WORLD FEDERATION FOR MENTAL HEALTH

INTERNATIONAL FORUM ON MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN EMERGENCY SETTINGS CONFERENCE REPORT

Sponsored and Organized
By the
WORLD FEDERATION FOR MENTAL HEALTH
IN COLLABORATION WITH
THE CENTRE ON INTERNATIONAL MENTAL HEALTH
INSTITUTE OF PSYCHIATRY
KING'S COLLEGE LONDON

AUGUST 28 – 29, 2008
King's College London
Waterloo Campus
London, England, United Kingdom

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The information in this report represents a summary of presentations and discussions from a WFMH International Forum held in London, England, UK, August 28 0 29, 2008. The purpose of this meeting was to bring together a diverse group of individuals working in various programs addressing the mental health consequences of natural and manmade disasters. The aim of the Forum was to provide new information to the participants, most of whom work with grassroots organizations in disaster and conflict areas, to inform WFMH's disaster response initiative, and to develop recommendations as to how WFMH might be able to address these issues through its advocacy, education, and constituency development strategies within its Disaster Response Initiative. This report can be accessed and downloaded from the WFMH website at **www.wfmh.org.**

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CONTENTS

INTRODUCTION AND ACKNOWLEDGEMENTS

The World Federation for Mental Health (WFMH) became aware of the problems facing those who delivered mental health and psychosocial support services (MHPSS) in emergency settings during the South Indian Ocean tsunami (December 2004) when member organisations in the affected areas e-mailed it for assistance. When the Federation was unable to secure funding from any of the major relief funding efforts (such as the UK-based Disaster Emergency Committee, MSF and US-based Democracy Corps) to support its organizations' rapid response efforts, the Board of Directors established the WFMH Disaster Response Support Initiative chaired by John Copeland. Through the promotion of this initiative WFMH was able to raise modest funds from individuals and member organizations around the world, and made contributions to support grassroots mental health organizations as they worked to address both the immediate and long term mental health consequences of the tsunami in the Andaman and Nicobar Islands, and in Sri Lanka, and then later in Pakistan following the Kashmir earthquake, as well as in Bangladesh after the 2007 cyclone. The principal objective of the WFMH Disaster Response Support Initiative is to assist grassroots mental health NGOs located in areas affected by major disasters as they attempt to respond to both the immediate and the lasting mental health consequences of emergency situations.

Through this initial experience, WFMH became deeply concerned about the lack of MHPSS due to the inability of grassroots mental health organizations to access funds from major disaster relief appeals to support these services, particularly in affected areas where regular mental health services are limited or generally unavailable prior to disasters. A number of serious issues are seen in such situations, including inappropriate interventions being offered by some organisations, the relative paucity of the science evidence base regarding planning and delivery of MHPSS, the lack of access to training by those likely to find themselves suddenly at the forefront of a disaster relief effort, and the uncertainty felt by many organisations and individuals as to what best to do in response to different kinds of disaster.

WFMH sent representatives to two meetings in London and then organized and convened a pre-Congress Forum at the WFMH World Mental Health Congress in Hong Kong in August 2007; the Forum was attended by approximately 75 delegates representing mental health organizations from all regions of the world. At that time, the Inter-Agency Standing Committee Task Force on Mental Health and Psychosocial Support Working Group was in the final stages of preparing its "Guidelines on Mental Health and Psychosocial Support in Emergency Settings." (The Inter-Agency Standing Committee is the primary mechanism for coordination among key UN agencies and non-UN humanitarian agencies offering humanitarian relief. It was established in 1992 in response to UN General Assembly Resolution 46/182 on the strengthening of humanitarian assistance.) WFMH was able to participate in the Task Force meeting in Geneva, and submitted the draft guidelines to its member organizations, inviting input to the IASC. Encouraged by the publication of the IASC Guidelines, the WFMH Disaster Support Initiative determined to use its ability to " identify problems, convene, co-ordinate and encourage towards solutions" to organize an International Forum in London that took place on August 28 and 29 at King's College London, and which is summarized in this document.

The aim of the Forum was to identify and address the problems associated with the delivery of MHPSS in Emergency Settings using the IASC guidelines as a basis for going forward. An important feature of this essentially working Forum was the set aside of time for discussion in breakout sessions and from the floor through plenary sessions. All individuals and organisations concerned with the mental health response to disaster situations were encouraged to participate and express their views, especially

organisations which deliver humanitarian care during disaster and emergency situations and grassroots mental health non-governmental organisations. We were especially concerned about those who are faced with longer term problems of mental health resulting from disasters in their communities or regions.

The organisation and presentation of this Forum was made much easier through the support and active participation of WFMH's Collaborating Centre on International Mental Health at the Institute of Psychiatry, King's College London. Professors Martin Prince and Graham Thornicroft and their staff at the Institute deserve acknowledgement and appreciation for their support and assistance throughout the planning and conducting of the Forum. Much assistance and support was received from Dr. Mark van Ommeren, a scientist in the World Health Organisation's Department of Mental Health and Substance Abuse, who, together with Dr. Michael Wessells led the work of developing the IASC Guidelines and provided invaluable advice to WFMH on the Forum. Thanks are also extended to the speakers and breakout session facilitators who helped make the program content interesting and informative. And, of course, ultimate thanks are extended to those who travelled from far places, not always without difficult and sacrifice, to participate in the Forum and to share their experience, knowledge and commitment with others. WFMH expresses its appreciation to the Department of Mental Health and Substance Abuse at the World Health Organisation for giving its support to this Forum by lending its name as a co-sponsoring organisation.

Hopefully, the presentations and discussions summarised in this report will be of use in advocacy, education, policy development, and efforts to improve delivery of much improved mental health and psychosocial support services to individuals affected by mental health problems during the trauma of manmade and natural disasters. It is also hoped that this report will raise awareness about the IASC Guidelines and their potential to improve the entire area of humanitarian relief during future disasters that are certain to take place across the world in coming years. There is no health without mental health, and there can be no adequate and appropriate humanitarian response to disaster situations without addressing and tending to the mental health consequences of these events.

John Copeland MD ScD (Cambridge) FRC P FRCPsych
President, World Federation for Mental Health
Chair, WFMH Disaster Response Support Initiative

FORUM AGENDA AND PROGRAM
WFMH Forum on Mental Health and Psychosocial Support in Emergency Settings

DAY ONE: 28th of August

08:15 Registration and coffee, signing up for workshops

09:00 Welcome

Professor John Copeland MD, ScD, **FRCP, FRCPsych**
President, WFMH Board of Directors, and Chair, WFMH Disaster Response Initiative

Opening Address

"Towards a Coordinated Response to Mental Health Consequences of Disasters and Emergencies: Implementing the IASC Guidelines"

Mark van Ommeren, PhD
WHO Scientist, Department of Mental Health and Substance Abuse
The World Health Organization, Geneva, Switzerland

09:45 General Discussion of IASC Guidelines and Implementation

10:30 **Coffee/tea**

11:00 ***"Exploring Training Issues in Regard to Planning and Providing Mental Health and Psychosocial Support Services (MHPSS) in Emergency Settings"***

Lynne Jones, OBE, MD, PhD FRCPsych
Senior Advisor in Mental Health
International Medical Corps, Santa Monica CA USA

Nancy Baron, PhD
Global Psycho-Social Initiatives (GPSI)
Nairobi, Kenya and Cairo, Egypt

12:00 General Discussion of MHPSS Training Issues

12:30 **Lunch**

13:30 "***Global Perspectives on the Mental Health Response to Natural and Manmade Disasters"***

The World Psychiatric Association's Institutional Program on Disasters

George Christodoulou, MD, **FRCPsych** Chair
Professor of Psychiatry, Athens University
President, Hellenic Centre for Mental Health and Research, Athens, Greece

13:50 Parallel Sessions – ***"Addressing the Challenges and Problems of Providing Mental Health and Psychosocial Support Services in Emergency Settings"***

15:00 **Coffee /tea**

15:30 Parallel Sessions – ***"Addressing the Challenges and Problems of Providing Mental Health and Psychosocial Support Services in Emergency Settings"***

18:50 End of Day One Sessions

DAY TWO 29th of August

09:00 Opening Address

"***Challenges, Opportunities and Strategies for Forming MHPSS Networks to Promote Coordinated Service Planning and Delivery in Emergency Settings"***

Michael Wessells, PhD
Professor of Clinical Population and Family Health

Heilbrunn Department of Population and Family Health
Columbia University Mailman School of Public Health
New York NY USA

Alison Strang BA, PhD
Senior Research Fellow,
Institute of International Health and Development
Queen Margaret University
Edinburgh, UK

09:40 General Discussion on Network-Building

10:00 ***"A Preliminary Report from the WFMH Science Panel Working Group on Developing the Science Evidence Base for MHPSS Planning and Delivery"***

Derrick Silove, MD, Chair
Professor and Director
Psychiatry Research and Training Unit
University of New South Wales
Sydney, Australia

10:45 **Coffee/Tea**

11:15 General Discussion on Developing the Science Evidence Base

12.00 Introduction to the Afternoon Workshops

12:30 **Lunch**

13:30 **Workshop Sessions**

Jane Gilbert MA, MSc (clin psych) C Psychol, AFBPsS, Consultant Clinical Psychologist: International mental health; Independent

1 Training for MHPSS: Developing Effective Delivery Strategies for Training and Preparedness

2 Addressing Current Funding Issues for Humanitarian Relief during Major Disasters: How Can Mental Health and Psychosocial Support Services be Included?

3 Developing Collaborative Relationships and Coordination among Humanitarian Relief Organizations and grassroots MHPSS providers: How can on-site coordination of MHPSS best be achieved?

4 *"When the Media Trucks are Gone."* MHPSS Provision in Post-Disaster and Emergency

Coffee/tea

15:30 Reports from the Workshops and Discussion: Jane Gilbert
Panel of the Workshop Moderators
Discussion – Suggestions and Recommendations for Next Steps
John Copeland

17:30 Forum Concludes

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN EMERGENCY SETTINGS FORUM
LONDON, UNITED KINGDOM
AUGUST 28-29 2008

OVERVIEW

John Copeland, Forum Chair and Organiser

The World Federation for Mental Health's concern for mental health and psychosocial support (MHPSS) in emergency settings arises from the apparent helplessness of its member organisations and individuals in the face of the Asian tsunami in December, 2004. No funding was immediately available for mental health and none was subsequently forthcoming. Workers had to develop their own ideas from scratch and pay for their own participation. Clearly something was wrong, and on further enquiries more and more unresolved issues became apparent. The Federation set up a Disaster Support Initiative with a separate website and was able to raise a little money of its own and to offer some small support.

