PSYCHOSOCIAL/MENTAL HEALTH PROGRAMMES IN HUMANITARIAN CONTEXTS: PROBLEMS, CHALLENGES AND SHARING GOOD PRACTICE

Tuesday 31st January 2006, 9:30am-3:30pm
Venue: British Red Cross Society
44 Moorfields, London EC2Y 9AL

SUMMARY REPORT

Jane Gilbert

February 2006

CONTENTS

A. SETTING THE SCENE

1. Aims of the day

- **To share experiences and learn from each other**
- **To identify the major challenges in designing and implementing psychosocial/mental health programmes**
- **To determine what organisations need**
- **Action planning – forum, training, funding**

2. Background

This report summarises the second meeting organised by Jane Gilbert [1] with the support of RedR-IHE and Red Cross. The first was held in September 2005 to launch the research survey "UK NGOs and International Mental Health: An Exploratory Review". Those present in September expressed a strong desire for a further meeting to discuss issues in greater depth, to widen participation, and to consider setting up a UK International Mental Health Forum. Jane therefore designed a programme (Appendix 1) and facilitated the meeting on Jan 31st. 35 people attended and a wide range of organisations was represented. (Appendix 2 - list of participants).

3. Introduction

Jane thanked all those whose help and support had enabled the event to take place in the absence of funding. She introduced the day by reviewing her original research study, commenting on the passion with which people interviewed spoke about their work, and reiterated the aims of the day. The day was predominantly to be able to share experiences and learn from each other and to consider the future of the forum. The greater part of the day would therefore be taken up with structured small group discussion. The day began with two formal presentations which were contrasting in both style and content, and provided a stimulating beginning to the event. (**Please contact the presenters for further details.**) During the course of the day there were also three mini presentations to increase awareness of some groups and initiatives.

[1] ***Jane Gilbert*** is a Consultant Clinical Psychologist. She has been working in the field of mental health for more than 15 years in Africa and the UK including the National Health Service (NHS). She has also conducted research on humanitarian mental health issues and published articles related to practical and policy issues in mental health. Jane specialises in psychological and mental health issues in cross cultural contexts, psychological self care, and the facilitation of change within organisations.
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B. PRESENTATIONS

1. Trauma Risk Reduction Programme of the Disaster & Development Centre

Janaka Jayawickrama
Trauma Risk Reduction Programme
Disaster & Development Centre
Northumbria University
Newcastle upon Tyne
j.jayawickrama@northumbria.ac.uk
Web: www.northumbria.ac.uk/ddc

Janaka introduced the work of the centre, and, through photographs and anecdotes illustrating his work in Sri Lanka and Sudan, outlined the philosophy underlying their approach.

Philosophy

- Communities know how to deal with disasters. They only want some help based on their needs.
- People live life as whole. Some times simple and silly things make people understand complicated life situations.
- Antidote to "trauma" is to take control. We have to follow the community.

Approach

- Cult + Ure – need to understand a community's relationship with the earth
- It is very important to understand the social, political, economical, cultural and environmental relationships within communities
- How do we engage with communities? Listen, articulate and ponder

Action

- Direct interventions in collaboration with local practitioners
- Education and training – formal and informal
- Need to address the trauma experienced through in the process of development – globalisation, growth and impact

Anecdotes from Sri Lanka and Sudan

- The national staff members of international agencies often includes those who have been traumatised by the disaster/conflict but who are not included in psychosocial programmes because they are regarded as the staff of an international agency rather than IDPs.

- Traditional practices for coping with trauma – rituals, traditional healers, etc. play an important role and need to be better understood by international agencies. In Thailand one relief agency had provided funds to Buddhist monks

for a large ritual ceremony. Traditional healers are often not paid for their services and have an ordinary job as their primary source of income. For example, a traditional healer providing trauma services was working as a guard for an international agency running a psychosocial programme but the agency was unaware they had such a capacity on their staff.

