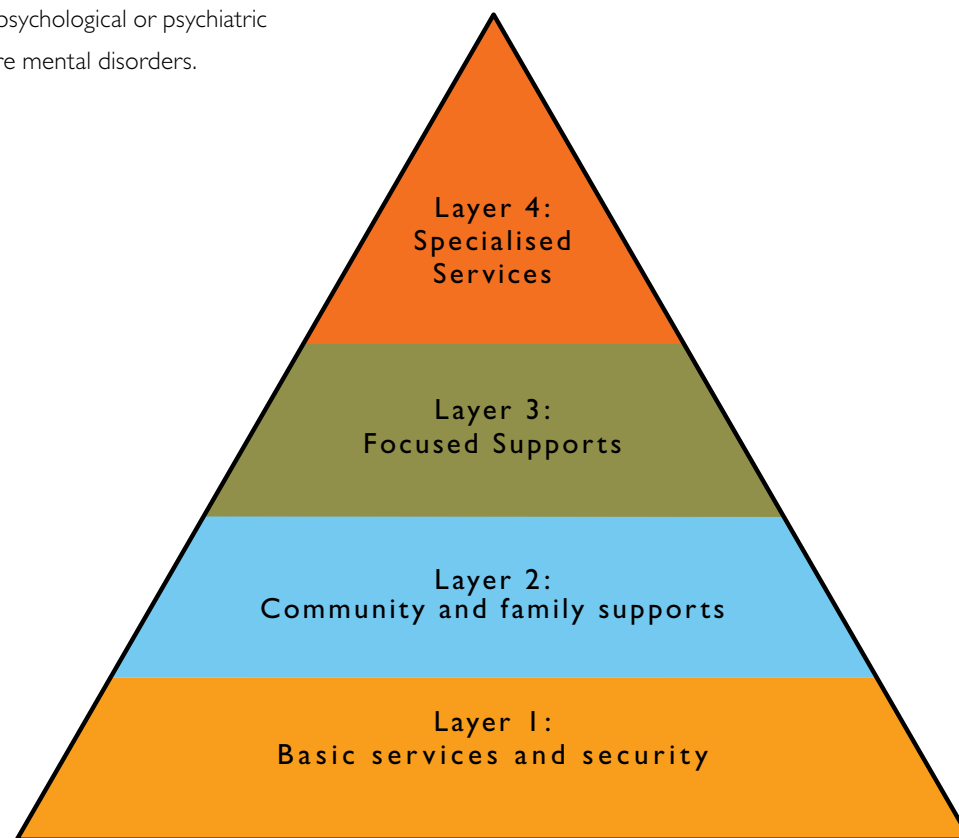


Figure: IASC MHPSS (2007) Intervention Pyramid for Emergencies.

IASC MHPSS Guidelines 4.3: Organise orientation, training and supervision of aid workers in mental health and psychosocial support

“National and international aid workers play a key role in the provision of mental health and psychosocial support (MHPSS) in emergencies.”

“To be prepared to do so requires that all workers have the necessary knowledge and skills.”

“Training should prepare workers to provide those emergency responses identified as priorities in needs assessments.”

“Though training content will have some similarities across emergencies, it must be modified for the culture, context, needs and capacities of each situation, and cannot be transferred automatically from one emergency to another.”

“Inadequately oriented and trained workers without the appropriate attitudes and motivation can be harmful to populations they seek to assist.”

“Essential teaching may be organized through brief orientation and training seminars followed by ongoing support and supervision.”

“Seminars should accentuate practical instruction and focus on the essential skills, knowledge, ethics and guidelines needed for emergency response.”

“Seminars should be participatory, should be adapted to the local culture and context and should utilise learning models in which participants are both learners and educators.”

Key actions:

1. Prepare a strategic, comprehensive, timely and realistic plan for training.

Plans must be coordinated and integrated between partners and should follow the guidelines.

2. Select competent, motivated trainers.

Local trainers or co-trainers with prior experience and/or knowledge when they have the necessary knowledge and skills.

3. Utilise learning methodologies that facilitate the immediate and practical application of learning.

- Use participatory teaching style.
- Utilise learning models in which participants are both learners and educators.
- Train participants in local languages or translation.
- Use audio/visual/reference materials adapted to local conditions.
- Use classrooms for theoretical learning and initial practice of skills.