This meeting and the previous Forum held in Hong Kong in 2007 have sought to focus on some of these issues: Lack of money for grassroots organizations; lack of understanding on what should be done and for whom; lack of apparent interest from the humanitarian organisations that had a great deal of money at the time from massive public donations; and more. Opinions varied, from those who considered everyone involved in a disaster as a potential victim in need of intervention, to those who claimed disasters had occurred throughout all time and that the people affected, although naturally upset at first, would quickly adapt so that no help would be required. We have tried to examine some of these issues here and the developments that have occurred after the tsunami.

Taking Derrick Silove's contribution first, it would now seem clear that there is ample evidence for enduring mental health problems resulting from disasters. Around 10% of the population exposed may be expected to have symptoms of stress but we should accept these as a normal reaction to trauma and expect most to remit spontaneously. Lynne Jones considers that around 2% are left with enduring problems.

Professor Silove points to the importance of understanding and recognising local ways of expressing distress. If these culturally determined symptoms are assessed in addition to those described in the international classifications, then the figure of those affected rises. Without culture sensitive methods these are likely to be missed. He stresses that these enduring cases, as well as those already psychiatrically ill before the trauma, represent an important group of seriously disabled people requiring intervention. For many, Western style treatments will be important for recovery. Even when moved to secure surroundings seriously traumatised people continue to suffer and for a variety of reasons fail to receive appropriate treatment.

Seriously mentally ill people are not likely to work and support themselves. Even in Western practice people can recover from physical damage after surgery to remain disabled due to

neglect of mental illness which has become established. There is therefore, a problem to be faced--that a proportion of people will be seriously disabled by trauma and unable to work, with the likelihood that if not treated this state will become chronic and lifelong.

Facing the problem of mental disability will involve tackling a number of further issues. What should be done to tackle the mental health problems? Here there would appear to be general agreement that the IASC Guidelines, based on extensive consultation worldwide and described to the Forum by one of the co-chairs, Mark Van Ommeren, provide a very important step forward in how matters are to be handled--how MHPSS aid workers must understand the local culture and work with and support local leaders and institutions that are still active, rather than set up stand-alone services which cannot be sustained and may be culturally insensitive or inapplicable. They must work if possible in the local language and consult the local people about what they really need and how they would like things done; identify vulnerable groups and give psychological first aid to those who need it; work if possible alongside and with cooperation from the large humanitarian organisations, and be prepared to remain behind after they have pulled out, to help build appropriate longer term services for those who have not recovered and others who may be showing late onset of stress or depression.

It was said that implementing the Guidelines will be more difficult than producing them. Before they can be put into action, tested and modified, workers must first be trained. It is clear from presentations from Nancy Baron and Lynne Jones that much thought has already been given to training methods and supervision. It is suggested that training should start before disasters, but how is that to be achieved unless training is widely adapted and dispersed? The Federation has advocated for Regional Training Units, which could offer expertise, training and supervision to other groups in their region, with the possibility of running training courses for the trainers at events such as the WFMH Biennial Congresses. The Federation's member organisations across the world could be approached but clearly some funding would be needed to start the process off.

George Christodoulou described his experiences following the Athens earthquake. He quoted the WHO definition of a disaster and drew a distinction between naturally occurring and man-made disasters, citing evidence that the consequences of the latter tended to be the more severe. He pointed out the importance of recognising that for every physically damaged individual there were likely to be three psychologically damaged ones as mental health problems impacted on families and work colleagues.

The need for funding MHPSS was considered by the Forum. Members of the general public need to understand that very little of the funds donated by them in the West at present goes towards mental health, and with one or two noticeable exceptions, very few humanitarian organisations are prepared to offer MHPSS or work with MHPSS-based organisations even though they may have been signatories to the IASC Guidelines. It is understandable why many humanitarian organisations find offering MHPSS difficult to embrace. The approaches are different; working closely with culturally sensitive methods in the local language and having to provide more long-term care goes somewhat beyond their normal organisational requirements

or remit. However, it is essential for good practice that the humanitarian and the MHPSS organisations should cooperate on site. If the humanitarian organisations are not prepared to offer or work with MHPSS organisations then who will fund MHPSS? Will the MHPSS organisations be forced to try to raise their own funds in competition with the humanitarian organisations? That would be very divisive and the humanitarian organisations would have to make it plain in their fund raising that they were not intending to address mental health issues, so that the public is clear where their money is going, which at present is not always the case. Emergency committees in Western countries are unlikely at present to understand or recognise the need for MHPSS and it seems mental health is poorly represented on them. We understand that the Disaster Emergency Committee in the UK, although it has HelpAge International as a member so that older people are represented, has no independent member to represent mental health issues; and rules for joining the committee are all but insurmountable for mental health organisations, yet most money from the general public responding to disaster appeals goes to this committee.

If the MHPSS community is to gather strength, like other areas of mental health advocacy it needs to express unity, and speaking with one voice on areas of consensus will be essential. As long as the movement remains divided its advocacy will be weak. Michael Wessells and Alison Strang laid out some of the essential prerequisites for a successful MHPSS network. Jane Gilbert's meetings of interested groups in London stressed the need for a network of communication. One of the first things which strikes outsiders is how little MHPSS workers around the world communicate or even seem to know about each other. This must change. This is why the setting up of a network of communication is so essential, in particular a network which serves the grassroots, shares knowledge, identifies areas of agreement and then advocates from a stronger base. There is much advocacy to be done.

Finally, there is an acknowledged need to strengthen the research base for interventions, to find out what is likely to be successful and what should not be done. It is vital that donor organisations appreciate the need for research. The Forum identified the need for academics to make common cause with practitioners and promote research into best practice. We can report that following the Forum a group came together and, having acquired funding, is now in the process of conducting a Delphi exercise to achieve consensus on the research issues that need to be pursued. In addition one of the Federation's member organisations has already put forward a funding proposal for establishing a Regional Training Centre. These are very encouraging moves, but more are needed.

The Federation wishes to thank all those who attended and contributed to the papers and the discussions. The parallel sessions demonstrated the wide range of relevant activities and the different types of disaster that occur, the ethical problems of research and the important gaps in our knowledge. We aim to move forward on the issues discussed here and the Federation will be considering mounting a third Forum in 2010 to assess advances and progress.

Rationale for the Forum

The Forum had a number of aims - to promote broader adoption and use of the IASC *Guidelines on Mental Health and Psychosocial Support in Emergency Settings (*2007) with particular emphasis on training and implementation; to draw attention to the need for greater collaboration and coordination among humanitarian relief organizations and grassroots mental health organisations, including the problems of funding; the establishment of connections and the development of networks between individuals and organizations engaged in MHPSS preparation; provision and coordination; and to encourage efforts to increase the evidence base for interventions and to support advocacy. It was also hoped that participants would help to identify problems experienced in providing MHPSS in emergency settings at the grassroots level and contribute to building strategies to find solutions for more effective responses to major disaster and emergency situations. The Forum included invited speakers, parallel sessions and participatory workshops. The programme was designed to provide time for adequate discussion from the floor. It is not possible to outline all that took place but this report summarises the main presentations, discussion points and workshops. (A list of Abstract titles from the parallel sessions, with the names of presenters can be found on pages 44-47).

DAY 1

1. **<u>Introduction</u> – John Copeland, Chair WFMH Disaster Support Initiative and President, WFMH, and organiser of the Forum**

Professor Copeland outlined how the Forum had come about. WFMH had been approached for help by many of its organisational and individual members after the Asian tsunami. It became apparent that funds were not readily available for MHPSS in spite of the substantial public and government donations to the disaster. So the Federation launched its own appeal with modest results but was able to offer some financial support for the Andaman and Nicobar Islands and later for the Pakistani earthquake. This stimulated the Federation to set up its own initiative. John Copeland represented WFMH at meetings in London with International NGOs facilitated by Jane Gilbert in 2005 and 2006. The problems for MHPSS at all levels became clear at these early meetings.

Many of those organisations trying to provide care were not in touch with one another and were not always sure of the value of their interventions. WFMH was also asked to participate in the IASC feedback discussions. The first WFMH Forum to address MHPSS issues was then held over one day in Hong Kong in conjunction with the 2007 WFMH Biennial World Congress. This Forum was attended by over 50 delegates, mainly from Asia and the Pacific Rim. The problems here were much the same, lack of communication, a feeling of isolation in the face of disasters, unsure what to do or how to fund operations, the need to share experiences, the lack of a secure evidence base for interventions and some conflicting views on what interventions were beneficial.

The Federation decided to set up this second Forum in London over 2 1/2 days to examine some of the major problems which had emerged from previous discussions. John Copeland explained WFMH's position. He said that the Federation had no corporate view of its own on these issues but it does have member organisations around the world that are usually at the forefront of disasters and for whom it has concern.

This meeting was called a "Forum" meaning a meeting place where anyone would have opportunity to state views and have them seriously debated. It aimed to be inclusive rather than exclusive. It was made clear that the Federation did not intend to be prescriptive nor was it in any sense competitive with other organisations or academic departments. It does not have the expertise among its staff to lead development in its chosen areas of interest but must depend on the experience and expertise of others. One of its purposes is to identify world problems in mental health; work with the United Nations and its agencies, including WHO, one of the sponsors of the Forum; convene experts; and encourage debate and solutions. It can provide an umbrella for a spectrum of participants, the grassroots providers of care, mental health related organisations around the world, consumers/users of mental health services, professionals, academics and managers, to meet, discuss, form action groups and work collaboratively to solve problems. John hoped the Forum would provide a firm step in that direction. The Federation was not unaware of the great difficulties ahead but there was an urgency to move forward in an attempt to tackle and solve them.

2. "Towards a Coordinated Response to Mental Health Consequences of Disasters and Emergencies: Implementing the IASC Guidelines"

Mark van Ommeren, **Department of Mental Health and Substance Abuse, WHO**

Mark van Ommeren gave an overview of the background to the development of the IASC Guidelines, with particular emphasis on the following:

- He noted concern for mental health is common when there is a high media attention, especially when there is an acute mortality risk.
- The Guidelines were drawn up using a broad consultative, participatory process with different agencies being responsible for drafting different parts of the Guidelines. The Guidelines utilised the field experience of leading practitioners and were subject to multiple reviews by diverse practitioners and academics.
- The rationale for developing the IASC guidelines included:
    - The recognition of the enormous and diverse needs associated with any disaster.
    - Social and psychological problems.
    - Pre-existing, emergency-induced & aid-induced problems.
    - Fragmented and sometimes controversial agency activities.
    - Polarisation of professional views.
    - The absence of a multi-sectoral, inter-agency framework that would enable coordination.
- The Guidelines can help with:
    - Improved coordination.
    - Identification of useful practices.
    - Identification of harmful practices.

    - Clarification of how different approaches to mental health and psychosocial support complement one another.
- The underlying core principles include:
    - Human rights.
    - Equity and participation.
    - "Do no harm".
    - Building on available resources and capacities.
    - Integrated support systems.
    - Multilayered supports.