2. A Case Example of a Psychosocial Programme: Community-based Psychosocial Services provided by ACT/Caritas in South and West Darfur

John Borton
Learning Support Adviser
ACT/Caritas Darfur Emergency Response Operation
johnborton@ntlworld.com

John presented on behalf of Abia Alphonsine and colleagues in the Psychosocial team within The ACT/Caritas Darfur Emergency Response Operation and Maria Lundberg in Swedish Church Aid and the ACT Psychosocial network. He began by outlining the background of ACT: an alliance of 150 Protestant and Orthodox churches and Caritas Internationalis: a confederation of 160 Catholic relief, development, and social service organizations, and describing their joint operational response in Darfur (DERO). This operation has been providing assistance to 325,000 IDPs and host communities at 35 camps/locations in South and West Darfur since early 2005.

Following a comprehensive assessment process, the Psychosocial sector was intentionally the last sector to become operational within the DERO Programme.

Principal Interventions

1. Emphasis on working with, and involving, local community structures

2. An integrated, multiple hearing approach designed along 4 main pillars:

A. Building and strengthening national capacity in psychosocial interventions. Training given to:

- A core team of 20 drawn from national partner agencies (12 months)
- Women in the community, school teachers and camp volunteers (5 days). This group works closely with the first group.
- Targeted groups of volunteers, traditional healers, sheiks, women and some youths (1-2 days). A minimum of 20 in each group for each camp.

B. Establishing counselling services, especially for women

- Community centres were constructed in the camps and used as venues for counselling services
- Culturally appropriate ways of support were explored and used
- Group counselling sessions were used among rape survivors

- Individual sessions during home visits proved to be helpful

C. Camp/community based social reintegration activities

- Community centres used for organised recreational, occupational, income generating activities
- The focus was the people, their experiences, stories and needs
- To re-establish trust in themselves and their capacities instead of remaining idle

D. Education and Awareness Raising campaigns among both IDPs and host communities on the psychosocial effects of the conflict

- Awareness raising meetings, discussions and training targeted at the general community and key stakeholders
- Central messages included effects of conflicts and wars, human rights, gender based violence, community participation and child issues
- Adult education classes held for both men, women and children, including kindergartens

Monitoring and Evaluation

- Community Centre records e.g. Participants lists, Daily attendance lists
- Monthly activity reports
- Monthly cash flow charts
- Regular meetings
- Monthly clinical supervision
- External evaluation of the Programme (Health Focus, Potsdam)

John concluded his presentation by describing the process of building capacity in Community-Based Psychosocial Services within the ACT Alliance. A Guide on Community Based Psychosocial Services has been prepared by the Church of Sweden, Presbyterian Disaster Assistance and Norwegian Church Aid and can be downloaded at www.svenskakyrkan.se/psychosocial

3. Discussion

Discussion following the first two presentations included questioning the linkage between the different agencies and the impact made, whether different responses to trauma can be brought together, the crucial role of culture, and the absence of indicators as to what is intended to be achieved by psychosocial programmes.

The need to educate the donor agencies was highlighted and it was pointed out that it is essential that needs assessement is done at the beginning, and clear indicators are established, both to convince funders of the need for support for this work and to establish if psychosocial programmes have been effective. There was a recognition of the central role of culture and some comment on the terminology used (e.g. ‘counselling’) and how such work was actually carried out in practice.

C. PARTICIPANTS' CONTRIBUTIONS: MAIN THEMES

Due to the need for participants to be able to share experiences, much of the morning and afternoon was spent in structured small group sessions. Groups were asked to discuss specific questions, after which they shared the main points with the whole group. To enable those with similar interests to spend time with each other, and for different perspectives to be articulated, in the afternoon there were five groups: fundraising; training; children; practitioners and managers. (See Appendix 3 for small group tasks)

Discussions amongst participants were wide ranging and animated. Many issues were raised. The following section summarises morning and afternoon discussions under the main themes which emerged. Although this analysis is somewhat "artificial" in its divisions, as all identified themes are inter-related to each other, it does bring together the maximum information from the day. This summary is not totally inclusive, and it is hoped that those who were present will correct any omissions.

1. Terminology

Concerns were expressed regarding lack of clarity of definitions e.g. the terms "mental health", "psychosocial", and the possible stigma attached to this area of work, "there is a fear of psychosocial". This lack of clarity can lead not only to confusion, but also to difficulties in designing programmes and providing evidence of impact. It is essential to provide key definitions and a common understanding of terminology. In this report the term "Mental Health and Psychosocial Support" (MHPSS) will be used, as this has been adopted by the IASC Working Group.

