Mental health and psychosocial support interventions in emergency and post-crisis settings

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This guide is intended for all Handicap International staff responsible for implementing or analysing mental health and psychosocial support interventions in emergency or post-crisis settings. It is by no means a book of recipes for success, but rather a list of ingredients the chef can select based on the specific grasp the professionals who work for Handicap International have with local issues. If you are unsure about how this guide applies in an operational context, please contact the Mental Health and Psychosocial Support Technical Advisors and Focal Points.
# Mental health and psychosocial support interventions in emergency and post-crisis settings

## Foreword

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## Principles and benchmarks

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“More than 10% of the global burden of disease, measured in disability-adjusted life years, is attributable to mental disorders. [...] Many factors that adversely affect psychological health are related to the way assistance e.g. food security, shelter, water and sanitation, is provided. [...] A common error when working in this area is to focus exclusively on deficits and forget that people have resources and assets that protect against mental health and psychosocial issues. [...] Mental health and psychosocial wellbeing benefits from a sense of normalcy, facilitation of community mobilisation and self-help.”¹
Since the birth of psychology at the end of the 19th century it has been clearly established that an individual's growth and development takes place within a social system which impacts on them and which they in turn impact. Indeed, Handicap International's extensive experience in the field has shown us the extent to which intense upheavals and chaos very seriously affect people, their family and their existing social connections. Motivated by a desire to help these people with their reconstruction, we analyse their trauma in a broader context than the individual themselves and examine them through the prism of social and cultural connections. It seems obvious that personal reconstruction is the product of an interaction between the individual and their environment. However, although personal reconstruction requires different forms of support to compensate for a traumatic loss or to adapt people's living spaces, it is also a question of a person's psyche. Standing on your own two feet means living, with yourself, connected to others. Supporting people by giving them back or preserving their dignity as set out in our mission statement, means we must address more insidious, less easily detectable forms of distress, as well as the more flagrant consequences of crisis situations. Although this distress is personal, the means used to relieve this distress must respect the local culture. This means our teams must work with curiosity, open-mindedness and a certain objectivity regarding the patterns engrained in western culture which do not work within different systems of reference. An anthropological approach is therefore a useful addition to the psychological approach when trying to understand different forms of distress and perceptions of impairment.

Although it may not immediately result in a disability, the onset of an impairment or trauma in a crisis situation is in itself a factor for psychological distress and a determining factor for personal vulnerability. This distress may lead to a lasting deterioration in the person's mental health or a permanent disability. Given the increased risk of experiencing symptoms of psychological distress in emergency situations, mental health and psychosocial support (MHPSS) interventions in these settings have emerged as a key issue for Handicap International to address. These interventions correspond to the objectives set out in our multi-annual strategy to protect and support the most vulnerable. Indeed active listening and psychological first aid implemented in the emergency phase play a decisive role in limiting the effects of psychological distress and in people's individual and collective reconstruction. In the long term they also facilitate the process of building community and individual resilience. The emergency setting and the sensitive nature of these types of interventions means it is important to make the best use of resources to avoid the negative consequences of a poorly implemented approach, most importantly, any potential adverse effects that might actually worsen people's circumstances. This guide is intended to help with this and ensure our teams continue to act with the audacity required to respond to these most disconcerting and problematic situations.

Nathalie HERLEMONT ZORITCHAK
Strategic Policy Unit Manager
Principles and benchmarks

THE IMPACT OF EMERGENCIES ON POPULATIONS’ MENTAL HEALTH

THE PRINCIPLES OF MENTAL HEALTH AND/OR PSYCHOSOCIAL SUPPORT INTERVENTIONS

A. Do no harm
B. Observance of people’s rights
C. Empowerment
D. Participation of the local affected populations

MENTAL HEALTH AND/OR PSYCHOSOCIAL SUPPORT APPROACHES

A. Pyramid approach for services
   Basic services and security
   Non-specialised services
   Specialised services
B. Twin-Track approach
   A person-centred approach
   An advocacy approach to inclusion

THE ROLE OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE CLUSTER SYSTEM

MENTAL HEALTH AND/OR PSYCHOSOCIAL SUPPORT INTERVENTIONS ACROSS THE THREE PHASES OF AN EMERGENCY
Handicap International has field experience of mental health and psychosocial support in emergency, post-emergency and development settings dating back to the 1990s. Although Handicap International’s remit initially covered the prevention and treatment of disabling mental health conditions resulting from war or genocide (trauma, depression, anxiety, psychosis, mental retardation), the scope was subsequently widened to take into account psychological distress resulting from numerous social and political issues (poverty, exclusion, vulnerability resulting from exile, migration, war, genocide). Today, Handicap International’s focus is broader still, taking in any situation which causes psychological distress and/or mental health disorders, or as Jean Furtos puts it, any situation leading to a deterioration in the person’s “ability to live with themselves and with others”.