3. "Exploring Training Issues in Regard to Planning and Providing Mental Health and Psychosocial Support Services (MHPSS) in Emergency Settings" –
Nancy Baron, Global Psycho-Social Initiatives (GPSI), Nairobi, Kenya and Egypt
Lynne Jones, Senior Advisor in Mental Health, International Medical Corps, USA

Nancy Baron reviewed Action Sheet 4.3 (Training) of the IASC Guidelines, finishing with two video clips illustrating training taking place in Uganda (available from Nancy on request) During this forum we will explore the workings of the IASC guidelines for MHPSS support in emergency settings.

- How are they useful?
- What are their constraints?
- What needs improvement?
- What do we recommend?

Nancy had no doubt that the guidelines are useful. A lot of people with much experience from all over the world took a lot of time to prepare them. **IF FOLLOWED**, Nancy believes that they can provide an important guide based on essential principles that will make a big difference both during and after emergencies.

The key question however, is **WOULD THE GUIDELINES BE FOLLOWED?** To ensure this the first step was to **INFORM** the international partner organizations about them. This was done exhaustively through workshops all over the world. Next, it required preparing the international partner organizations to use the Guidelines effectively and not just to bring them to each new emergency. This continues to be one of the challenges that confront the world's MHPSS partners. Some efforts have already been made to explore this, using information from new lessons learned.

A meeting of the Psychosocial working group that will take place in September 2009 in Geneva will specifically explore the impact of what has already been done and will prepare a tool box of best practices that can be shared with the international partner organizations. Hopefully, ideas generated by this Forum can inform this work.

An essential KEY ELEMENT to ensure that the partners FOLLOW the guidelines is TRAINING. It is not enough to hand people the guidelines, suggest they read them and then expect them to be implemented. Effective ways must be developed to train people in the principles of how they

can PRACTICALLY, EFFECTIVELY AND EASILY INTEGRATE THEM INTO WORK. It is difficult at present to judge the effectiveness of the Guidelines since a clear, consistent means for training people how to use them has not yet been developed. In fact, we could be judging the results of training rather than the Guidelines themselves.

Ensuring that we are using effective methods for training in psychosocial mental health work is not restricted only to the use of the Guidelines. TRAINING is an essential key to all effective MHPSS work. A creative intervention model is only as good as the training done to prepare the professionals, paraprofessionals, community leaders or families or whoever will use it. Poor training of those who implement it can lead to the failure of even the best intervention model.

Review of Action Sheet 4.3 Organise orientation, training and supervision of aid workers in mental health and psychosocial support. (Nancy's comments in italics)

Background

National and international aid workers play a key role in the provision of mental health and psychosocial support 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. Decisions about who participates in training and about the mode, content and methodology vary according to the emergency conditions and workers' capacities. Training content will have some similarities across emergencies. However it must be modified for the culture, context, needs and capacities of each situation, and not 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.
Training often leads to a cascade. A cascade with inaccurate information or poor planning can have disastrous results.

Key actions

ACTION 1. Prepare a strategic, comprehensive, timely and realistic plan for training.
All organizations must develop training plans that are coordinated and integrated among partners. They must follow the completed assessments of problems and resources.

> *"Realistic" includes ensuring that there is enough time for proper training. Content must be limited according to what is reasonable to teach, and try to ensure trainees know how practically to use the time allotted.*

ACTION 2. Select competent, motivated trainers.
Local trainers or co-trainers with prior experience and/or knowledge of the affected location are preferred when they have the necessary knowledge and skills.

> *International trainers must be used carefully. Having an advanced degree and altruistic interest is not enough. International trainers must have relevant skills and experience.*

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

Teaching may be organised through **brief orientation** and **training seminars** followed by **ongoing support and supervision.** Seminars should:

- Accentuate practical instruction and focus on teaching essential skills, knowledge, ethics and guidelines needed for emergency response.
- Be participatory and actively engage participants.
- Adapt to the local culture and context.
- Utilise learning models in which participants are both learners and educators.
- Training and training materials should be in local languages or, when this is not possible, provide 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 that are in or resemble the emergency-affected area. **"An ounce of practice is worth more than tons of preaching." Gandhi**
- Distribute written reference materials in accessible language.
- Complete immediate evaluations of training (by trainers, trainees and assisted populations) to benefit from lessons learned.

ACTION 4. Match trainees' learning needs with appropriate modes of learning.

Length and content of training seminars should vary according to trainees' needs and capacities.

- Brief orientation seminars should be provided to everyone working at every level of response.
- Orientation seminars should preferably be organised before workers begin their missions.
- Training seminars with more extensive knowledge and skills are recommended for those working on the top 2 layers of the pyramid.
- Timing of seminars must not interfere with the provision of emergency response.

Use of short, consecutive modules for cumulative learning is recommended because this:

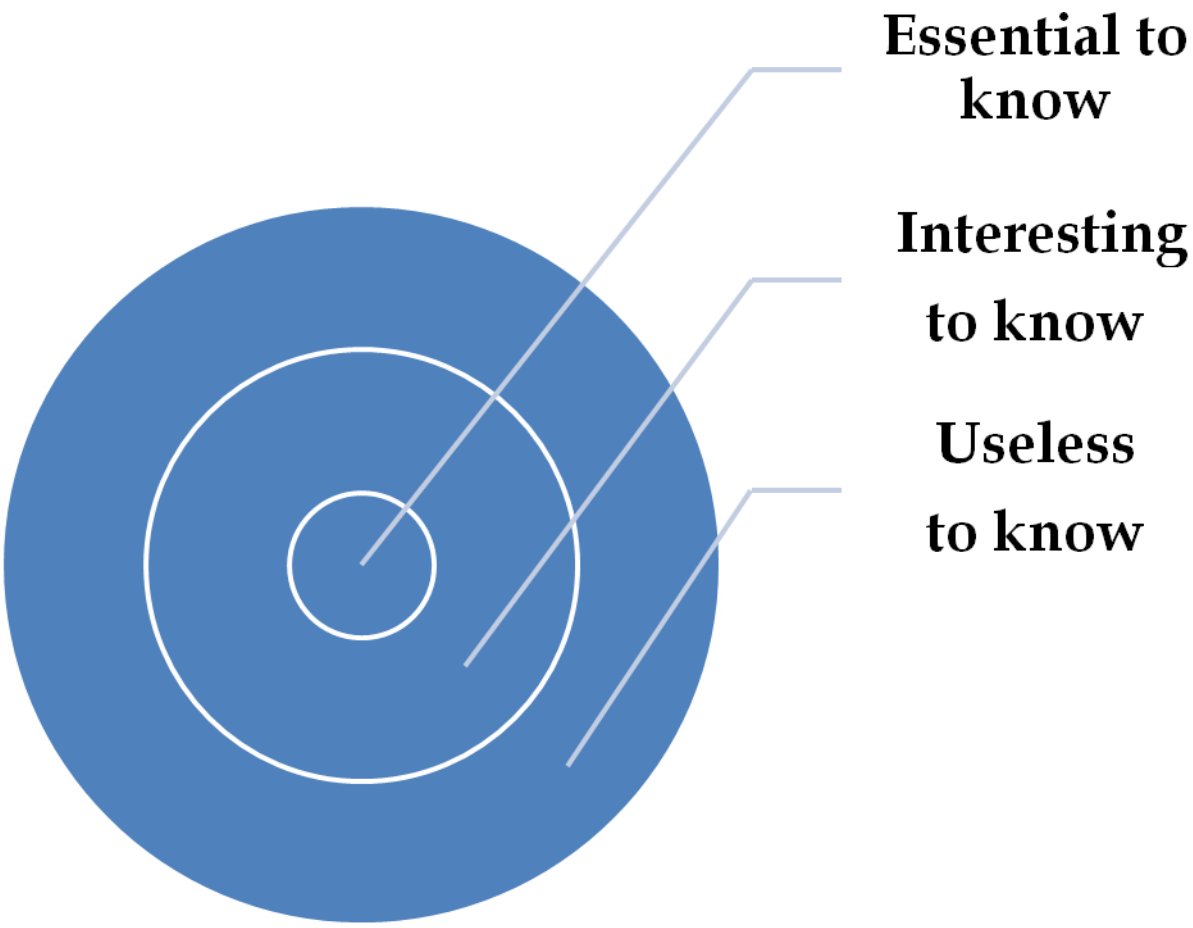
- Limits the need to remove staff from their duties for extended periods.
- Allows staff to practise skills between training sessions with support and supervision, before the next new modules are introduced.

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

List of recommended content included in 4.3.

- ONLY teach what trainees need to learn in order to provide the necessary response.
- Use the Bull's Eye method for curriculum development.

- Curriculum is designed to hit the CENTER: <u>ESSENTIAL TO KNOW</u>.



HOWEVER*….*
Not enough to teach only technical intervention skills. Seems to limit trainees' abilities to modify with culture and change with time.
Essential for trainees to understand WHY they do certain interventions and use specific skills.
Important to teach WHY based on attitudes, culture, theories, beliefs, research etc.
Then teach how to do the skills….

Then practice the skills safely in the classroom.
Then practice the skills in the field with feedback, support and supervision …
Ensure the provision of institutional and personal Care for the Caregivers…
Continue to provide feedback, support and supervision over time.

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

- ToT programmes educate TRAINERS to competently train others.

- ToT must have careful planning and be taught by experienced and skilled master trainers.
- Poorly prepared ToTs tend to fail and may lead to poor or even harmful outcomes.
- After a ToT, follow-up support is essential for the future trainers and their trainees, to achieve accuracy of training and quality of the aid response.

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

- Supervision is important to try to ensure that training is actually put into practice.
- These follow-up activities should be properly planned before the start of any training.

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

Nancy stated that she believed that Action 6, establishing the Training of Trainers programmes is one of the most essential keys to effective MHPPS work. Well-trained Trainers will provide effective training so that workers actually learn how to do the interventions we hope that they will do. We often put considerable time into a program's design and far less time into ensuring that our trainers actually have the skills to effectively train.

Training MHPSS workers is complicated. It requires cumulative training in which people must learn basic knowledge. Then they might learn skills that lead to the use of this knowledge in order to activate intervention. Trainers must know how to teach actual skills and have the time to ensure that their trainees internalize what they learn and can use it! Because of this Nancy offers special workshops to train MHPSS Trainers.

Nancy introduced her 14-step framework then showed a video clip of TOT in Uganda.

Global Psycho-Social Initiatives
Dr. Nancy Baron 2007

14 STEP FRAMEWORK FOR TRAINING TRAINERS (TOT)

From ***On the road to peace of mind*** **Film and Guide**

Baron / Molenwiek films 2007

Before the TOT:

Step 1 Select the TOT Master-Trainer(s) and participants.