2. Integration of mental health and psychosocial support into programming

This theme was raised by all discussion groups – a recognition that MHPSS needed to be an integral part of all programmes, but that there were significant difficulties in achieving this.

Identified difficulties included:

- NGOs tend to focus on material items
- limitations stemming from the scale and capacity of organisations on the ground, pre-existing infrastrucutres and the demand for projects to work within existing structures
- difficulties in transferring understanding of MHPSS into programming
- the chaos that follows emergencies can allow little time for reflection, and survival needs take priority over MHPSS.
- individuals who have experienced traumas may not develop symptoms for months – possibly after relief agencies providing psychosocial programmes "have come and gone". How long can a MHPSS response be?
- there is a risk that community-based psychosocial approaches simply reflect pre-existing class or ethnically-based exclusions within the society and that the excluded groups are missed by the programmes
- lack of clarity between disaster response and development needs and emergency and chronic situations

Suggestions put forward by participants to address these difficulties included:

- the need to acknowledge two streams of intervention – community based and individual
- the need to mainstream MHPSS
- clear policy guidelines
- to build in sustainability and clear exit strategies
- to integrate MHPSS programmes with **practical** ways of protecting people e g providing firewood as security, and re-unifying families
- MHPSS work has to be well linked to health programmes
- Increase cross-sectoral integration.

The provision of guidelines was thought to be useful, but participants felt that they need to be drawn up by people with field experience, rather than "experts".

3. Outcomes/evaluation

The difficulty in measuring outcomes in MHPSS programmes stems in large part from the difficulties identified in 1 and 2 and also has a direct impact on fundraising (7).

Comments included:

"lack of clarity about what we are doing and lack of evidence of impact"
"Assessment difficult due to lack of clarity, lack of time, appropriate tools"
"What are the desired outcomes?"
"Where is the point of intervention?"
"Communities that "manage" can then face greater problems in the future";
"psychosocial interventions risk pacifying populations affected by conflict so that they accept their fate".

Participants proposed the following:

- "clarify what we are trying to achieve"
- develop more effective approaches to measurement of impact of MHPSS programmes and evaluation
- need recognised indicators to measure the effectiveness of MHPSS inputs
- Need to be able to articulate project aims/outcomes with greater clarity
- Greater sharing of information
- Successful MHPSS interventions are often very local and small scale, projects need to be evaluated in terms of potential for "scaling up".

In terms of related developments in measuring impact, John Borton suggested a link up with ALNAP which is beginning a process to develop ways of measuring the impact of protection programmes. http://www.odi.org.uk/alnap/

4. Training

Discussion regarding training was also related to 1, 2, 3 and specifically to organisational culture (5).

There was debate as to how much the short and long term emotional effects on aid workers of the stressful nature of their work is related to, and affects their capacity, to implement/integrate MHPSS programmes. It was suggested by some that agencies undertaking psychosocial programmes had to look first at themselves and the treatment of their **own** staff.

It was agreed that people need to be able to talk and listen to others as part of their working life and that the psychological well being of staff can affect the quality of their relationships with communities and beneficiaries. It was also suggested that sharing and modelling of practices, particularly the capacity for active listening, needs to be built in to all training and inductions, and staff need to be models of sensitivity and self awareness.

Some participants felt that there is a lack of training for all staff in listening, "people skills" and in utilising local resources and existing knowledge – community, government, civil society. Also insufficient recognition that working with communities needs to be a mutually respectful cultural exchange.

While there was a recognition that greater training in MHPSS is required, there was debate as to the assessment of competence and the need for "qualifications". There was also an acknowledged lack of information as to "who is doing what and where" in relation to training and that a data base would be helpful. (CF Section D)Options for the Future)

For those organisations particularly interested in the care of their own staff, consult People in Aid http://www.peopleinaid.org/news/. They have extensive resources and networks and in October 2005 ran a joint workshop with InterHealth, 'Managing People under Pressure'.

5. Organisational culture

There was general agreement that the "Rambo culture" of emergency work hinders programming and staff development, and that this culture can lead to the psychosocial needs of aid workers, both expatriate and national staff being ignored. As mentioned in 4, some participants felt that a culture change needed to take place in terms of how organisations cared for their own staff before staff worked within psychosocial programmes.