With this in mind, reasonably good mental health can be defined as follows:

“The capacity to live with oneself and with others, in the search for pleasure, happiness and a meaningful life. In a given but not immutable environment, that is to say transformable thanks to the activity of individuals and human groups. Without destruction but not without revolt, that is the capacity to say “no” to what goes against the needs and respect for individual and social life, which allows a true “yes”. Implying the capacity to suffer whilst remaining alive, connected to oneself and with others.”

The impact of emergencies on populations’ mental health

Crisis situations such as natural disasters and conflicts cause significant upheaval amongst the affected population. They can potentially cause mental health problems due to the different types of losses suffered. Firstly, these situations cause significant material damage, notably in terms of road and sanitary infrastructure, buildings, food and energy sources. There are also often colossal economic losses across all sectors (primary, secondary, tertiary). People’s livelihoods and jobs are nearly always impacted by the crisis. There are often heavy losses of human life. People go missing and die, others are injured and often suffer from disabling physical after-effects, yet others are separated from their loved ones.

These losses undermine the foundations of community life and the internal resources of the families and individuals affected. These mechanisms are weakened to a greater extent in people who are already vulnerable prior to the event in question (vulnerabilities related to age, gender, incapacities and impairments, social and economic status, etc.). The entire social fabric may be altered or destroyed, placing the individuals who comprise it in an abnormal state of suffering. This may manifest itself in the form of psychological distress, or in a more disabling manner in the form of mental health disorders.

Psychological distress is “a state of disquiet which is not necessarily symptomatic of a pathology or mental health disorder. It reveals the presence of non-severe or temporary symptoms of anxiety and depression which do not meet the diagnostic criteria for mental health disorders and which may be a reaction to stressful situations (migration, exile, natural disaster which can induce symptoms of psychological trauma) or to existential difficulties. When the psychological distress is temporary and follows a stressful event, it is
considered to be a normal coping response. However, when it is intense and sustained it can be considered to reveal a [mental health] disorder.5

Mental health disorders are diagnosed using reference manuals (DSM IV–TR6–ICD 10/107). They refer to target criteria of variable duration which can be more or less severe or disabling. Handicap International focuses on the following mental health disorders as these have high levels of mortality, morbidity and disability:

- Psychotic disorders (schizophrenia, manic depression, chronic delusional state),
- Depressive disorders (depression, dysthymia),
- Anxiety disorders (post-traumatic syndromes, phobias, obsessive compulsive disorder),
- Psychoactive substance abuse disorders (alcohol, drugs and medical products),
- Personality disorders (including antisocial personality disorders),
- Developmental disorders resulting from chromosomal or genetic disease (Down’s, Fragile X, Prader-Willi, Smith-Magenis, and Williams syndromes),
- Pervasive developmental disorders (autism spectrum disorders, Rett syndrome, childhood disintegrative disorders, Asperger’s syndrome, pervasive developmental disorder not otherwise specified).

In the wake of a major crisis it is important to implement mental health and/or psychosocial support interventions to support the people susceptible to mental health problems in order to prevent onset or provide support, as required. Handicap International’s objective is not to provide health care for people requiring medical treatment, but to refer them to pre-identified services. The actions carried out must take into account the specific needs of the most vulnerable populations, in particular people with disabilities. These populations include people with physical, sensorial and mental disabilities, people with mental health disorders or other disabling diseases (see appendix), and older people, children and women. MHPSS projects in emergency and post-crisis settings are not intended to “treat” the causes of disabilities but to support individuals to improve their well-being. This guide is intended for all Handicap International staff responsible for implementing or analysing MHPSS interventions in emergency or post-crisis settings: Psychosocial/Mental Health/ Protection Project Managers and Technical Advisors; Psychologists, Occupational Therapists and Social Workers; Anthropologists, Sociologists, Public Health Physicians and Project Evaluators. Implementing the activities proposed in this guide requires a prior understanding of psychosocial support and assistance practices. Taken in isolation, this guide cannot guarantee the quality levels required for field interventions. Support through technical and clinical supervisions is required to ensure the projects implemented are effective both for the beneficiaries and the team deploying them.
The principles of mental health and/or psychosocial support interventions

The principles for MHPSS interventions are derived from Handicap International’s general principles of intervention and broadly based on the Inter-Agency Standing Committee (IASC) guidelines on mental health and psychosocial support in emergency settings. These principles form the frame of reference for all humanitarian aid.