Step 2 Assess the learning needs of the TOT group.

Step 3 Design the TOT course structure and curriculum.

During the TOT:

Step 4 Form a supportive group process.

Step 5 Use TOT classes as a *model* of participatory training skills.

Step 6 Mobilize self-care.

Step 7 Ensure mastery of relevant base of knowledge and skills.

***Step 8 In the classroom: Teach skills for HOW TO train. Including HOW TO: facilitate participatory presentations and discussions; use training tools; assess training groups; plan a curriculum; use experiential training ie: role play, drama, story telling, music, art etc.**

***Step 9 In the field: Provide opportunities for *applying* and practising training skills.**

Step 10 Monitor the learning process.

Step 11 Facilitate preparation of individualized future Action Plans.

Step 12 Distribute mobile library.

Step 13 Evaluate the Up-and-Coming Trainers skills and TOT course.

After the TOT:

Step 14 Follow up the application of the TOT learning by the Up-And-Coming Trainers over time.

Lynne Jones covered four topics, illustrating most from her own experience and commenting on the two years she was involved in the development of the IASC Guidelines:

- Should we be doing training?
- A brief biased history
- The IASC guidelines- dos and don'ts
- Training primary health care workers

Training

Much training has **Western psychiatric "baggage"** including:

- A focus on the individual
- A bio-psychosocial model of causation
- The main role is to deal with medical pathology – diagnosis, prescription, treatment
- A multidisciplinary team addressing social issues
    - Political and communal problems are not addressed in this context
    - Management training is brief
    - Because care is free at the point of need in UK – training does not include financing
    - Patients have rights - such as autonomy, gender equality, confidentiality and consent, continuity of care
- We know who our clients are
- We know what our approach should be
- We know what to focus upon
- We have help
- We know what is outside our remit
- We operate within a framework of rights, codes of practice and the law

Western Therapeutic options include: Psychopharmacology, Psychotherapies (Group, Family, Individual) where the emphasis is on ventilation of emotion, exploration of deeper feelings and unconscious defence mechanisms seen as significant. There is a common understanding that problems are caused by biopsychosocial factors.

What have Western trained psychiatrists to offer in disasters involving huge populations? For example, in Darfur and in the aftermath of the Pakistan earthquake.

There are two options:

1. **Stay away**

*"War affected people have not given permission for their personal psychology to be objectified and until they do it is not the business of the humanitarian field"**. Derek Summerfield, Social Science and Medicine, 48, 1999, 1449-1462***

2. **Re-think what they are doing**

"Humanitarian agencies have a duty to recognise distress but then to attend to what people carrying the distress want to signal by it. War affected populations are largely directing their attention not inwards to their mental processes but outwards to their devastated social worlds and to questions of rights and justice. They know they will stand or fall by what they do in and about that world. There is a risk that agencies will reproduce constructions of war that suit their institutional interests and assumptions as well as donor fashions. What is fundamental is whether people themselves have the power to define the problem, and whether their concerns, knowledge and current priorities can be the basic frame of reference within which offers of assistance are shaped". ***Derek Summerfield; Trauma and the experience of War: a reply. Lancet (1998) 351, 1580-****1*

Lynne then gave a brief history of training in emergencies from her own experience including the Balkans in the 1990's (Gorazde Kosovo/Macedonian border); Iraq 2003; and Aceh 2005, highlighting questionable practice, mistakes made and successful interventions

In summary –

- **The majority of people are not made clinically unwell by exposure to trauma (using Western criteria for assessment).**
- **Most studies measuring symptoms show 10 - 40% are symptomatic.**
- **But less than 10% have more enduring problems.**
- **Self recovery is the norm.**

NEVERTHELESS - there are really severe psychiatric needs for which a Western psychiatric training has much to offer - as for learning disability, major depression, somatic conditions, stress and anxiety disorders including PTSD, acute psychosis, chronic mental illness, epilepsy, and substance abuse

The IASC pyramid illustrates different layers of support, and the likely scale of demand for each of those layers.

Basic services – the wellbeing of most people will be protected by re-establishing security and providing services that address basic needs – food, water, shelter, health care, structured activity – these are mainstream services – but for the population, in addition to the relief of having such basic needs addressed, their mental health and psychosocial wellbeing will be enhanced if these services are provided in ways that involve the population as more than recipients of aid, that are socially and culturally sensitive etc

Community and family supports – required for a smaller number of people – who, faced with the disruption and losses created by the emergency, need help in accessing key community and family supports to regain their mental health and psychosocial wellbeing. For example, family tracing, education programmes, social networks such as women's groups.

Focused non-specialised supports – for a smaller number again – who require some additional help – e.g. survivors of GBV.

Specialised services – top layer, a small number whose suffering – despite all of the other services/supports – is intolerable – who face significant difficulties in daily functioning and need psychological/psychiatric support.

Do's and don'ts of training

DO'S	DON'TS
Recognise that people are affected by emergencies in different ways. More resilient people may function well, whereas others may be severely affected and may need specialised support.	Do not assume that everyone in an emergency is traumatised or that those who appear resilient need no support.
After trainings on mental health and psychosocial support, provide follow-up supervision and monitoring to ensure that interventions are implemented correctly.	Do not use one-time, stand-alone trainings or very short trainings without follow-up if preparing people to perform complex psychological interventions.
Build local capacities, supporting self-help and strengthening the resources already present in affected groups.	Do not organise supports that undermine or ignore local responsibilities and capacities.

Lynne concluded by describing the foci of International Medical Corps training:

- Integrate mental health into primary health care.
- Concentrate on substance abuse.
- Concentrate on early child development.

Who to train?

- Identify members of the health care team who have time to integrate mental health training into their daily practice.
- Select those who can sustain the service supported by the relevant authorities.
- YOU MAY HAVE TO ADD OTHERS, BUT IF SO WHO PAYS?

Remember one size does not fit all… for example, psychiatric registrars helped in Kosovo, MOMH in Sri Lanka, community health workers in Sierra Leone, GPs (General Medical Practitioners) in Ethiopia , community mental health nurses in Aceh.

Must Include traditional healers in a two-way collaborative process with joint clinics, consultative meetings and exchange consultations, but challenge human rights abuses.

Training is a two way street ….

Discussion points

1. Why do people volunteer to become trainers in their own country? Often because of career advancement, but what happens when the NGO leaves? Is it worth training volunteers? It is much more important to work within existing community structures, particularly with those who already have a commitment to being community leaders.
2. Is there training in countries in advance of disasters? It is possible to obtain funding for up to 3 years so it is possible to build something in the longer term and hand over to other agencies. It is essential to have a longer term perspective in mental health. The IASC group is planning training to roll out the Guidelines, and there is a need to prepare professionals for the work. MSF is also doing training.
3. There is a need for mental health in primary healthcare, and disasters and development need to be joined together.
4. The reality is often that people are using out-of-date books, have no internet access, and the libraries are empty. Suggested that 10-20 basic books are provided to all universities.
5. There is very little collaboration around the world, much more likely to be competition for funding and between egos.
6. There is a need for qualitative research but also a need to think through ethical guidelines for research in emergencies. Donors rarely fund research. Have to have someone responsible for data collection, otherwise research will not take place. Must be culturally appropriate. The problem is, there are no baselines. One cannot take a baseline in an emergency.
7. Part of training needs to be building research capacity. It is a misconception that only numbers matter. Need collaboration between academics and NGOs.

4. "**Global Perspectives on the Mental Health Response to Natural and Manmade Disasters*"***
George Christodoulou, **The World Psychiatric Association's Institutional Program on Disasters, Professor of Psychiatry, Athens University, President, Hellenic Centre for Mental Health and Research, Athens, Greece**

George Christodoulou commented that it was good to hear about practicalities, rather than theory. He described his experience of an earthquake in Athens where experts in psychosocial approaches had been engaged and a telephone helpline set up. He disagreed with WHO's view and considered that after any disaster there were always elements of PTSD, particularly Acute Stress Reaction.

George defined a disaster as "A severe psychological and psychosocial disruption that largely exceeds the ability of the affected community to cope" (WHO, 1991) and differentiated between disasters which were natural and those which were manmade. Those which are manmade have more frequent and more persistent psychosocial consequences (Norris et al, 2002). The consequences of natural disasters are worse and the death toll is greater in developing countries (Benz, 1989). Disasters produce very serious negative effects on individual and societal bases, having a negative impact on social structure. Yet in some cases a disaster may enhance a new vista of the world and a sense of purpose that may open new opportunities (Quaranteli,1998; Foa et als, 2000) In terms of psychological consequences, for every physically damaged individual there are three psychologically damaged ones.

Predictors for psychopathology after a disaster include:-

- Direct exposure to trauma.
- The size of the "Dose" of the stressor.
- Being a primary victim, but also attached to the primary victim, first responder or support provider.
- Being psychologically vulnerable.
- Suffering a physical injury during the disaster.
- Being a child or an adolescent.
- Having experienced media exposure of the disastrous event.

(Fullerton and Ursano, 2005)

The most common reactions are:

- Acute stress reaction (ASR)
- Post-traumatic Stress Disorder (PTSD)

One of the most consistent predictors for PTSD development is the appearance of ASR. (Harvey and Bryant, 2000;Christodoulou et al, 2003, 2005).

Having outlined symptoms in more detail, George described the role of mental health professionals as providing advice to Government, consultations to Health Authorities and advice to the public.

He then described the work of the World Psychiatric Association (WPA), which has 65 sections. WPA had an institutional programme on disasters before the tsunami and have set up task forces after most major disasters. He then described their role as mediators, for example in Georgia, not just attending to mental health; and noted the role of the chair of the WPA Institutional Program on Disasters in relation to mass violence in Lebanon and Israel (December 2006 and January 2007). George considered it the responsibility and an ethical obligation of WPA to state the mental health consequences of war and mass violence. He also considered it unethical to undertake research in disasters without offering services to the victims, as this was most often carried out by "parachuters", including psychiatrists who did not contact the local psychiatric association. He recommended mobile units for disaster intervention as well as mental health centres with personnel specialized in disaster management which could be expanded when needed to function as disaster intervention centers in cases of emergency.

Discussion points

1. Using her slide of prevalence of PTSD in Lebanon, Lynne commented on the low rates after 30 years of conflict. Only 2% of population suffered from PTSD and there were high rates of self recovery. But Attention Deficit Disorder was under diagnosed in children. This and impulse control problems in adults can alter family dynamics.
2. However, it was pointed out that even 2% of a population could be a large number of people and there can be difficulties created by media coverage.
3. It was suggested that other cultures exhibit a reaction of "shame" rather than PTSD but this is not usually reported.