There were other specific problems identified within organisations:

- The remit/mandate of an organisation may limit their capacity to provide a base for MHPSS programmes, e.g. emotional recovery of both communities and individuals can be related to enabling communities to carry out religious practices, and this may be difficult for organisations to "justify".
- Priority is given to the concerns of policy makers and funders
- Practitioners have insufficient opportunities to influence decision making

Suggestions in terms of addressing organisational culture change included:

- "Putting a human face on the work," i.e.developing a culture in which it is permitted to say you are having a hard time, and acknowledgement within the organisation that staff may have problems in coping with their work/stress.
- Modelling the practice of active listening, acceptance and emotional literacy
- Improving organisational procedures, including induction and debriefing.
- Ensuring a "buddying "system
- Training, education and raising awareness of MHPSS issues throughout all levels of the organisation.
- Greater clarity re organisations' remit for MHPSS
- Identify gaps in MHPSS knowledge within organisations
- Collaboration forum in the field – NGOs and communities
- Donor education in MHPSS issues
- Create a space for dialogue between practitioners and policymakers

It is considered essential that problems and difficulties are viewed from the perspective of local practitioners, to counterbalance the priority given to policy makers and funders.

6. Culture/context

Working in cultures different from one's own underlies all humanitarian work and, although the role of "culture" is often mentioned, the "challenge of leaving cultural baggage behind when approaching new situations" and "the danger of imposing Western ideas/tools in diverse cultures" are ever present.

Participants recognised the need to fully understand local cultural context - social, political, religious – and "what goes on behind closed doors", but felt that often there is insufficient time allowed for assessment. Also an organisation's mandate may limit what is done to support pre-existing infrastructures and existing coping strategies eg religious ceremonies, burial rituals, traditional healers, local leaders.

Suggestions to support working in diverse cultural contexts included:

- A recognition of the need for *cultural exchange*, i.e. mutual learning, and that aid workers may learn most from listening to local beneficiaries
- Projects should be required to work with local infrastructure
- Recognition that the wellbeing of staff can determine the quality of their interaction with communities and individuals
- Problems should be addressed from both individual and community perspectives.
- Excluded groups need to be identified
- Aid workers need specific training in listening and "how to speak to beneficiaries"
- Organisations have a baseline information system about cultures

Although not specifically mentioned by the participants, issues of language, religion, how to take control of life, and attribution of meaning as to what has happened, are also essential factors in understanding cultural context.

7. Funding/donors

Difficulties in relation to fundraising identified by the participants included:

- Restrictions on the allocation of funds – funds raised for one emergency cannot be allocated to another
- poor quality of proposals for MHPSS programmes means that some proposals have been turned down (ECHO)
- access to funding in the UK for MHPSS programmes can be difficult

Suggestions as to how to overcome these difficulties included:

- donor education, particularly on the scale of psychosocial needs and the length of time that is required to properly address such needs
- the use of Sphere and IASC guidelines to define quality and hold funders and projects to account
- advocacy with funders on the allocation of money
- awareness of sources of funding available internationally that forum members can access e.g. ECHO
- linkages to elsewhere, for example France, Denmark
- to "tap into" good practice on funding applications
- exchange information
- establish international links/standards

8. Children

The concerns of children were discussed by one specialist group in the afternoon. Issues raised included:

- NGOs are "almost victims of our own success" in that children are recognised as a group with specific needs
- Viewing children as a homogeneous group can be to the disadvantage of some specific groups of children, e.g. those with disabilities, those who are excluded
- family reunification is usually seen as the best option and the impression is given that this cannot be questioned, but this may not be the best outcome for some children

Suggestions put forward included:

- recognise and operationalise diversity – age, gender, ability
- develop models of working which are inclusive
- hold donors to account
- recognise and promote resilience of children
- Target teachers/education systems as key resources

D. THE FUTURE

There have been many recent initiatives which indicate a groundswell of interest in mental health and psychosocial programming, and a need has been expressed for "some sort of forum where agencies can share their experiences". As one participant commented, "formation of a forum may be advantageous now while interest is still salient". The following suggestions for the future are compiled from the small group work on the day, and the "next steps" question in the evaluation form.

1. The forum

- Does it have a role/purpose/rationale?
- How could it be organised/funded?
- Who should attend?

- **Role/purpose/rationale**

There was general agreement among the participants about the desirability of setting up a UK based MHPSS forum, and a small number of participants offered direct help for the future. There was also an awareness that many people did not know about the different networks and groups that already exist and that further research is required to establish the remit of other organisation or networks.