A

Do no harm

Humanitarian aid is a vital means for aiding people affected by crisis situations. However, this aid can also inadvertently cause harm. MHPSS interventions also have the potential to inflict damage as they deal with very sensitive issues which go right to the heart of the private life of a community and the people who make up that community affecting their cultures, living habits, their perception of people’s place in society and the policies by which they live.

The principle of avoiding harm can be implemented on several levels:

1. The first level is the intervention design phase. The analysis of social and cultural determinants in the crisis zone gives an indication of the types of intervention that can be implemented as it provides vital information on people’s conceptions of men, women, family and community. The activities implemented must respect these determinants.

2. The second level regards project programming and monitoring. It is important to forward plan for the potential negative or positive impact an activity might have. The unforeseen circumstances which may arise throughout the duration of a project should also be planned for. This forward planning should help to mitigate any harm the actions might cause. Furthermore, the use of tools for monitoring, external and internal evaluation and supervision is vital to ensure the principle of “do no harm” is respected. They provide project stakeholders with hard facts and allow them to critically analyse their actions and adjust them where required.

3. Internal human resources policies on child protection and protection from sexual exploitation and abuse, as well as Handicap International’s gender policy are also vital in ensuring our actions do no harm. All Handicap International stakeholders should be made aware of the organisation’s policies. A code of conduct should also be drawn up and signed by the whole team. This should be displayed in the organisation’s premises and places of work. All of the organisation’s beneficiaries and partners should also be aware of its policies and code of conduct. In situations where there is a risk of sexual violence, an anonymous system for reporting any concerns should be made accessible to all members of the team and to the beneficiaries.

4. Finally, the final level is that of coordination and experience sharing between stakeholders within the organisation and external stakeholders in order to ensure the best possible orchestration of their actions.
B

Observance of people's rights

Handicap International promotes the observance of people's rights and the fair treatment of any individual at risk of a rights' violation. Our interventions take the international conventions on the subject as their frame of reference. In crisis settings, the rights of people with psychosocial impairments and/or psychopathological disorders are generally not sufficiently taken into consideration. MHPSS projects aim to promote the rights of people with mental health disorders and their inclusion in the community.

The articles of the Convention on the Rights of Persons with Disabilities (CRPD) establish:

- The right to an adequate standard of living and social protection (article 28), accessible, high quality health services (article 25),
- The right to liberty and security (articles 12 and 14),
- The right to freedom from torture or cruel, inhuman or degrading treatment or punishment (articles 15 and 16),
- The right to live independently and be included in the community (article 19).

According to the identified needs, the actions implemented should be impartial, regardless of the gender, age, membership of linguistic, ethnic or religious groups, or place of residence of the people involved, according to the identified needs.

The extreme vulnerability to violence and abuse (notably sexual) of people living with psychosocial or mental health disorders means it is vital that any MHPSS project develops systems for implementing Handicap International's child protection and protection from sexual exploitation and abuse policies before deploying its activities. It is important to remember that these policies are intended to set out a framework for preventing or, in the worst-case scenario, limiting the number of these types of incidents by:

- Training Handicap International's teams in these policies,
- Putting a code of conduct into place, drawn up and signed by the whole team, and displayed in the workplace,
- Setting up an anonymous reporting system, open to both beneficiaries and members of the team,
- Raising our beneficiaries' and partners' awareness of existing protection systems.

C

Empowerment

The third principle of psychosocial interventions in emergency settings aims to encourage the people in psychological distress or living with a mental health disorder to act autonomously and take charge of their lives. This is what is known as empowerment. It is a complex process by which a person recovers the power they have within themselves through a relationship with one or more people. Empowerment has multiple objectives including to:

- Foster the empowerment of individuals or groups so that they are able to accomplish something and become emancipated from their environment,
- Allow a person or group to analyse the constraints relating to their own personal circumstances and to break free from these, influence their own lives, take action or change course,
- Ensure people realise that they are not alone, that they belong to a group and can change their own circumstances by acting and interacting in conjunction with the community.
Participation of the local affected populations

One key component of the empowerment process described above is the involvement of the affected population in the humanitarian response. This is one of the ways of ensuring the project's success. It makes the projects more relevant, more flexible, and better adapted to the local environment, and also increases their impact and sustainability. Participating allows the population to keep or take back control over the decisions that affect them and includes them as stakeholders in the interventions implemented.