- Use hands-on field-based training to practice skills in locations like emergency-affected area.
- Distribute written reference materials in accessible language.
- Complete immediate evaluations of training (by trainers, trainees and assisted populations).

4. Match trainees’ learning needs with appropriate modes of learning.

Brief orientation seminars (half or full-day seminars) should provide immediate basic, essential, functional knowledge and skills relating to psychosocial needs, problems and available resources to everyone working at each level of response.

Training seminars. More extensive knowledge and skills recommended for those working on focused and specialised MHPSS.

- Length and content of training vary according to trainees’ needs and capacities.
- Timing of seminars must not interfere with the provision of emergency response.
- Use of short, consecutive modules for cumulative learning is recommended.
- Training seminars must always be followed up with field-based support and/or supervision.

5. Prepare orientation and training seminar content directly related to the expected emergency response.

The contents of **brief orientation seminars** may include:

- Review of safety and security procedures.
- Methods for workers to cope with work-related problems.
- Codes of conduct and other ethical considerations.
- Human rights and rights-based approaches to humanitarian assistance.
- Importance of empowerment and of involving the local population in relief activities.
- Basic knowledge on impact of emergencies on mental health and psychosocial wellbeing.
- Techniques for Psychological First Aid (PFA).
- Methods to promote the dignity of the affected population, using lessons learned.
- Knowledge about local socio-cultural and historical context.
- Basic knowledge about crisis and world view(s) of affected populations.
- Basic information about cultural attitudes, practices and social organisation.
- Basic information on workers' behaviours that might be offensive.
- Information about available sources of referral.
- Information on how and where to participate in relevant inter-agency coordination.

The content of **training seminars** may include:

- All information covered in the orientation seminars.
- Emergency individual, family and community psychosocial and mental health assessment.
- Emergency psychosocial and mental health response techniques that can be taught quickly, based on existing capacities, contexts and cultures of trainees and known to be effective in related contexts.
- Knowledge and skills necessary for implementing interventions that are (a) part of minimum response and (b) identified as necessary through assessment.

This applies to training of:

- Health workers.
- Protection workers.
- Formal and non-formal community workers.
- Teachers.

6. Consider establishing Training of Trainers (ToT) programmes to prepare trainers prior to training.

7. After any training, establish a follow-up system for monitoring, support, feedback and supervision of all trainees, as appropriate to the situation.

8. Document and evaluate orientation and training to identify lessons learned, to be shared with partners and to enhance future responses.

Action Sheet 5.4: Facilitate support for young children (0-8 years) and their caregivers

“Early childhood (0–8 years) is the most important period in human life for physical, cognitive, emotional and social development. During this period, critical brain development occurs rapidly and depends on adequate protection, stimulation and effective care.”

Early losses (e.g. the death of a parent), witnessing physical or sexual violence, and other distressing events can disrupt bonding and undermine healthy long-term social and emotional development.

However, most children recover from such experiences, especially if they are given appropriate care and support.

In emergencies, the well-being of young children depends to a large extent on their family and community situations. Their wellbeing may suffer if they have overwhelmed, exhausted or depressed mothers or caregivers who are physically or emotionally unable to provide effective care, routine and support.”

Key actions

- 1.** Keep children with their mothers, fathers, family or other familiar care-givers.
- 2.** Promote the continuation of breastfeeding.
- 3.** Facilitate play, nurturing care and social support.
- 4.** Care for caregivers.

Action Sheet 6.1: Include specific psychological and social considerations in provision of general health care.

“There is a gap in most emergencies between mental health and psychosocial supports and general health care.”

“However, the way in which health care is provided often affects the psychosocial wellbeing of people living through an emergency. Compassionate, emotionally supportive care protects the wellbeing of survivors, whereas disrespectful treatment or poor communication threatens dignity, deters people from seeking health care and undermines adherence to treatment regimes, including for life-threatening diseases such as HIV/AIDS.”

Physical and mental health problems frequently co-occur, especially among survivors of emergencies. However, strong inter-relationships between social, mental and physical aspects of health are commonly ignored in the rush to organise and provide health care.