Participants envisaged the purpose/role/rationale of a proposed UK forum to be:

→ To share best practice
→ To provide a support network and enable those working in MHPSS programmes to access knowledge and share good practice
→ To provide a coherent voice for advocacy, education and persuasion of potential funders/donors
→ To exchange information on funders interested in funding MHPSS work.
→ To establish clear policies and guidelines and inform thinking on MHPSS issues
→ To provided a knowledge base
→ To be "a centralised resource with 'teeth'"
→ To bring together practitioners and experts
→ To provide a data base - training providers, courses, resources, who is doing what and where
→ To follow up on programmes and examine lessons learned
→ To focus on specific areas of interest to group e g opportunity for individual organisations to review practice/policy, areas of measurement, development of training
→ To provide a "pool of experts to sell the message"
→ To maintain a "hands on" practitioner focus and be "user friendly"

- **Organisation/funding**

There was insufficient time for participants to put forward specific proposals for the practical organisation and funding of a forum, but a number of suggestions were made which could form the basis of future developments:

→ "Make the forum more formal – adopt a constitution, recruit members and extract fees from them. Thereafter set up an action plan that identifies donors and submits proposals"
→ Build linkages with other UK groups and with other European Groups
→ Put together a meeting of interested parties to formally put together a forum for the UK to have a direct link into the IASC working group
→ Formation of "an arrangement" that would provide the services of a forum to interested organisations
→ "An information exchange could be easily developed as a first stage and an attempt (via Echo?) to contact other groups of like minded people elsewhere"
→ "Start up the forum, possibly with link to either the mental health advisor in Amsterdam (MSF Holland) or MSF UK psychosocial care support officer"
→ Link (informally) with other similar groups.

Sources of funding were not discussed in detail but suggested possibilities included:

→ NGO membership contributions
→ The Health Foundation
→ Form a network to which members subscribe
→ Recruit members, extract fees from them
→ Group to make a direct approach to funders
→ One organisation to fund the onward development of the forum.

- **Membership**

24 organisations were represented at the meeting on Jan 31st. This was more extensive than attendance in September 05, but circulation was to a limited network. A future forum would need to include a wider spectrum of practitioners and NGOs while still maintaining a "hands on", practitioner focus.

Participants also felt that the forum needed to be both local, i.e. UK, and international, i.e. participate on the "world stage".

- **Questions to be answered**

Before being able to proceed with any of the above suggestions, participants raised the following questions:

→ What would be the added value of the forum over and above existing groups?
→ What would be the "mission"?
→ Who would carry out the required research into other organisations and networks?
→ What would be the relationship of the forum to other established groups, e.g. the Psychosocial Working Group

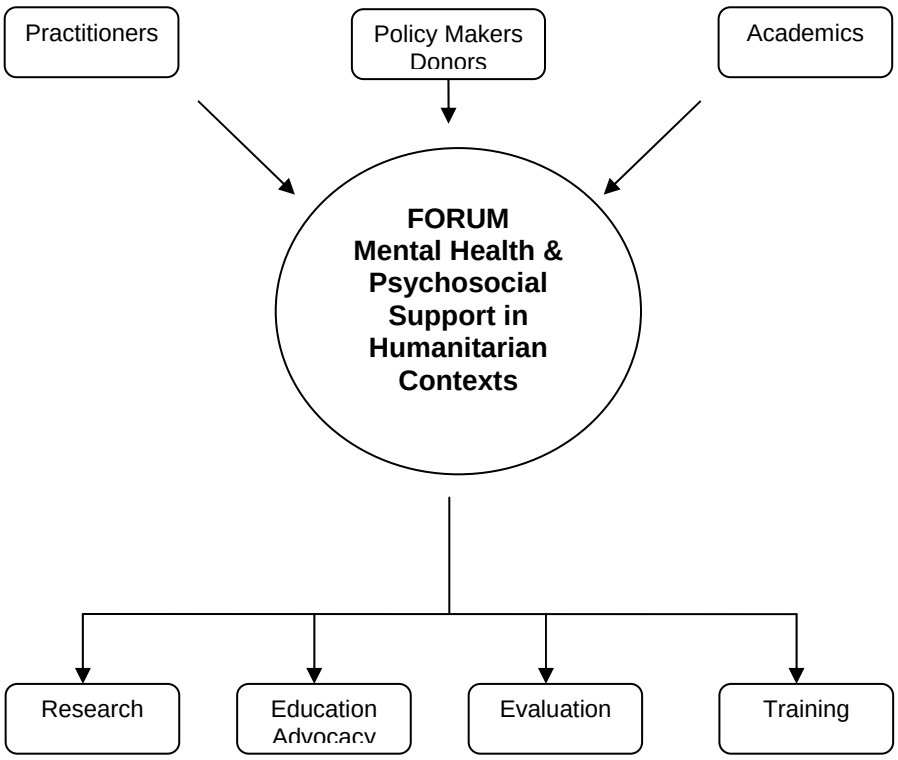
From all of the above, the most pressing need is for a group of individuals and organisations to take responsibility for the next stages, and to explore possible sources of funding. The last two meetings have taken place on a goodwill basis. For the forum to be able to develop in the ways hoped for by the participants, secure funding would need to be obtained and a clear organisational structure be established.