In most emergency settings a significant percentage of the population has the resilience needed to participate in the measures deployed in the emergency, post-emergency and reconstruction phases. The participants should be representative of the population in the crisis zone as a whole (refugees, displaced people, host populations, authorities, professionals and other stakeholders, etc.) and should respect equality in terms of gender, age and disability. Participation therefore means including different – and sometimes competing – groups.

Numerous MHPSS measures can be implemented by the affected communities themselves rather than external stakeholders. Right from the very first phases of the emergency situation, participation requires:

- Involving the local population to the greatest possible extent in identifying needs, and in planning, implementing, monitoring and evaluating the assistance provided,
- Rebuilding local capacities, supporting self-help mechanisms and reinforcing existing resources,
- Where possible and appropriate, building the capacities of both the State and civil society.

Mental health and/or psychosocial support approaches

Handicap International uses recognised, coherent operational approaches to programme and implement its MHPSS activities. Determining the level of needs and the services to be implemented or supported is done using a pyramid approach. The development of the activity is then designed using the twin track approach in order to focus the intervention both on the person’s specific needs and improving how they are taken into consideration in the general context. Finally, our activities come under the general coordination framework set up by the international community for emergency situations: the cluster system.

Pyramid approach for services

When preparing a MHPSS intervention, the analysis, design and implementation of interventions should be based on a multi-layered system of complementary services which respond to the needs of different groups during different phases of the emergency. This system can be represented as a pyramid of services. For the purposes of clarity, the IASC intervention pyramid has been adapted and reduced to three levels of services:
Basic services and security
The well-being of all people should be protected through the (re)establishment of security, adequate governance and services that address basic physical needs (food, shelter, water, basic health care, control of communicable diseases). In most emergencies, specialists in sectors such as food, health and shelter provide basic services. An MHPSS response to the need for basic services and security may include:
- Identifying and listing existing basic services,
- Informing the population about these basic services and how they can be accessed,
- Advocating that these services are put in place by responsible actors,
- Disseminating information on the impact these services have on mental health and psychosocial well-being,
- Influencing humanitarian actors to deliver these services in a way that promotes mental health and psychosocial well-being.
These basic services should be established in participatory, safe and socially appropriate ways that protect local people’s dignity, strengthen local social supports and mobilise community networks.

Non-specialised services
In most emergencies, there are significant disruptions of family and community networks due to loss, displacement, family separation, community fears and distrust. The affected population may then benefit from the strengthening of community networks. Useful responses in this layer include family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women’s groups and youth clubs.

At this level, the groups of people worst affected by the situation may also be supported through specific activities (family mediation, support groups, psychological first aid, safe spaces, etc.) implemented by qualified, supervised professionals (doctors, psychologists, qualified social workers.) For example, survivors of gender-based violence might need a mixture of emotional and livelihood support from community workers. As for amputees, they may benefit from attending a psychological support group to help come to terms with their situation. This layer also includes psychological first aid (PFA) and basic mental health care from primary health care workers.

Specialised services
The top layer of the pyramid represents the additional support required for the small percentage of the population whose suffering, despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning. This assistance should include psychological or psychiatric support for people with severe mental health disorders whenever their needs exceed the capacities of existing primary/general health services. Such problems require either (a) referral to specialised services if they exist, or (b) initiation of longer-term training and
supervision of primary/general health care providers. Although specialised services are needed only for a small percentage of the population, in most large emergencies this group may amount to thousands of individuals. In some emergency situations, these specialised services simply cannot meet the demand. For example, in Haiti following the 2010 earthquake there were not enough local psychiatrists and psychologists to meet the needs of all the people experiencing psychological distress. This was compounded by the fact that the existing psychiatric hospitals were destroyed in the earthquake. In other countries there are simply no specialised services available. In emergency situations, the first priority is to identify the existing specialised services (psychiatry, psychotherapy, etc.) in order to understand the needs in the field and decide what types of activities should be implemented.

### Twin-Track approach

Handicap International promotes the twin track approach in order to ensure equal rights and opportunities for the most vulnerable people. Under this “dual approach” the actions directly target the most vulnerable populations, including people with disabilities, as well as other humanitarian response actors to ensure they are attentive to and inclusive of the needs of the most vulnerable populations and take these into account in their actions.
A person-centred approach

Direct action targeting affected people aims to support those suffering from severe psychological distress, especially when the person's life may be at risk. People with disabilities are not always included by humanitarian actors in their MHPSS projects as this would mean adapting their resources. People living with intellectual or sensory disabilities may communicate differently; their psychological suffering might express itself differently. It is important to set up MHPSS activities that are adapted to different people's needs.