4. The more severe the problems, the more likely to be universal. Less severe psychological problems are more influenced by culture. We know more about what works for psychosis. The IASC Guidelines distinguish between mild, moderate and severe conditions. The view was expressed that services needed to focus on those with more severe problems.
5. Can research be trusted? Is there a real difference in reactions after natural or manmade disasters? Differences have not been demonstrated.
6. Experts live in a "theoretical world". How can you compare Somalia with the USA? What needs to be measured in Africa? Outcomes do not reflect the life of the people. We should not apply Western instruments uncritically.
7. High quality qualitative research is required.

DAY 2

1. "***Challenges, Opportunities and Strategies for Forming MHPSS Networks to Promote Coordinated Service Planning and Delivery in Emergency Settings"***
   Michael Wessells, **Professor of Clinical Population and Family Health, Columbia University, New York NY, USA and Senior Advisor on Child Protection, Christian Children's Fund**

Michael Wessells spoke about the power of networking in developing the IASC Guidelines, which had entailed collaboration between 27 UN and NGO agencies and the people in their networks in different countries, in reaching the first consensus on how to support people affected by emergencies. Since knowledge is culturally constructed, he thought it vital to draw on the insights of people from different socio-cultural systems. Also, networking at field level is a powerful way for enabling much needed support for affected people. He gave an example from an orphanage in Angola where children were sleepless and fearful due to believing a ghost was haunting them. He described how, using networks to find out where the children came from, and enlisting an appropriate healer from that locality to conduct a ritual believed to appease the angry spirit, the children's sleep had been restored.

War tears up networks which have to be rebuilt. Yet networks are channels to power and influence and are laden with values. It is vital to approach networking with a social justice lens and show respect for establishing human rights and social equality, particularly since networks may be difficult to access for people living in dispersed places. For example, people in Northern developed nations may have access to networks that are denied to or difficult to access for people living in developing countries. Similar circumstances occur within countries. For example, people living in rural areas in a conflict-torn country may be marginalized by networks that are controlled by powerful people in the capital city.

Globally, psychiatry and psychology are dominated by Western, Northern approaches, and this creates the risk that mental health and psychosocial networks will marginalize people from the South or preserve inequalities and elites. There is a danger of psychiatry and psychology being another version of colonialism [most countries, although not all, now have their own indigenous psychiatrists and psychologists. The danger is that they may be ignored by "well-meaning" Western-based aid workers - JRMC]. We have to always ask "who benefits"? Whose expertise matters? Whose agenda matters? Local power elites need to be challenged by a social justice approach. Rather than imposing networks from outside, we need to always ask how others

understand their situation, what networks would they find valuable, and what local resources are available. This approach makes it possible to achieve the full power of support and "accompaniment", which is often underestimated.

Why Build Global Networks?

Because these may bring:

- Technical improvement through sharing, mutual learning and capacity building, cross-fertilization of approaches.
- Effective support, culturally grounded practice.
- Mental health and psychosocial well-being which are in part culturally constructed.
- Learning from indigenous practices, recognizing the need for a critical approach—leverage of resources.
- Opportunities for expanding the scope of practice, addressing human needs on a wider scale.
- Opportunities for support, including for practitioners in situations of isolation and rights violations.
- Avoidance of duplication of efforts.
- More effective coordination across regions.
- Opportunities to strengthen coherence in the field.

Challenges

- Security, chaos, access.
- Diverse approaches among the aid workers—clinical, victim-oriented, resilience oriented, intervention and social mobilization, NGO charity vs. NGO rights-based approaches.
- Coordination issues
    - Structure of the humanitarian enterprise may create competition, clusters, funding problems.
    - Specialized training.
    -Dogmas and urgency of focus.
    - MHPSS perceived to be the business of psychologists and psychiatrists only.
    - Lack of consensus on what constitutes a comprehensive response as well a minimum response, for development and implementation.
- Space, language, logistics.

Opportunities

- Authentic desire to strengthen practice
- Opportunity to influence policy
- Existence of multiple networks in different regions
- Readiness to learn together across regions
- Desire to produce better research and strengthen the evidence base for MHPSS in different contexts
- Increased humanitarian emphasis on accountability and coordination
- Technology availability & access

- Desire to implement IASC MHPSS Guidelines

There are different expectations in a network, some may assume that they will receive help in their hour of need. It has been easier to develop the Guidelines than to implement them, but practitioners are taking them seriously and there is a willingness to work together.

2. **Mental Health and Psychosocial Support in Emergencies: What contribution can networking make to improving practice?**
3. **Dr Alison Strang, Senior Research Fellow, Institute for International Health and Development, Queen Margaret University, Edinburgh.**

Alison provided an update on UNICEF-funded work aimed at reviewing networking within the psychosocial sector. Although the IASC networks and other informal networks already existed, the predominance of Western type conferences could imply that others lack a voice.

What brings us together?
Our concern to improve mental health and psychosocial well-being in emergencies and situations of extreme stress

What divides us? Theoretical perspectives and historical traditions**,** geography**,** language**,** culture**,** role**,** status and power

Building connections
Core elements of effective networking:

- Quality of relationships – trust
- Building on existing relationships and connections
- Seeking out the excluded
- Institutions that are more enabling than controlling
- Shared values
- Good leadership

Meeting in Geneva, September 2007

Attended by

- Members of the IASC Task force
- The Psychosocial Working Group
- Leaders of some regional networks

Minutes available at: http://www.humanitarianinfo.org/iasc/content/

At this meeting the group agreed to prioritise the following:

A. Potential purposes of networking

Emergency response – Coordination, IASC guidelines**,** accessing expertise
Capacity building – Training, exchange, peer review

Knowledge Building – Research, documentation of practice**,** advocacy

B. Principles of a network:

Should be flexible and responsive with a clear remit and structure**:** inclusive, pluralistic with the 'local' interests at the centre; international agents to support participation of local agents**;** light structure, realistic goals.

A proposal has now been developed to set up a network to serve these priorities.

Proposal:

***Web platform* -** a user-led interactive web platform to provide a base for exchanging knowledge and a facility for making connection with others working in the sector, and for creating joint working space.

Local 'networkers' - the network will also be supported by local networkers located across the world and across different sectors whose role will be to connect with each other, with the web platform, and act as catalysts to stimulate face-to-face networking within their own context.

Occasional meetings – Recognising the benefits of occasional face-to-face workshops and conferences, we hope (if funding permits) to use the mechanism of the network to facilitate these.

Governance and structure:

(lightweight, flexible, decentralised, sustainable)

- Minimal core secretariat group (to manage the web site and set up meetings).
- Stewardship group (to provide leadership and accountability) – membership to reflect diversity of potential actors.
- 'Network fellows' (regional networkers to strengthen local engagement and provide direct links with local interests).
-

Funding:

- Funding partners
- Institutional and individual membership

What next?

- Join the mailing list (contact astrang@gmu.ac.uk).
- Become an active user of the web platform (add documents/links; use it as a mechanism for discussion; request new facilities). https://psychosocialnetwork.net
- Persuade your organisation to become a founder member.

Discussion points:

1. What are the other elements to the proposal? An experimental site is being developed – like Facebook, sharing experiences/resources, developing groups and private spaces, perhaps advertising MHPSS jobs, publicising meetings/conferences.
2. Reliefweb is already an excellent website. Also many parts of the world have no electronic access. Meetings need to be face to face. The importance of this principle is incorporated into the proposal in the provision for a 'world wide web' of people – local networkers in their own area or sphere who will draw people in, help them to access and use the web as appropriate, enable them to be in touch with wider resources, people and ideas.
3. A network needs to be from grassroots up, not top down.
4. What is the purpose of the network? If it is emergency response, there are already good websites, e.g. the one dealing with child soldiers. The value of the network in emergencies will depend on its wide use at other times. The more it becomes a facility that people find useful and want to be connected to, the more relevant and up-to-date will be the information about people and resources that will be accessible in an emergency.
5. It is a struggle to generate initiatives from the grassroots and there is a dilemma if you give it too much shape. Now it is only representative of IASC groups in Geneva but it needs room to grow. Emphasis will be put into supporting the network to grow in such a way as to become increasingly accessible to those involved at the grassroots.
6. There has been much debate on terminology in the field of mental health and psychosocial support in emergencies and other situations of extreme stress across the world'.

4. *"*The science of refugee mental health: a fugitive in need of protection*?"*

Derrick Silove, Professor, Chair and Director, Psychiatry Research and Training Unit University of New South Wales, Sydney, Australia

Derrick Silove introduced the findings from his research by pointing out that there was no specific methodology for research amongst refugee and post-conflict populations. Existing methods reflect those borrowed from other disciplines of research with efforts to amalgamate approaches (for example, qualitative and quantitative) to present as comprehensive and as rich a picture as possible. Creative methodologies should be pursued given the complexity of the range of phenomena being studied.

- In summary, there is no established single method or guiding framework for researching the relationship between human rights and mental health in the refugee and post-conflict field.

Derrick suggested that it would be useful to consider a tentative typology of methods applied to the emerging field of human rights + mental health research methods as a foundation for potential integration. Clearly, we are committed to devising methods that address core questions rather than adapting or limiting the nature of the inquiry to conform to existing methodologies. Ultimately, we are all interested in the translation of research into practice. In considering contemporary research methods, we need to identify the *intra-research* or processual factors (that is, the impact of the ongoing research process on participants and their communities), and *extra-research* outcomes, or the extent to which the data transforms (or has the capacity to do so) the conditions leading to abuses or their consequences.

Derrick identified five types of research method:

Type 1 Research with a Primary Human Rights Focus: Documentary Research. Here, the primary focus is on human rights violations with mental health indices acting as corroborating factors rather than being the primary concern. Examples are the work of Physicians for Human Rights and Amnesty International in documenting the occurrence of torture, drawing on the physical and mental health consequences to validate the findings and to promote advocacy against these abuses.

Type 2 Population Research. There has been an exponential increase in epidemiological research documenting the effects of trauma across diverse populations of refugees and conflict-affected countries. Here, the **"**trauma model" has tended to predominate with the key index being the prevalence of PTSD and the relevant risk factors pertaining to that outcome. Human rights issues tend to be subordinated or implicit. Standardized methods allow for comparisons within and across diverse fields. Criticisms included that the focus on prevalence/general risk factor research has become "exhausted" in the knowledge it can reveal and the findings are not directly applicable in shaping services or mental health responses. Some regard the application of "universalistic" diagnostic formulations (represented by the category of PTSD) as culturally blind*, that is, the approach does not recognize indigenous manifestations of distress. Examples from East Timor and Vietnam suggest the value of adding indigenous constructs of mental suffering to "universalistic categories". In general, epidemiological research does not mandate community participation but sustained criticism of "parachute" research in low- and middle-income countries conducted by academics from developed countries has been largely heeded, with partnerships, local leadership, and capacity building now being regarded as integral and essential to the process*.