2. Training

RedR-IHE is well respected and highly valued as a training provider and has included mental health in one of its training programmes (Public Health in Emergencies Course) for many years. Due to limited time this has consisted of one half day with additional written resources for the participants. Feedback has been unanimously positive but RedR-IHE now recognises that insufficient time is being given to such an important topic and that the psychological care of humanitarian workers themselves is not included.

Under the leadership of Yohannes Ligiam (Yohannes@redr.org), Training Programme Manager, RedR-IHE are developing proposals for a more extensive training module in mental health and psychosocial support. The proposals utilise the recommendations of the IASC Working Group's draft guidelines, specifically the components of training considered desirable for emergency and humanitarian workers, but will also include psychological self care for aid workers, consultancy to organisations and donors, and support in the field.

SUGGESTED "VISION" FOR A UK FORUM



Mental Health and Psychosocial Support in Humanitarian Contexts

The forum would be based on the principle of Creative Praxis - a space for practitioners, policy makers and academics who are working in humanitarian emergencies to develop new strategies, mechanisms and processes to improve services related to psychosocial and mental health.

The basic principle of Creative Praxis is that we learn from each others' experience, knowledge and imagination, enabling us to become more effective and reflective practitioners, policy makers and academics.

It also provides a space for humanitarian workers in the field to receive fresh air and develop strengths.

D. EVALUATION

Only a flavour of the evaluation is presented here. Please contact Jane Gilbert if you would like a complete evaluation summary.

All who completed the evaluation form were glad to have been present at the event. Some attended because of their own professional experience, some because of specific interest, and others were present as a representative of their organisation.

In terms of which parts of the day participants had found most useful, the majority commented on the small group work and opportunities for networking, and others on the quality and interest generated by the morning presentations.

> *"Networking, introduction to core issues, case studies", "Group discussions and sharing of practical experience, practical implementation of approaches", "Mixed group before lunch and multi-practice discussions – sharing and collective problem solving", "All useful, especially group discussions", "Sharing experiences – organisational and practitioner perspectives".*

There was relatively little comment on what had been least relevant in the day. Some had felt the additional short presentations had been less useful. Other comments included:

> *"While useful, I think (hindsight is 20/20) that the morning session on the overall challenges, also came out very strongly in the afternoon and was largely consistent across the morning groups. Perhaps a quick questionnaire from attendees prior to the workshop would have been equally good for this. All in all, though, was quite good.", "afternoon group discussion would have been nice to develop over more time as really interesting discussion was started"*

Most participants felt that their experiences on the day would be relevant to their own work. For example,

> *"Some of the contacts I made may have provided useful information for my work. Also seeing the possibility of doing training for staff.","I will be in a better position to approach donors about this kind of work", "Has widened interest in some areas and consolidated some already existing ideas.", "I shall possibly have further evaluations on P/S activities but the experience will be of use in other work that I am doing on humanitarian assistance policy more generally."*

Comments relating to "next steps" were included in Section D.

Participants' additional comments included:

> *"Incredibly useful to feel part of a network", "Nice job bringing together different groups' interests", "Excellent forum for sharing ideas/discussion and new contacts – thank you.","* *Thank you – it worked out very well – the organisation, leading of discussions and facilities. A slightly warmer room would have been good, but that is minor. This is one of the few occasions since I came back from Rwanda to meet people and other professionals with diverse experiences."*

Only a flavour of the evaluation is presented here. Please contact Jane Gilbert if you would like a complete evaluation summary.