Particularly vulnerable people often suffer from a certain level of exclusion, including during the emergency response phase. They are often “invisible” to humanitarian response actors, may have limited mobility, insufficient access to information, etc. Handicap International’s actions “for all” should take into account the specific needs of people who are excluded, at all stages of project design and development, in particular for projects to restore access to basic services, general health services, mental health services, psychosocial support and protection.

An advocacy approach to inclusion

In order to take into account the specific needs of excluded individuals, it is vital to incorporate issues relating to the needs of vulnerable individuals into the various assessments carried out by other actors. To this end, it is vital to carry out advocacy work with key actors and raise their awareness of the importance of incorporating the issues which affect the most vulnerable and excluded populations into their intervention strategies. For example, Handicap International can encourage the participants attending inter-actor coordination meetings to add questions to their assessment forms or to include people with disabilities in their assessment and operational teams.

Collecting this data provides detailed, accurate information on the situations vulnerable people find themselves in. This then makes it possible to draw up recommendations and suggestions for including these people in the intervention strategies adopted by both external actors and Handicap International.

Training should be provided alongside these recommendations to pass on the various techniques used to support people with disabilities. This helps to calm the fears and apprehension people may feel about providing support to these populations. The most successful training sessions are often those which combine both theoretical and practical components. Workers in the field often need to feel they are properly equipped, that at the end of the session they take away the practical tools they need in the field. The most common questions raised are: “How can an activity be made inclusive? What modifications need to be put into place?
How can we support people with disabilities? Older people? How should a child with an intellectual disability be interviewed? However, given the complexity of emergency situations and in order to ensure good skills transfer and high quality field support between Handicap International actors and external actors, it is vital that a focal point is designated within each organisation. This facilitates the coordination and implementation of the recommendations.

The role of mental health and psychosocial support in the cluster system

The cluster approach, or sector-based approach, was introduced by the UN in 2005. It aims to improve the humanitarian response by introducing a system to coordinate the actions of different humanitarian actors within and between different sectors of intervention. The clusters provide a framework which should allow the actors involved in providing a response in a given sector to:

- Take concerted action to meet the jointly identified needs,
- Develop strategic response plans with shared objectives,
- More effectively coordinate responses between actors,
- Share information and good practices at national and regional level,
- Build actors’ capacities.

The cluster system has been designed to operate at a global level (“global clusters”) and the same model is applied to set-ups in the field. The whole system is headed up by the Humanitarian Coordinator in country, mandated by the IASC, and is steered by OCHA.

The sector-based groups are made up of humanitarian organisations and other stakeholders such as United Nations agencies, non-governmental organisations and the representatives of local authorities, as well as civil society organisations. There are 11 clusters in total, operating in different sectors, with very specific mandates approved by the Inter-Agency Standing Committee (IASC).

In the field, each cluster is headed up by a lead agency: this is a United Nations agency, sometimes supported by a non-governmental organisation. Clusters are sometimes jointly led by a United Nations agency and the local authorities. The overall cluster system is headed up by a Humanitarian Coordinator (HC) who is
Principles and benchmarks

Responsible for inter-cluster coordination and ensuring cross-cutting themes are taken into account (gender, age, HIV/AIDS, disability, etc.). However, depending on the crisis in question, not all the clusters are systematically activated in the field. How the system is implemented and operated also varies from one country to another and depends to a great extent on the personality and authority of the Humanitarian Coordinator.

Furthermore, working groups are often set up to work on specific cross-cutting themes affecting existing clusters (for example, the MHPSS reference group). These working groups, which also operate under the IASC, support other clusters such as: Education, Water, Sanitation and Hygiene, Shelter, etc. to help adapt their intervention strategies.

In Haiti, for example, a working group was able to share with the Health, Water, Sanitation and Hygiene clusters its understanding of Haitian's attitudes to cholera and consequently adapt the control strategy deployed.

Another example from Haiti, after the 2010 earthquake Handicap International, CBM and the local government set up a sub-cluster within the Health cluster, dealing specifically with care management for the injured.

In Pakistan, as part of the response to the 2011 floods, Handicap International and HelpAge set up an age and disability task force under the Protection cluster, in order to improve how specific needs relating to age and disability were taken into account in the humanitarian response.