Type 3 Research with a Clear Human Rights Focus in a Mental Health Context. Applies standard research methods that are consistent with orthodox scientific frameworks. Does not mandate active community participation. Researchers often work informally within a wide network of health and grassroot workers. No mandated requirement that the research process itself generates social transformation or community empowerment. Produces data of scientific standing that can be applied to initiate emancipatory change. For example studies on asylum seekers in Australia. Have carried out studies on the effects of detention on mental health. After a change of government there is no longer long term detention but evidence from studies has been influential.

Type 4 Psychosocial Research Grounded in Social Sciences. Chronicles the experiences of, and humanitarian responses to disasters. Examines social, historical, cultural and political factors in a contextual framework. Human rights emphasis varies according to the study and tends to favour qualitative research with its distinctive epistemic framework (which is becoming more "respectable" even in mainstream journals.) Focuses on researching the community rather than the individual. More likely to emphasize participation by community but does not mandate social transformation as an intrinsic function. Some have claimed that proponents are excessively preoccupied with the trauma critique. Criticized (how justly?) for variability in rigour.

Type 5 Participatory Action Human Rights Research. Human rights are the core focus of the research. Applied strategically in settings involving oppressed and marginalized groups. Aim is to empower communities to improve mental health and defend human rights. Applies qualitative or quantitative methods, or both. Action to ameliorate oppression, advocate for communities or challenge oppressive structures *during the course of the study*. Participation of

community as partner in research is fundamental. Emphasizes intra-research or processual outcomes promoting community empowerment and social action, as well as extra-research outcomes related to the publication of findings to influence policy and practice.

Epidemiological surveys: can they help? Long-term mental health outcome of Vietnamese war. Zachary Steel, Derrick Silove, Thuy Phan, Tien Chey, Professor Giao et al

Studying the long-term effects of war and displacement in relation to the Vietnamese has the potential for answering some key questions about the psychiatric effects of mass trauma within distinct ethnocultural contexts. Some questions posed by our research: Does mass trauma cause long-lasting mental disorder and associated disability amongst populations exposed to mass violence and displacement? Do culture/ethnic factors protect some communities from these effects (particularly since East Asian communities appear to have lower rates of common mental disorders overall, based on general epidemiological studies)? Are we asking the right questions culturally, that is, are we measuring the "correct" manifestations of distress?

The Vietnamese may represent a critical test of these issues: Based on surrounding Asian countries, they should have *low* rates; but as a war-affected, refugee population, they should have *high* rates.

In terms of traditional concepts: are we asking the right questions? *The Vietnamese have a rich tradition of describing emotional states within their cultural context. Examples are: Tam trung dam dam dai dong* (an extreme excitement of psyche and an empty feeling) – both psychological and physical factors, excessive *am,* a negative charge which leads to an imbalance of energy and body heat. Treatment involved strengthening the *duong* (positive charge).

Single term: *suy yeu than kinh* (weakness of the nervous system) could apply to several forms of abnormal behaviours and feelings.

Cosmological theory, Yin and Yang also important - five elements and four seasons: disturbances between them can lead to bio-psychological problems. Seven types of emotion (Marciocia): anger, joy, worry, pensiveness, sadness, fear and shock.

These concepts and foundational ethnocultural research were used to develop the **Phan Vietmamese Psychiatric Scale** (Transcultural Psychiatry, 2004, 41, p200). The measure was used in parallel with the CIDI (generating DSM-IV and ICD-10 diagnoses) in two epidemiological surveys, one amongst Vietnamese resettled in Australia, the other in the Mekong Delta region of Vietnam itself.

The main findings:

1. Overall rates of "Western" diagnoses were very low, and even lower in Mekong Delta population.

2. Rates were greatly increased when the indigenous measure was added. This suggests that western measures can "miss" important manifestations of distress across cultures and indicates the risk of comparing rates of trauma-related mental disorder using Western-based measures only.

3. Nevertheless, a robust dose-response relationship was still apparent - the greater the trauma, the higher the overall rates of mental disorder.

4. Time in a secure environment reduced the rates of trauma-related mental disorder, but the most traumatized group continued to have elevated rates even after 10 years living in Australia.

5. General prevalence rates can obscure the presence of highly symptomatic subgroups, for example, combat veterans who suffered extensive war trauma and persecution in the post-conflict setting.

6. The rates of mental health treatment for those disabled by long-term trauma-related mental disorders were very low, suggesting that there is ongoing neglect of these subpopulations in the source country and in well-resourced countries of resettlement.

Challenges for Psychiatry in the Developing World

- **Key issues** What are the main causes of mental suffering? Are we assessing mental problems accurately across cultures and contexts? Are all mental problems illnesses? The example of mass trauma. How great is the need for services and professional interventions? How should services be provided? Should developing countries adopt the approach of the West?

- **Where are the "big" causes of mental suffering?** Although modern, scientific psychiatry is focusing more on the biological/brain problems underlying psychiatric disorder, the main challenges to mental health appear to be social and environmental: War, conflict and social upheavals, natural disasters, poverty, physical illnesses (HIV-AIDS), rapid social change, loss of social cohesion, economic security, developmental experiences, poor parenting, family problems, alcohol and drugs.

- **Are we assessing the needs accurately?** Tendency to adopt international classifications of mental disorder (DSM-IV, ICD-10) without adapting them fully to specific cultures and contexts. Low prevalence disorders now showing substantial differences across populations: see, for example, Caribbean immigrants to England. Epidemiological studies show vast differences across countries in prevalence of common disorders (anxiety, depression, PTSD, substance abuse): see World Psychiatric Survey.

- **World Patterns** Rates always highest in USA, moderately high in Western Europe, lower in Asia and Africa. Reasons - measurement, loss of traditional society, extreme forms of competition and modernization, social and political instability, history of war and conflict, ethnic and cultural factors.

- **Is psychiatric measurement accurate across cultures?** Use of international diagnostic instruments e.g. CIDI, SCID but what about culturally specific ways of

expressing distress? The Tho study shows that cultural ways of expressing emotional distress (somatization, anxiety and depression) may give a more accurate picture of local need and disability than the Composite International Diagnostic Instrument (CIDI): A world first!

- **Vietnamese models of understanding mental suffering** A long and rich history, with many influences from inside and outside the country – own traditions for understanding and classifying mental disorder. Different ways of experiencing, describing and understanding particular disorders, for example panic disorder.

- **Traditional ways of understanding mental suffering** Blurring of concepts of mental and physical health towards a more holistic perspective are:

- *Tam than* defined by *Tu dien dong y hoc co truyen* as "Psyche" includes aspects of energy and central nervous system functions; it relates to the general functioning of the brain and the heart. Psyche means the overall functional system of life.
  "Than" bao gom cong nang trung khu than kinh, dai nao va ca tam noic chung, cho nene moi noi tam tang than. Than la tieng goi chung cho moi hien tuong hoat dong cua sinh mang

- **Studies on other populations** It is only possible to understand the way that a community expresses mental disorder by in-depth ethnographic or "emic" studies. East Timorese: work of the Centre for Population Mental Health Research identifying terms, for example, "half-moon" psychosis, "thinking too much", and the causes of mental disorder – breaking taboos, offending the ancestors or the earth spirit.

  Cambodia has a large number of mental illness categories that overlap with but are not identical to Western diagnoses (Harvard Program in Refugee Trauma). In Africa too, each culture has its own terms for mental illness, and the categories are not exactly the same as for ICD-10 or DSM-IV (for example, also has a category for "thinking too much").

- **Should all the problems be dealt with by psychiatry?** Is there a risk that we will ask Psychiatry to do too much, beyond its capacity and resource-base? Should as much attention be given to social structures in society as to mental health services? [I understand that we are discussing here mental health in traumatised societies and therefore mainly different forms of severe anxiety and depression, not including the very serious forms of mental illness such as schizophrenia, mania, delusional depression, Alzheimer's disease etc-JRMC]

- **The dilemma of mass trauma** Large numbers exposed to mass violence and disasters. Responsibility falls on poor, war-affected societies with limited resources and many demands in health, welfare, economic survival. Should all persons exposed to trauma receive psychiatric interventions? Are early signs of PTSD (nightmares, flashbacks, avoidance, arousal) an indication of mental illness?

- **Psychobiology of fear responses** Natural fear response (fight or flight) is a primitive, immediate survival response mediated by the limbic system of the brain, especially the amygdala. Cortical (thinking) centres can inhibit this response over time, by evaluating

the level of ongoing threat. Therefore the immediate posttraumatic stress reaction may be based on an evolutionary survival reaction and should not be labelled as a psychiatric disorder unless it persists and leads to dysfunction.

Boat people now settled in Sydney (Steel, Silove, Phan and Bauman, Lancet, 2002; Steel et al, Acta Psychiatrica Scand, 2005)

- **Low levels of mental health service utilization amongst Vietnamese living in other countries**. Reasons: Inaccurate assessment, somatization, stigma, resilience or stoicism, family business, use of traditional healers, unfamiliarity with or culturally insensitive mainstream services.

- **Major differences between low-income and emerging middle-income countries** Very low income countries: virtually no mental health services or professionals, with or without old institutions where mentally ill are held for years. Traditional healing and primary care. Emerging middle-income countries: Growing but still inadequate numbers of mental health personnel and facilities, rapid social change (urbanization, industrialization), decisions need to be made about service needs and directions.

- **Underutilization of services in Australia** Vietnamese with mental problems do see their family doctors but not for mental health problems. Very few get referred onto specialist mental health services. Reasons: Somatization, treated by own doctor who often is Vietnamese, not properly detected or both doctor and patient avoid referral, cost, language, services are culturally insensitive/don't know how to use them. (Study showed much greater satisfaction with specialist service with Vietnamese bicultural counsellor.)

- **Somatization** First postulated by Kleinman in China: Reason for "low" levels of depression is because Chinese somatize their distress. Others have claimed the opposite: if you ask the correct questions, you will discover depression, anxiety, PTSD. Our study does suggest that somatization is important, but the problem is that there are no specific "Western" treatments for somatization as there are for depression!

- **Stigma or family business?** Two views about under or late utilization of services in Western countries: Community stigma about mental illness stops individuals and families declaring the problem or presenting for treatment….family hides the problem until it is very late. Because of strong family ties, a member's distress is a problem for everyone and the family does everything it can to help so that outside help is not needed as much. (Although traditional healers are used in Australia, this does not account for a lot of treatment.)

- **Resilience or stoicism** Vietnamese are "strong" – they don't complain as much but try their best to cope! Study in Australia suggests that this is partly true, that is, disability had to be higher in Vietnamese people for them to start admitting symptoms…but whose standards are "correct"?