C. OTHER GROUPS AND INITIATIVES

1. World Federation for Mental Health

Prof. John Copeland
President-elect
World Federation for Mental Health (WFMH)
jrmcop@btinternet.com

John gave a brief history of the founding of WFMH, its worldwide network and the Disaster Response and Support Initiative. Further information is available from John. See also http://www.wfmh.org/

2. Introduction to Inter Agency Standing Committee Task Force (IASC) on Mental Health and Psychosocial Support in Emergency Settings

John Copeland/Jane Gilbert

John described the structure of the Guidelines and the consultation process currently being undertaken by the InterAgency Standing Committee Task Force on Mental Health and Psychosocial Support. The consultation process is closely following that used by the IASC Task Force on HIV/AIDS. Necessary steps are considered under the headings of: Emergency Preparedness; Minimum Response; Comprehensive Response. The matrix and first Working Draft of 20 Action Sheets have been prepared and feedback is being sought. Jane had sent the matrix and action sheets to participants in advance of the meeting and she reiterated the importance and value of participants' feedback Feedback can either be sent to Jane for collation or directly to the Co-Chairs of the IASC Working Group. Additional copies are available for those who did not attend.

Co-Chairs
Mark Van Ommeren: vanommerenm@who.int
Mike Wessells: mwessells@rmc.edu
Refer to http://www.humanitarianinfo.org/iasc/default.asp

3. Psychosocial Working Group

Dr Alison Strang
Coordinator Psychosocial Working Group
Institute for International Health and Development
astrang@qmuc.ac.uk

Although not scheduled on the original programme, Alison Strang attended the event on behalf of the Psychosocial Working Group, and gave a brief account of their work. The group was set up 5 years ago by ten organisations. An initial focus of their work was the clarification of concepts and terms. They have also reviewed training and guidance materials developed by agencies and are currently doing a mapping exercise of groups working in the Psychosocial field. They are linked to the Forced Migration group at Queen Elizabeth House in Oxford.
Refer to http://www.forcedmigration.org/psychosocial/PWGinfo.htm

G. RESOURCES

People in Aid are concerned with HR issues in the sector. They ran a joint workshop with InterHealth in October 2005 'Managing People Under Pressure' which covered such issues http://www.peopleinaid.org/news/).

Federation Reference Centre for Psychosocial Support http://psp.drk.dk/sw2955.asp Danish Red Cross on behalf of the International Federation.

The IASC consultation process http://www.humanitarianinfo.org/iasc/default.asp

The Psychosocial Working Group
http://www.forcedmigration.org/psychosocial/PWGinfo.htm

RedR-IHE Training
http://www.ihe.org.uk/
http://www.redr.org/redr/training/

Reference materials

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www.id21.org/insights/insights-h06

APPENDIX 1 PROGRAMME

PSYCHOSOCIAL/MENTAL HEALTH PROGRAMMES IN HUMANITARIAN CONTEXTS: PROBLEMS, CHALLENGES AND SHARING GOOD PRACTICE

Tuesday 31st January 2006, 9:30am-3:30pm
Venue: British Red Cross Society, 44 Moorfields, London,EC2Y 9AL
(Nearest tube: Moorgate)

This workshop follows the success of a seminar conducted in September 2005 which presented the findings of research into mental health and the NGO sector (available on request) [1]. Issues raised by participants at the seminar included:

- *Roles and responsibilities of major relief organisations for mental health issues*
- *Definition of terms, challenges of culture and language*
- *Integrating mental health with physical relief, field coordination on-site*
- *Designing evaluation, securing funding for mental health work.*
- *Lack of adequate staff training and training qualifications*

Objectives: The workshop will involve group discussions and opportunities for critical reflection and action planning. Objectives include:

- *Exploring some of the major challenges in the design and implementation of MH/psychosocial programmes in Humanitarian contexts*
- *Understanding IASC draft guidelines for Mental Health and Psychosocial Support*
- *Sharing information from interventions in the field*
- *Action planning for the future – the forum, training and learning, funding*

Target audience: NGO fieldworkers, programme managers, donors, practitioners, including psychologists, counsellors, psychiatrists.