Often general health care settings – such as primary health care (PHC) settings – offer the first point of contact for helping people with mental health and psychosocial problems.

General health care providers frequently encounter survivors' emotional issues in treating diseases and injuries, especially in treating the health consequences of human rights violations such as torture and rape.

Some forms of psychological support (i.e. very basic psychological first aid) for people in acute psychological distress do not require advanced knowledge and can easily be taught to workers who have no previous training in mental health.

Key actions

1. Include specific social considerations in providing general health care.
2. Provide birth and death certificates (if needed).
3. Facilitate referral to key resources outside the health system.
4. Orient general health staff and mental health staff in psychological components of emergency health care.
5. Make available psychological support for survivors of extreme stressors (also known as traumatic stressors).

Most individuals experiencing acute mental distress following exposure to extremely stressful events are best supported without medication.

Provide half-day or, preferably, one-day orientation seminars to national and international health staff.

Psycho-education and general information, including:

- The importance of treating disaster survivors with respect to protect their dignity.
- Basic information on what is known about the mental

health and psychosocial impact of emergencies (see Chapter 1), including understanding of local psychosocial responses to an emergency.

- Key conclusions drawn from local mental health and psychosocial support assessments (see Action Sheet 2.1).
- Avoiding inappropriate pathologising/ medicalisation (i.e. distinguishing non-pathological distress from mental disorders requiring clinical treatment and/or referral).
- Knowledge of any available mental health care in the region to enable appropriate referral for people with severe mental disorders (see Action Sheet 6.2).
- Knowledge of locally available social supports and protection mechanisms in the community to enable appropriate referrals (see Action Sheets 5.2 and 3.2).

Communicating to patients, giving clear and accurate information on their health status and on relevant services such as family tracing. A refresher on communicating in a supportive manner could include:

- Active listening.
- Basic knowledge on how to deliver bad news in a supportive manner.
- Basic knowledge on how to deal with angry, very anxious, suicidal, psychotic or withdrawn patients.
- Basic knowledge on how to respond to the sharing of extremely private and emotional events, such as sexual violence.

How to support problem management and empowerment by helping people to clarify their problems, brainstorming together on ways of coping, identifying choices and evaluating the value and consequences of choices;

Basic stress management techniques, including local (traditional) relaxation techniques;

Non-pharmacological management and referral of medically unexplained somatic complaints, after exclusion of physical causes.

All aid workers, and especially health workers, should be able to provide very basic psychological first aid (PFA).

PFA encompasses:

- Protecting from further harm.
- Providing the opportunity for survivors to talk about the events, but without pressure. Respect the wish not to talk and avoid pushing for more information than the person may be ready to give.
- Listening patiently in an accepting and non-judgmental manner.
- Conveying genuine compassion.
- Identifying basic practical needs and ensuring that these are met.
- Asking for people's concerns and trying to address these.
- Discouraging negative ways of coping (specifically discouraging coping through use of alcohol and other

substances, explaining that people in severe distress are at much higher risk of developing substance use problems).

- Encouraging participation in normal daily routines (if possible) and use of positive means of coping (e.g. culturally appropriate relaxation methods, accessing helpful cultural and spiritual supports).
- Encouraging, but not forcing, company from one or more family member or friends.
- As appropriate, offering the possibility to return for further support.
- As appropriate, referring to locally available support mechanisms or to trained clinicians.

In a minority of cases, when severe acute distress limits basic functioning, clinical treatment will probably be needed (for guidance, see *Where There is No Psychiatrist*). If possible, refer the patient to a clinician trained and supervised in helping people with mental disorders (see Action Sheet 6.2). Clinical treatment should be provided in combination with (other) formal or non-formal supports.

With regards to clinical treatment of acute distress, benzodiazepines are greatly over-prescribed in most emergencies. However, this medication may be appropriately prescribed for a very short time for certain specific clinical problems (e.g. severe insomnia). Nevertheless, caution is required as use of benzodiazepines may sometimes quickly lead to dependence, especially among very distressed persons.

Also, various experts have argued that benzodiazepines may slow down the recovery process after exposure to extreme stressors.