- **Important principles/questions for service development** How to balance/integrate international and Vietnamese ways of diagnosing and understanding mental disorder? Balance between institutional and community services. Balance of interventions: cultural, social, biological, psychological, spiritual. Risk of medications.

- **;Key issues** How to engage the community in self-help; participation; destigmatization; family support; early detection and intervention; how to approach somatisation; specialization; what to do about higher rates of disorder amongst the elderly?

Discussion points

1. Is research needed?
2. We need to know, we think we know but we do not. We have assumptions about the protective effect of culture but we do not really know.
3. This presentation strengthens the need for culture-relevant assessment tools.
4. This raises disturbing questions. Who decides on the research questions? There are complaints from students in Uganda that they are asked to change topics. Also respondents in research are usually not consulted. Are we answering questions relevant to the people or the agencies? Have we shared findings with affected populations? Current research may not be relevant as we may not be addressing real problems in the community. The community needs to be consulted.
5. Donors expect monitoring and evaluation but that is not really research – it would not get published, and is not available to be read by others.
6. The ALNAP website (Active Learning Network for Accountability and Performance in humanitarian action, www.proventionconsortium.org) encourages everyone to send monitoring and evaluation reports to them. A randomized control trial is still considered the most prestigious and there are now an increasing number of them.
7. A study focused on employment should rather focus on functionality – are mental illness symptoms making a difference in people's lives. Derrick considered the study did address functionality but the questions were limited.
8. We are caught between the field and the academics. We bring back very interesting issues from the field that normal research does not answer. It is possible to do a randomised controlled trial, including capacity building for researchers, but it is not possible to control for all variables.
9. Research has to be turned into something useful for interventions and has to be taken back to communities. Is loss of family the most important disaster?
10. Trauma does matter in the long term. Iraqis resettled in Australia are most distressed about leaving loved ones behind.
11. Researchers masquerading as aid workers are very different from the research Derrick has undertaken. Action research cannot solve complex problems.

CONCLUSIONS

Ten general issues/considerations that should inform practice in emergency and post-emergency settings:

1. It is invariable that there will be very high levels of immediate and short-term distress amongst populations exposed to disasters and humanitarian emergencies. This established observation does not require confirmation by large-scale epidemiological studies in the acute phase (although studies may be useful for other purposes). In most settings, rigorous qualitative methods can be used for rapid assessment of the major psychological and social needs of the population; to identify the range and needs of vulnerable groups; to identify the contextual and cultural factors influencing the way distress is expressed and dealt with; and to map the available resources and systems of care.

2. Offering direct face-to-face psychological treatments for traumatic stress across the entire population in the acute crisis is neither necessary nor feasible. Indiscriminate debriefing (in which the focus is on recalling trauma experiences and "catharsis"), often conducted in groups, is not recommended, either for adults or children.

3. Psychological first aid, although yet to be defined clearly, has emerged as the preferred approach to immediate intervention. It is vital that the approach is consistent with local systems of support and, where possible, works through them. Components include the accurate dissemination of information about the disaster, including advice about normative responses and suggestions for personal and family/communal strategies that may be helpful in dealing with acute stress reactions; provision of non-intrusive psychosocial support for individuals and families in need; establishing and enacting referral pathways for practical support to ensure that those in distress have their basic needs met (food and water, shelter, health care, etc.); and detecting those who, for a range of reasons, are not able to manage, ensuring appropriate and targeted referral to generic or specialized helping agencies. How psychological first aid is delivered is dependent on the context, resources and culture of each disaster setting. The emphasis should be on strengthening and promoting existing mechanisms of support within that society rather than on generating new and potentially competing systems.

4. Attending to the needs of those at greatest risk. There is a core place for an emergency mental health response that attends to persons in severe mental distress including those with severe mental disorders who, for a combination of reasons, are at social risk in the disaster/post-disaster setting. Clearly, an emergency mental health service cannot attend to all those with a mental disorder or who are experiencing extreme levels of distress. The threshold for emergency care should be based on a social criterion, that is, priority attention should be given to those with severe psychological disturbances who are at risk of adverse outcomes if not provided with immediate assistance. For example, a high priority would be given to those who are suicidal, acting in a bizarre or dangerous manner (because of mental disorder), unable to care for themselves or dependents such as children, or are at risk of exploitation and abuse. In practice, emergency clinics attend to high-risk persons with a range of diagnoses and other psychological problems including those with psychosis, severe mood disturbances, organic brain disorders (in many settings, including epilepsy), the more severe "stress reactions" including complicated grief, PTSD, anxiety and somatizing disorders, culture-

based manifestations of distress, and selective persons with drug and alcohol conditions. To be effective, services need to learn about and identify cultural manifestations of distress, drawing on indigenous concepts of healing to develop integrated approaches to care.

5. Coordination and the development of flexible, rolling plans are vital to ensuring that participating agencies cooperate in the provision of services, that there is little redundancy or duplication in efforts, and that resources are allocated in a rational manner to the various components of psychosocial care and mental health.

6. Social programs should work closely with mental health services and vice versa to ensure a seamless provision of care ranging from those with severe mental disorders to the wider community in which broader psychosocial needs receive attention.

7. Priority should given to indigenous participation and leadership in the design, development and management of services. Capacity building and strengthening of existing structures and services are vital elements – new, stand alone services should be avoided where resources can be invested in existing services or agencies. Training should be incremental with a step-by-step building of the knowledge base matched by supervision and practical experience.

8. Planning for the transition to the recovery phase in which humanitarian agencies will leave the arena is vital to ensure sustainability of existing services.

9. Anticipation of the medium-term needs of disaster-affected populations is vital. Persons with enduring traumatic stress reactions often are "hidden" because their disabilities are not as evident as persons with "externalizing" characteristics such as those with severe psychosis. Services should be designed to identify and encourage the minority with unremitting traumatic stress into treatment. That challenge is made even greater by the tendency for humanitarian support to be withdrawn from services in the medium-term after an emergency.

10. Overall, there is a pressing need to establish a solid evidence base for mental health and psychosocial programs in emergency and post-emergency settings: we need to know *what works* in *which settings* and *for whom*. In all our endeavours, we need to ensure that attention to 4 key issues: *culture, human rights, history/context of the conflict, and gender*.

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Workshop Sessions

Feedback from workshop sessions was facilitated by Jane Gilbert.

Workshop 1 facilitated by Nancy Baron

Training for MHPSS: Developing Effective Delivery Strategies for Training and Preparedness

Expectations
What do we teach?
Who do we teach?
What levels to target
How to follow up training
How to use PME methodologies
How to integrate
How many do training?

Stakeholders – humanitarian workers, academics, ministries, private institutions, primary healthcare, communities, policy makers, managers, libraries, others.

Need:-

- To adopt a systematic strategy.
- Commitments from stakeholders.
- To be legitimized in policies.

- Interpretations/translations in understandable language, showing others how to use training materials, offering concrete ideas.
- Senior partners in UN organizations at national and regional levels.

Next conference – Mental Health - academic network, awareness and capacity building, every two years. Need for WFMH to support psychosocial issues at all levels. Need an inclusive approach. IASC Guidelines have not had sufficient media coverage, limited awareness, dissemination and follow up at field level and with donors.

Multilateral and bilateral organizations and others
Are people informed? Is it continuous? How often? Is it structured? Does it target various stakeholders? What about funding limitations from donors? Is there a follow up?
Who? How? When? Where?

Training at organizational level
How? Using structured tools, case examples, identify trainers(health workers), e-learning, from top to bottom and to appreciate grassroots input, hands-on training, audio-visual learning, materials in different languages and characters with supportive interpretations e.g. drama, role play.

Who? Team of consultants.

How do you change organizational behaviour?
- EU and European funding diversification
- Donor stimulation focusing on donor governments, explore participatory planning, implementation and dissemination in one package
- Push the main idea of IASC Guidelines – have schematic presentation, use Face book and U-tube. Reach the audience of the modern world through electronic media.

How can IASC Guidelines spread in your location? (brainstorm)

Darfur –
use of local NGOs with creative learning materials, target psychosocial and "move beyond".

Sri Lanka –
- Community mobilization being mindful of limitations of language.
- Prioritise IASC Guidelines and include in donor proposals with transparency,
- Have observable outputs to be included in the monitoring and evaluation process,
- Selectively prioritise, focusing on the general principles of IASC Guidelines.

Nepal – willingness to introduce IASC Guidelines to mental health team and commit to networking with other advocates, but limited funding.

Sudan (south) – mental health policies non existent so where do we even start?
IASC Guidelines came at the right time.
Need capacity building of limited human resources, useful tools would be a beneficial resource.
Need psychosocial first aid training.
Focus on mental well being.

Need to narrow down what we want people to do, e.g. communication skills and listening if you want people to be nice.
Revise some of the contents of the IASC Guidelines.

Summary

- Training in the IASC Guidelines should be practically oriented and easily accessible.
- Create tailored versions with simplified questions and answers on how to start.

How can WFMH be involved?

Networking with NGOs, educate the WFMH Congress, seek national representatives, identify donors and trainers, provide support and advocacy at international, national and local levels.

Workshop 2 facilitated by Mike Wessells

Addressing Current Funding Issues for Humanitarian Relief during Major Disasters: How Can Mental Health and Psychosocial Support Services be Included?

- There is a serious lack of funding for mental health and psychosocial needs.
- No co-ordinated lobby to access funding – no clear message.
- Funders/donors want to fund evidence-based interventions.
- The nature of funding is often problematic – often short-term, e.g. one year, rather than multi-year funding to support long-term interventions.
- There is a need for an integrated approach to current mental health services.
- Need to expose the fact that funding given to NGO structures is often not directed at mental health needs. Funding is used for other humanitarian aid, e.g. food and shelter.
- Advocacy strategy and change agents need to be placed within donor organizations – e.g. ascertain DFID's funding priorities and ensure that mental health and psychosocial needs/priorities are placed on their funding radar.
- Needs to be a long-term commitment to advocacy. Good lobbying needs to start before a disaster happens.
- Who do we target? Governments, foundations,e.g the Gates Foundation, etc., international funding organizations, e.g. DFID, USAID.
- Need an inter-agency approach to advocacy, i.e. collectively defined messages, speak with one voice.
- Engage the media as a powerful tool to expose the need and to access regular funding.
- Agencies need to record and write up best practice evidence-based programmes to support information used in proposals. Need monitoring and evaluation outcomes on a website, and transparency.
- Need clear strategy for funding proposals.
- Building an alliance with academics and practitioners is critical to accessing funding.

Workshop 3 facilitated by Mark Van Ommeren

Developing Collaborative Relationships and Coordination among Humanitarian Relief Organizations and Grassroots MHPSS Providers: How can on-site coordination of MHPSS best be achieved?