This diagram sets out the overall set-up of the cluster system and the corresponding lead agencies.
Handicap International’s strategic positioning in relation to the cluster system

For an organisation such as Handicap International the cluster system has both advantages and disadvantages. It certainly brings humanitarian aid actors together, providing an effective forum for sharing information and raising awareness. However, the separation into distinct sectors also has pernicious effects. Generally speaking cross-cutting issues relating to vulnerable populations have to be promoted in all the clusters, which is particularly time consuming. Furthermore, the creation of sub-clusters tends to confine the issue in hand within the scope of the one cluster to which it is attached. This sometimes hinders the involvement of the other clusters who consider that the theme in question is already covered. Although it has reservations regarding the system, Handicap International decided that participating in the cluster coordination mechanism was vital in order to achieve its objective of ensuring that vulnerable populations are included in the humanitarian response. In all the countries where Handicap International works, the programme teams must be aware of the coordination mechanisms in place, in order to prioritise in which clusters our participation could further our projects. With regards to its psychosocial support activities, the organisation works with the Protection and Health clusters and with the Child Protection and MHPSS working groups.

This participation specifically involves:
- Attending meetings,
- Sharing information on the programme,
- Contributing to the 4Ws database (who, what, where, why),
- Contributing to needs assessment, response planning and implementation,
- Monitoring implementation,
- Sharing good practices with other actors and promoting MHPSS reference manuals,
- Raising the awareness of other local and international actors to ensure their interventions are accessible to people with disabilities,
- Where required, offering training on disability issues and how to adapt interventions to the specific needs of vulnerable populations,
- Providing feedback on perceived needs and on concerns raised in the field.
Mental health and/or psychosocial support interventions across the three phases of an emergency

The mechanisms and specificities of emergency interventions have often been modeled as a chronological process. From this chronological perspective, in the acute emergency phase, the actions implemented constitute a direct response to basic needs which are unmet due to the crisis. The nature of this phase means that the affected population is generally not involved. Indeed, whilst it is generally possible to consult the affected population during the deployment of an initial response, a fully participative approach may be challenging, primarily due to the time constraints involved. This phase progressively evolves into the post-emergency phase, with increased consultation with the population and a refined response according to their specific needs. This then moves into a rehabilitation phase or early recovery phase which includes the gradual implementation of increasingly participative strategies and partnerships, with the population increasingly involved in planning, implementing and evaluating the humanitarian interventions. In this phase, the emphasis is placed on supporting spontaneous initiatives to restore capacities by setting in motion a dynamic (where the context is sufficiently stable) which will see the international actors shift from their role as direct actors in the humanitarian response to indirect actors, mainly by positioning themselves as partners to the local actors who provide direct support to the populations affected by the crisis.

Although this concept of a continuum between these phases may seem easy to grasp, in reality the process is not quite so simple. We prefer to speak of a contiguum, which is a more accurate reflection of what actually takes place. Indeed, development programmes (in stable humanitarian sectors or zones where local and national authorities, opportunities and capacities are being restored) often operate alongside emergency aid operations (in sectors or zones as required) and transitional sectors or areas (which are still vulnerable or volatile but where there are some signs of recovery). The contiguum importantly also refer to the fact that in a given situation, it is not always a logical progressing (from emergency to post-emergency to…) but that there may be some back and forth.

The diagram below sets out the specific characteristics of these emergency phases, as well as details on the target populations and intervention principles.
### Characteristics

- **Saving lives**
  - Covering physical and security needs
  - Preventing the immediate onset/immediate aggravation
- **Providing comprehensive coverage of the basic needs of individuals and families**
- **Managing the specific needs relating to the crisis**
- **Promoting people, families and communities to live independently**
- **Rebuild communities’ capacities**

### Phases

- **Acute emergency**
  - 1st month

- **Post-emergency**
  - 2–6 months

- **Early recovery**
  - + 6 months (shift towards development)

### Target population

- **Affected populations, including vulnerable groups**
  - Affected zones and communities
  - Affected, vulnerable households & individuals (access to basic needs & specific needs)

- **Affected zones and communities, targeted according to the activity**
  - Affected, vulnerable households & individuals (access to basic needs & specific needs), targeted according to the activity
  - Local associations, civil society, government actors

### Response principles

- **Deployment of an initial response (based on experience)**
  - Aiming for immediate effectiveness
  - Simultaneous situation assessment
  - At least a minimum level of consultation with beneficiaries and local actors

- **Response refined according to the initial assessment**
  - Flexibility/adaptability
  - Comprehensive coverage of needs
  - Increasingly taking into account the opinion/perceptions of the affected populations

- **Involvement of affected populations and local actors**
  - Consideration of sustainability or exit strategy
  - Making preparations for the move into the development phase
  - Implementing disaster risk reduction and preparedness
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RECRUIT AND TRAIN 36

SUPPORT AND SUPERVISE 36
Psychosocial interventions can be rapidly implemented during the very first hours of an emergency, in the form of active listening and early psychological first aid, for example (see technical files). These actions are relatively straightforward to put into place as they do not require any particular technical expertise, just an awareness of support principles and practices. Medical and psychological care services should be identified by Handicap International’s teams in order to refer people suffering from severe psychological distress who require psychiatric care. These teams must therefore be able to identify the key psychological symptoms (disorientation, dissociation, decompensation, suicidal tendencies, etc.) which show that these people need to be referred to specialist structures.