In most cases, acute distress will decrease naturally, without outside intervention, over time. However, in a minority of cases, a chronic mood or anxiety disorder (including severe post-traumatic stress disorder) will develop. If the disorder is severe, then it should be treated by a trained clinician as part of the minimum emergency response (see Action Sheet 6.2). If the disorder is not severe (e.g. the person is able to function and tolerate the suffering), then the person should receive appropriate care as part of a more comprehensive aid response. Where appropriate, support for these cases may be given by trained and clinically supervised community health workers (e.g. social workers, counsellors) attached to health services.

Action Sheet 6.2: Provide access to care for people with severe mental disorders

“Mental disorders account for four of the ten leading causes of disability worldwide, but mental health is among the most under-resourced areas of health care.”

“Few countries meet their clinical mental health needs in normal times, let alone in emergencies.”

“Those clinical mental health services that do exist in low- and middle-income countries tend to be hospital-based in large cities, and are often inaccessible to the wider population.”

“It has been projected that in emergencies, on average, the percentage of people with a severe mental disorder (e.g. psychosis and severely disabling presentations of mood and anxiety disorders) increases by 1 percent over and above an estimated baseline of 2–3 percent.”

“In addition, the percentage of people with mild or moderate mental disorders, including most presentations of mood and anxiety disorders (such as post-traumatic stress disorder, or PTSD), may increase by 5–10 percent above an estimated baseline of 10 percent.”

“In most situations natural recovery over time (i.e. healing without outside intervention) will occur for many – but not all – survivors with mild and moderate disorders.”

The severe disorders covered in this sheet may be **pre-existing or emergency-induced** and include the following conditions:

- Psychoses of all kinds.
- Severely disabling presentations of mood and anxiety disorders (including severely disabling presentations of PTSD).
- Severe mental disorders due to the use of alcohol or other psychoactive substances (see Action Sheet 6.5 for guidance on problems related to substance use).
- Severe behavioural and emotional disorders among children and youth.
- Severe pre-existing developmental disabilities.
- Neuropsychiatric disorders including epilepsy, delirium and dementia and mental disorders resulting from brain injury or other underlying medical conditions (e.g. toxic substances, infection, metabolic disease, tumour, degenerative disease).
- Any other severe mental health problem, including (a) locally defined severe disorders that do not readily fit established international classification systems (see Action Sheet 6.4) and (b) risk behaviours commonly associated with mental disorder (e.g. suicidal feelings, self-harm behaviour).

People with mental disorders may initially present at primary health care (PHC) facilities to seek help for medically unexplained somatic complaints.

However, people with severe mental disorders may fail to present at all because of isolation, stigma, fear, self-neglect, disability or poor access. These people are doubly vulnerable, both because of their severe disorder and because the emergency may deprive them of social supports that had previously sustained them. Families are often stressed and stigmatised by the burden of care in normal times. This puts such individuals at an elevated risk of abandonment in emergencies that involve displacement.

Once they are identified, however, steps can be taken to provide immediate protection and relief, and to support existing carers.

Priority should be given to those at major survival risk or who are living in settings where their dignity and human rights are being undermined, or where social supports are weak and where family members are struggling to cope.

Treatment and support of people with severe clinical responses typically requires a combination of biological, social and psychological interventions. Both under-treating and over-medicalisation can be avoided through staff training and supervision.

Typically, people suffering from disaster-induced, sub-clinical distress should not receive medication but will respond well to psychological first aid (see Action Sheet 6.1) and to individual

and community social support (see Action Sheet 5.2).

Moreover, some mental conditions can be effectively treated by practical psychological interventions alone, and medication should not be used unless such interventions have failed.

While the actions outlined below are the minimum response necessary to address the needs of people with severe clinical responses in emergencies, they can also provide the first steps in a more comprehensive response.

They are addressed to local health authorities, local health care workers and local and international medical organisations.

If at the outset there is no local health infrastructure or local capacity, outside organisations should provide emergency mental health services.

However, services need to be established in such a way that they do not displace existing social and informal means of healing and coping, and in such a way that they can be integrated with government-run health services at a later date.