Programme

09.30 - 10.00	**Registration & Tea/Coffee**
10.00 - 10.15	Welcome & Introductions Outline of the day & update *Jane Gilbert, Consultant Clinical Psychologist*
10.15 - 11.00	Case studies: Implementing psychosocial/mental health programmes: *Janaka Jayawickrama - Disaster&Development Centre, Northumbria University* *John Borden - ACT/Caritas*
11.00 - 11.15	**Coffee break**
11.15 – 12.00	Sharing experiences: organisational and practitioner perspectives.
12.00 - 12.30	Review
12.30 - 12.45	World Federation for Mental Health: *Prof John Copeland (WFMH Chair Elect)*
12.45 - 13.30	**Lunch**
13.30 - 14.00	Introduction to Inter Agency Standing Committee Task Force (IASC) on Mental Health and Psychosocial Support in Emergency Settings: *Jane Gilbert/John Copeland*
14:00 - 15:00	Action planning – forum, funding, training (Position, Problem, Possibilities and Proposals)
15.00 - 15.30	Summary of the day, tasks, timescales, evaluation
	END

Workshop Facilitator: The workshop will be facilitated by Jane Gilbert, Consultant Clinical Psychologist

[1] Gilbert, J. (2005). *UK NGOs and International Mental Health: An Exploratory Review*

APPENDIX 2 LIST OF PARTICIPANTS

Title	First Name	Surname	Organisation
	Vivien	Walden	Oxfam
	Maia	Gedde	The Tropical Health and Education Trust
	Yohannes	Lignes	RedR-IHE
	Julia	Baxter	RedR-IHE
	Cathy	Mears	Red Cross
	Mark	Snelling	Red Cross
	Prudence	Lambert	Red Cross
	Janaka	Jayawickrama	Disaster and Development Centre Northumbria University
	Jane	Gilbert	Consultant Clinical Psychologist
	Sian	Kelly	Save the Children
	Rachel	Tribe	UCL
	Alison	Swan	Clinical Psychologist, NHS
	Maria	Kett	LC Centre for Conflict Recovery
	Alec	Leggat	RedR-IHE
	Dilanthi	Weerasinghe	Bridges for Children
	Kuhan	Satkunanayagam	UK/Sri Lanka Trauma Grp
	Martina	Hunt	Consultant – Diana Memorial Fund
	Alyson	Eynon	Save the Children
	Bill	Yule	IoP, UK/Sri Lanka Trauma Group
	Lola	Omotayo	Educational psychologist
	John	Kirkby	ETC UK Ltd
Prof	Salim	Sumar	Focus Humanitarian Assistance Europe
	Saira	Reshamwalla	Focus Humanitarian Assistance Europe
	Julia	Koch	Echo
	Giorgia	Dona	Refugee Research Centre
	Mariel	Weighill	War Child
	Catherine	Russ	RedR-IHE
Prof	John	Copeland	World Federation for Mental Health
	Libby	Kerr	Peace Brigades International
	John	Borton	ACT/Caritas
	Claire	De Menezes	Action against Hunger
	Marleen	Deerenberg	MSF
	Alison	Strang	Psychosocial Working Group Edinburgh
	Alison	McCall	Helpage International
	Tracey	Sissley	IMC UK

APPENDIX 3 SMALL GROUP TASKS

Task 1

1. Identify a chairperson and a scribe
2. Briefly introduce yourselves
3. Consider the following two questions:

    - **What are the major challenges in the design and implementation of psychosocial/mental health programmes in humanitarian contexts?**
    - **What do organisations/NGOs need to help them address these challenges?**

4. Spend five minutes thinking about these questions silently and making some notes before discussing with others in your group.
5. Discuss as a group
6. Write the main points of your discussion on the flipchart ready to present for feedback to the whole group.
7. Decide on someone from the group to do this.

Task 2

2. Consider the future of the forum

    - Does it have a role/purpose/rationale?
    - How could it be organised/funded?
    - Who should attend?

2. Using the template – **Position/Problem/Possibilities/Proposals**, what are the next steps you think need to be taken from the perspective of your group?

    Groups

    - Fundraising
    - Training
    - Children
    - Managers within organisations
    - Practitioners (face to face work in the field)