In parallel a diagnosis of the local context and situation and a study of the psychosocial resources and needs should be carried out and used to design the MHPSS intervention.

The assessment should provide sufficient information on the population’s mental health status and their psychosocial support needs to implement an appropriate intervention strategy which takes into account the specific and variable resources intrinsic to the affected populations and the local culture. It should also be noted that the response to these needs should take into consideration the age and gender of the populations affected, as well as family, social and ethnic relationships.

Assess

A

Target population

Handicap International’s priority is to provide the most vulnerable and isolated populations with the support they lack. Vulnerability is a dynamic concept which is dependent on the interaction between individual’s personal factors and environmental factors. People with disabilities are often highly vulnerable in crisis situations and they should be accorded special attention.

Vulnerable populations include people who have disabilities, are injured, displaced, older, unaccompanied children and people suffering from chronic diseases, including people with mental health disorders, who may not seek out the assistance they require due to their specific physical or mental condition and the destructured environment in which they find themselves. Physical, social and environmental disturbances may particularly destabilise people who are dependent and may cause anxiety. A person suffering from a mental health disorder may show more symptoms of distress because they cannot access their medication; a blind person may feel “lost” and vulnerable because they no longer recognise their surroundings.

It is also important not to forget about caregivers when identifying the target populations. They are a vital resource for vulnerable individuals and offer a vector for interventions targeting these populations. Their commitment and responsibilities may however lead them to a state of exhaustion which can manifest itself in the form of irritability, negligence, disinterest and even ill-treatment directed at themselves or other people. It is therefore important to set up support systems for these people, which can be structured (support groups, supervision sessions, etc.) or not.
The data collected should be cross-referenced with the intervention pyramid (see Principles and benchmarks) of basic services, non-specialised services and specialised services.

**B**

**Assessment principles**

The following basic principles should be applied when carrying out situation assessments in emergency settings:

1. Assessments should be carried out using a participative, concerted approach including, where possible, the government, non-governmental organisations (local and international), community and religious organisations. Participation should be entirely voluntary. It is also important to ask participants to provide feedback on the results and the assessment process.

2. The affected population should be involved in defining well-being and distress and generally speaking all the typologies used to structure the assessment (typologies of disability, mental health disorders, formal and informal services, relationships of solidarity, etc.).

3. The assessment should be carried out on several groups of the affected population, and should therefore include the breakdown of data by type of disability and interviews which are adapted to the specific type of disability (see the specificities, following section C).

4. Where possible, people with specific needs should be included in the assessment team.

5. In conflict situations, it is important to identify the parties to the conflict and understand the relationships and dynamics between them. The assessors should remain impartial and independent in order to avoid inflaming social tensions or endangering members of the community and staff. They should also be aware of diverging interests which may influence the assessment.

6. The assessment methods need to be sensitive to cultural differences and the local context in order to avoid stigmatisation. They should also be adapted to the different populations concerned (age, gender, disabilities/specific needs).

7. Conform to ethical guidelines when carrying out the assessment:
   a. Respect the private lives and interests of the people interviewed,
   b. Avoid asking indiscreet questions not required for the assessment.

8. The assessment teams should be trained in ethical considerations and have the skills required to carry out the interviews.

9. The assessment should take place in as short a timeframe as possible in order to influence emergency response planning.

**C**

**Specificities of assessing people with disabilities**

Readers are invited to consult the practical guide “Using testimony: supporting our denunciation and advocacy actions” produced by Handicap International in 2012, which sets out the specific requirements for carrying out an interview with a person with disabilities as well as the rules of consent. The following extract gives an overview of these specificities which apply to any direct intervention involving people with disabilities.

“...The following text outlines some more specific suggestions relating to people with different types of impairments. However, please note: these are only very general suggestions – you need to check with each individual and not make assumptions. These guidelines are not exhaustive; they do not
cover every type of health condition or impairment and there are many different types and degrees of disability.

**Conducting an interview with an individual with a physical or mobility disability**
Try to ensure the interview location is easily accessible (absence of stairs, leveled thresholds and wide passages). If the person has difficulties moving around, the interviewer can offer his/her assistance and in all cases should try to set up an interview space which requires a minimum of moving around. If the person is in a wheelchair or uses a device on wheels or any other assistive device, it is important to address him/her at his/her own head height: lean forward to listen to him/her, to speak to him/her or to hand him/her objects at arm's reach or in sight.