Key actions

1. Assess.

2. Ensure adequate supplies of essential psychiatric drugs in all emergency drug kits.

4. Train and supervise available PHC staff in the

frontline care of severe mental disorder (see also Action Sheet 4.3).

Training should involve both theory and practice and can be begun at the outset of the emergency by a national or international mental health supervisor working in collaboration with local health authorities. This training should continue beyond the emergency as part of a more comprehensive response.

Training should include all skills mentioned in Key Action 4 of Action Sheet 6.1 plus:

- Treating all service users and their care-givers with dignity and respect.
- The mental status examination.
- Recognition and frontline management of all the severe disorders listed in the background section above.
- The provision of guidelines and protocols for the above (see Key Resources).
- Time management skills, focusing on how to integrate mental health work into normal clinical work.
- Simple practical psychological interventions, as covered in *Where There is No Psychiatrist* (see Key Resources).
- Keeping proper clinical records. Give copies to care-givers if possible, as the population may be mobile.
- Maintaining confidentiality. When confidentiality must be broken for protection reasons, address guardianship and medico-legal issues and inform service users and caregivers.

- Setting up appropriate lines of referral to supports in the community (see Action Sheets 5.2 and 6.4) and to secondary and tertiary services if they exist and are accessible.
- For personnel authorised to use medication in the affected country, good prescribing practices include:
 - » Rational use of essential psychiatric drugs in emergency kits, according to the guidelines in *Essential Drugs in Psychiatry* and consistent with *Where There is No Psychiatrist* (see Key Resources).
 - » How to facilitate continuing access and adherence to prescribed medication for people with chronic disorders (e.g. chronic psychosis, epilepsy).
 - » How to avoid prescribing psychotropics to people with disaster-induced, non-pathological distress (see Action sheet 6.1) by developing nonpharmacological strategies for stress management.
 - » How to avoid prescribing placebo medications for medically unexplained somatic complaints.
 - » Understanding both the risks and benefits of benzodiazepines, particularly the risk of dependence from long-term prescribing.
 - » How to minimise the unnecessary prescription of multiple medications.

- The management of and support for persons with severe mental disorders who have been chained or physically restrained by care-givers involves the following steps:
 - » First, facilitate very basic means of psychiatric and social care e.g. the provision of appropriate medication, family education and support. Promote humane living conditions.
 - » Second, consider untying the person. However, in those rare instances where the person has a history of violent behaviour, ensure basic security for others before doing so.

5. Avoid overburdening PHC workers with multiple, different training sessions.

- Trainees should have time to integrate mental health training into their daily practice so that they can deliver mental health care.
- Trainees should not be trained in numerous different skill areas (e.g. mental health, TB, malaria, HIV counselling) without planning how these skills will be integrated and used.
- Theoretical training in short courses is insufficient and may result in harmful interventions. It must always be followed up with extensive on-the-job supervision (see Action Sheet 4.3).

6. Establish mental health care at additional, logical points of access.

Use general public health criteria (e.g. population coverage, expected caseload of service users with severe disorders, potential sustainability of services) to determine where to establish mental health care. Mobile PHC or community mental health teams may be an effective way of establishing emergency care at different places within an area. Examples of logical points of access are:

- Emergency rooms.
- Outpatient clinics at secondary and tertiary facilities.
- Mental health drop-in centres.
- General hospital wards with a high number of emergency-related hospitalisations.
- Home visits (including visits to tents, collection centres, barracks or any temporary housing location).
- Schools and child-friendly spaces.

7. Try to avoid the creation of parallel mental health services focused on specific diagnoses (e.g. PTSD) or on narrow groups (e.g. widows).

This may result in fragmented, unsustainable services and the continuing neglect of people who do not fit the specific diagnostic category or group. It may also contribute to the labelling and stigmatisation of those who do. This does not preclude targeted outreach to broad populations (such as outreach clinics for children at schools) as part of an integrated service.

8. Inform the population about the availability of mental health care.

- Advertise using relevant information sources, such as radio (see Action Sheet 8.1).
- Ensure that all messages are delivered in a sensitive manner that does not result in people viewing normal behaviours and responses to stress as indicative of severe mental disorder.
- Inform the community leadership and, if appropriate, local police of the availability of mental health care.