- Try to keep power conflicts in check, e.g. share power.
- Do pre-mapping if possible.
- Have TOR for leader of co-ordination agreed by everyone, e.g. advocacy.
- Conduct meetings in local language.
- Co-ordination needs to have facilitative style (can this be taught?).
- Consult with local key informants – power, capacity, needs.
- Need a roster of co-ordinators who are trained regularly.
- Need interagency training on co-ordination and contents of IASC Guidelines.

Workshop 4 facilitated by Preston Garrison

***"When the Media Trucks are Gone:"* MHPSS Provision in Post-Disaster and Emergency Settings**

1. Long-lasting impact of disasters
    - Infrastructural weaknesses are often intensified.
    - Rules and regulations of government can impact adversely the capacity to deliver services – approval of outside support, fear of being blamed when mistakes occur, attitude towards victims/survivors of disaster.
    - Long-term impact of disasters is often more extensive and long lasting in more isolated areas which have fewer resources to start with.
2. Similarities and differences between "incident" disasters and extended emergency settings.
3. Need for visitors to respect local services and agencies.
4. Need help to re-build and maximize existing resources, provide opportunities for positive activities and responses.
5. Need to recognise needs and strengths of all parts of affected population.

Final thoughts/work to be done

- Training for MHPSS: Developing Effective Delivery Strategies for Training and Preparedness.
- Addressing Current Funding Issues for Humanitarian Relief during Major Disasters: How Can Mental Health and Psychosocial Support Services be Included?

- Developing Collaborative Relationships and Coordination among Humanitarian Relief Organizations and Grassroots MHPSS Providers: How can on-site coordination of MHPSS best be achieved?
- Defining Effective Strategies for the Provision of MHPSS in Emergency Settings.

ABSTRACTS ACCEPTED FOR BREAKOUT PRESENTATIONS

Name	Abstract Title	Organization	E-mail
GILBERT, Jane	**POWER AND ETHICS IN PSYCHOSOCIAL COUNSELLING: REFLECTIONS ON THE EXPERIENCE OF AN INTERNATIOAL NGO PROVIDING SERVICES FOR IRAQI REFUGEES IN JORDAN**		janegilbert@janegilbert.entadsl.com
ABBS, Karen	**Critical Incident Stress Management for Humanitarian Workers in Darfur**	**RedR UK Psychosocial Program in Darfur**	**Karen.Abbs@redr.org**
ZAPPAROLI, G. C., GISLON, M. C., & RUFFINO, M.	**Focus-based Integrated Psychotherapy**	**Institute for Study and Research on Psychic Diseases (ISeRDIP)**	**nuffinomilena@gmail.com**
RAY, Tapas	**WFMH's Initiatives in Disaster Response- Sharing from SEVAC – a Mental Health NGO Working in India**	**SEVAC Mental Health and Human Rights Resource Center**	
QURAQE, Khawla	**The Experience of**	**YMCA/Rehabilitation**	**khawla@psccw.org**

	the Psychosocial Emergency Intervention in the West Bank	**Program/Beit Sahour/West Bank**	
TSOVILI, Theodora D.	**The Implementation of IASC Guidelines within the Context of UNICEF—Syrian Arab Red Crescent (SARC) Assistance Programs for Iraqi Refugee Children, Adolescents, and Mothers in Syria**	**UNICEF, Damascus, Syria**	**ttsovlli@unicef.org**
ALMAQRANI, Mohammed	**Strengths and Difficulties of the Post-Conflict Psychosocial Support Project in Yemen**	**Department of Psychiatry, Dhamar University, Yemen**	**almagrami@yahoo.com**
BERGLUND, Else	**Community-Based Psychosocial Services in Humanitarian Assistance – A Facilitator's Guide**	**Church of Sweden**	**else.berglund@svenskakyrkan.se**
LOUGHRY, Maryanne	**Addressing the Mental Health Needs of Urban Refugees**	**Refugee Study Centre, University of Oxford**	
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RICHARD, Kinyera	**Delivery of MH/PSS in Politically Unstable Environments**	**TPO Uganda Somalia Program**	
EKANAYAKE, Evangline	**Community Mental Wellbeing in Rural Areas: Indigenizing Treatment Techniques**	**GTZ, National Institute of Education, Sri Lanka**	**sophocles23@yahoo.com**
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HETTIARACHCHI, Malkanthi & De Zoysa, Roshan	**Disaster Survivors to User-Led Community Mental Health Workers**	**Rebuilding Lives Project, The Foundation of Goodness, Sri Lanka**	**malshanthi@gmail.com**
SELLAS. Ety	**Normalizing the Abnormal – Ongoing Mental Health Care During Ongoing Emergency Settings**	**Israel Mental Health Association (ENOSH)**	**hasbara@bezeqint.net**
DANIELS, Ingrid	**Mental Health & Psycho-Social Support in Emergency**	**Cape Mental Health Society, Cape Town, South Africa**	**ingrid@cmhs.co.za**

	Settings: Addressing the Response and Challenges Pertaining to the Xenophobic Attacks on Foreigners in South Africa		
ENOH-ARTHUR, Suzanne & VAN DAMME, Patrick	**The Potential of *Mkringa oleifera* in Alleviating Common Symptoms of Depression**	**East London NHS Foundation**	**sarthur@hotmail.co.uk**
ERDELYIOVA, Rut	**Crisis Intervention And Post-Traumatic Care Provision In Mental Rescue Services In Slovakia**	**Emergency Medical Operations Center of the Slovak Republic**	**erdelyiova@oszzs-sr.sk**
GRAHAM, Zoe	**Stress & Trauma – Training Scuba Divers Post-Tsunami 2004**		**zoegraham@talk21.com**
GRAHAM, Zoe	**"A Small Fish…."**		**zoegraham@talk21.com**
PARE`, Marie-Helene	**A Global Study on Local Participation in Disaster Mental Health Projects**	**Department of Social Policy & Social Work, University of Oxford**	**marie-helene.pare@stcatz.ox.ac.uk**

FEEDBACK ON THE WFMH INTERNATIONAL FORUM ON MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SERVICES IN EMERGENCY SETTINGS

AVERAGE RATINGS FROM FEEDBACK FORM RESPONSES

NUMBER OF COMPLETED FEEDBACK FORMS RECEIVED N = 16

FORUM AS A WHOLE	***N = 16***	***AVERAGE RESPONSE = 4.25***
PRE-CONFERENCE COMMUNICATION	***N = 16***	***AVERAGE RESPONSE = 3.18***
VENUE	***N= 16***	***AVERAGE RESPONSE = 3.5***
MATERIAL	***N = 13***	***AVERAGE RESPONSE = 3.53***
CONFERENCE ORGANIZATION	***N = 16***	***AVERAGE RESPONSE = 3.5***
TOPICS	***N = 16***	***AVERAGE RESPONSE = 4.37***

WERE THE TOPICS RELEVANT TO YOUR PROFESSIONAL POSITION?
N = 15 VERY = 10 SOMEWHAT = 5 NOT AT ALL = 0

WHAT TOPICS DID YOU FIND MOST INTERESTING?

- ***IASC GUIDELINES***
- ***LYNNE JONES' SESSION***
- ***ALL TOPICS WERE INTERESTING AND USEFUL***
- ***FUNDING WORKSHOP***
- ***RESEARCH SESSION***
- ***INTRODUCTORY TOPICS AT BOTH DAYS & EXPERIENCES FROM THE FIELD***
- ***HEARING FROM SO MANY VAST PERSPECTIVES AND EXPERIENCES***
- ***DISCUSSON ON TRAINING – LYNNE AND NANCY***

WHAT WOULD YOU LIKE TO SEE IN FUTURE CONFERENCES?

- ***REPRESENTATIVES OF LOCAL NGOs TO SPEAK ON THEIR EXPERIENCES***
- ***MORE INTERACTIVE SESSIONS***
- ***DISCUSSION OF LARGE-SCALE INTERNATIONAL SUPPORT INITIATIVES***
- ***"DO NO HARM" ISSUES***
- ***CASE STUDIES IN GROUPS***
- ***WORKING TOWARD PRACTICAL GUIDELINES IN RELATION TO THE IASC GUIDELINES***
- ***PERHAPS MORE TIME TO HEAR ABOUT INDIVIDUAL PRESENTERS' WORK***
- ***IT WOULD BE NICE TO HAVE COPIES OF THE POWERPOINTS DURING PRESENTATIONS TO MAKE NOTE TAKING EASIER***

MORE ON HOW TO COMBINE RESEARCH AND PROGRAMMMING
MORE MAINSTREAM INTERNATIONAL NGOs AND MEDICAL ANTHROPOLOGY ACADEMICS

OTHER COMMENTS:

"INSPIRING TO SEE SO MANY PEOPLE WITH SO MUCH PASSION FOR THE AREA"

"VERY INTERESTING AND USEFUL"

"PLENARY DISCUSSION WAS USUALLY LIMITED TO SAME INDIVIDUALS SPEAKING. MIGHT BE BETTER TO MAKE MORE BREAKOUT SESSIONS FOR DISCUSSION TO ENCOURAGE OTHERS TO PARTICIPATE"

"EXTREMELY STIMULATING FORUM AND DISCUSSIONS; GAVE ME A LOT OF IDEAS FOR CAREER PREPARATION"

"OVERALL, I THOROUGHLY ENJOYED THE EXPERIENCE. THANKS"

"THIS WAS A WONDERFUL INITIATIVE WITH A GREAT COLLECTION OF PEOPLE"

"LIKED THE INTENSIVE DISCUSSION. BETTER TIME MANAGEMENT NEEDED"

"NEED CONTINUED COORDINATION TO GET INFORMATION FROM WFMH"

"VENUES FOR PARALLEL SESSIONS WERE NOT SATISFACTORY. PEOPLE TRAVELED FROM FAR PLACES TO DO PRESENTATIONS AND COULDN'T DELIVER PROPER "FACE TO FACE" PRESENTATION. PLEASE CONSIDER THIS."

"AMAZING TO BE IN A ROOM OF PEOPLE WHO WORK IN THIS AREA – I'VE FOUND IT HARD TO GET INFORMATION ABOUT THIS TYPE OF WORK, BEEN DISCOURAGED THAT WITHIN MENTAL HEALTH, IT WAS IMPOSSIBLE TO WORK TRANSCULTURALLY. I FEEL INSPIRED TO LOOK INTO THIS MORE, AND HAPPY TO HAVE MADE FRIENDS WITH STUDENTS WHO SHARE MY INTEREST. BEFORE TODAY, I KNEW ONLY ONE OTHER PERSON."

"THE CONFERENCE HAS BEEN VERY USEFUL AND FASCINATING. I HOPE IT WOULD BE THE CULTURE TO CONTINUE WITH MORE CONFERENCES TO IMPROVE BETTER INTERVENTIONS IN EMERGENCY SITUATIONS."

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