9. Work with local community structures, to discover, visit and assist people with severe mental disorders.

10. Be involved in all inter-agency coordination on mental health.

Action Sheet 6.3: Protect and care for people with severe mental disorders and other mental and neurological disabilities living in institutions

“People living in institutions are among the most vulnerable people in society, and they are especially at risk in emergencies. The chaos of the emergency environment adds to their general vulnerability. People in institutions may be abandoned by staff and left unprotected from the effects of natural disaster or conflict.”

Severe mental disorder is often met with stigma and prejudice, resulting in neglect, abandonment and human rights violations. Living in an institution isolates people from potential family protection and support, which may be essential for survival in emergencies. Some people with severe mental disorders living in institutions are (too) dependent on institutionalised care to easily go elsewhere during an emergency. Total dependency on institutional care may create further anxiety, agitation or complete withdrawal. Difficulties in reacting adequately to the fast-changing emergency environment may limit self-protection and survival mechanisms.

Local professionals should lead the emergency response whenever possible. Intervention must focus on protection and the re-establishment of basic pre-existing care.

Key Actions:

1. Ensure that at least one agency involved in health care accepts responsibility for ongoing care and protection of people in institutions.
2. If staff have abandoned psychiatric institutions, mobilise human resources from the community and the health system to care for people with severe mental disorders who have been abandoned.
3. Protect the lives and dignity of people living in psychiatric institutions.
4. Enable basic health and mental health care throughout the emergency.

Action Sheet 6.4: Learn about and, where appropriate, collaborate with local, indigenous and traditional healing systems.

“...local populations may prefer to turn to local and traditional help for mental and physical health issues. Such help may be cheaper, more accessible, more socially acceptable and less stigmatizing and, in some cases, may be potentially effective. It often uses models of causation that are locally understood. Such practices include healing by religious leaders using prayer or recitation; specialized healers sanctioned by the religious community using similar methods; or healing by specialized healers operating within the local cultural framework. The latter may involve the use of herbs or other natural substances, massage or other physical manipulation, rituals and/or magic, as well as rituals

dealing with spirits. Although some religious leaders may not sanction or may actively proscribe indigenous medications. Some religious groups may offer faith-based healing.”

It should be noted that some traditional healing practices are not experienced as helpful and may even be harmful. Local populations may be assisted to review these practices and suggest constructive alternatives.

Dialogues with traditional healers can lead to positive outcomes.

Key actions:

1. Assess and map the provision of care.
2. Learn about national policy regarding traditional healers.
3. Establish rapport with identified healers.
4. Encourage the participation of local healers in information sharing and training sessions.
5. If possible, set up collaborative services.

Action Sheet 6.5: Minimise harm related to alcohol and other substance use.

Conflict and natural disasters create situations in which people may experience severe problems related to alcohol and other substance use (AOSU). These include far reaching protection, psychosocial, mental health, medical and socio-economic problems.

- AOSU may increase among emergency-affected populations as people attempt to cope with stress. This may lead to harmful use or dependence.
- Communities have difficulties recovering from the effects of emergencies when:
 - » AOSU inhibits individuals and communities from addressing problems.
 - » Limited resources in families and communities are spent on AOSU.
 - » AOSU is associated with violence, exploitation, neglect of children and other protection threats.
 - » AOSU is associated with risky health behaviour, such as unsafe sex while intoxicated with alcohol, and it promotes transmission of HIV and other sexually transmitted infections. Sharing injection equipment is a common means of transmitting HIV and other blood-borne viruses.

- Emergencies can disrupt supply of substances and any pre-existing treatment of AOSU problems, causing sudden withdrawal among people dependent on substances. In some cases, particularly with alcohol, such withdrawal can be life threatening.
- Moreover, lack of access to commonly available drugs can promote transition to injection drug use as a more efficient route of administration, and may promote unsafe injection drug use.

Harm related to AOSU is increasingly recognised as an important public health and protection issue that requires a multi-sectoral response in emergency settings.

Key actions

1. Conduct a rapid assessment.
2. Prevent harmful alcohol and other substance use and dependence.
3. Facilitate harm reduction interventions in the community.
4. Manage withdrawal and other acute problems.



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