**Conducting an interview with deaf person or an individual with a hearing impairment**
To facilitate the understanding of messages, interviewers must take care to speak simply, without raising their voice, in a well-lit place and facing the individual. They should place themselves close to the individual to maximise communication. The sentences used should not be too long and instructions should be simple. Written and visual items (images, photos, drawings) can potentially be used in order to facilitate communication and expression. Gestures and expressive features also help with understanding. Call upon the services of a sign language interpreter if this proves to be necessary.

**Conducting an interview with an individual with an intellectual disability**
Individuals with an intellectual disability can experience one or several of the following difficulties: difficulties communicating what has happened, remembering the precise order of events, naming people, places and dates and providing a consistent testimony. Nevertheless, individuals with an intellectual disability should be viewed as witnesses of relevance. It is, however, necessary to prepare the interview appropriately (in addition to the general suggestions set out previously [in the mentioned document]).

**Conducting an interview with an individual with mental disability**
Mental disability does not imply an intellectual disability. The majority of individuals affected can be 'stabilised' in medical terms (medication, therapy), but they sometimes suffer from profound psychological after-effects which can be exacerbated at any time, and especially in the course of an interview.
Interviewers need to be attentive to their behaviour and to any change in their mood. They should not insist on an event which appears to upset the person. In the event of an anxiety attack or similar, it is important to help the person to get out of danger and to entrust him/her to the competent persons: doctor, psychiatrist, psychologist.

**D**

**Type of data to be collected and methodologies**

The assessment should provide enough data to accurately determine the target population to be supported and then to implement an adapted approach according to the perceived needs, the local resources, culture and context, and the services available. It is vitally important that an initial database is set up containing the figures and findings from the preliminary assessment. This baseline makes it possible to record the progress made, evaluate and report on our actions.

Note that making the intervention results externally available is both helpful and necessary. On the one hand it avoids duplicating assessments. On the other, it helps other organisations to take into account the needs of vulnerable populations. This ensures both optimal coordination with other actors in the field and avoids unnecessarily tiring populations who are already very weak and vulnerable and just want to be helped, with repeat questioning.

The handbook entitled: Assessing mental health and psychosocial needs and resources: *Toolkit for humanitarian settings* can be downloaded from the following link:

http://apps.who.int/iris/bitstream/10665/76796/1/9789241548533_eng.pdf

The Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support tool is also very helpful and is the tool most commonly used by MHPSS working groups at national level:

http://www.who.int/mental_health/publications/iasc_4ws.pdf

Other assessment tools in English are also available on the Mental Health and Psychosocial Support Network’s website:

http://mhpss.net/resources/assessment-monitoring-evaluation-and-research
Design—Defining the intervention

Once the needs in the field have been recorded and prioritised, the activities implemented can either directly provide mental health and psychosocial support, or take the form of support interventions to back up other local or international non-governmental organisations.

- Support interventions for other organisations depend on the needs identified by both partners. They may focus on capacity building by providing training and support, with financial support provided as needed.
- When the intervention is directly implemented by Handicap International, the activities put into place depend on the needs in the field. The intervention may be carried out on a geographical basis, based on the assumption that anyone who finds themselves in a given area will be suffering from psychological distress. Another possibility is for the intervention to be implemented according to the sector of activity, with MHPSS activities being latched on to existing health, social and livelihoods activities developed either by Handicap International or other local or international NGOs.

In certain specific circumstances the intervention can be made up of both types of activity with the aim of optimising the actions already in place by initiating complementary activities.

However, as already mentioned, in the event of a direct intervention it is extremely important to think about its impact prior to its launch. Vulnerable people are often dependent and extremely fragile. The potential power imbalance between the “carer” (who has the power to care) and the “beneficiary” can reinforce this dependency and even lead to a deterioration in the person's psychological condition if the relationship ends abruptly. In this context, the movement from the status of someone who is assisted to someone who takes charge of their own life is an essential step towards freeing them of this dependency.

How to avoid dependency in affected people

- Involve the beneficiaries as much as possible in the design, implementation and assessment of MHPSS activities. This allows them to adopt the project and become active stakeholders,
- Assign responsibility for project implementation and monitoring to local persons with the required skills sets,
- Be very clear with all those involved about the potential duration of the project. Give an end date where possible.

Reminder of the main objectives of MHPSS interventions

- Promote the well-being of vulnerable people:
  - Offer relaxation and psychological support sessions,
  - Set up therapeutic mediation activities,
  - Encourage people to return to their daily activities (going back to school, to work, etc.); establish a daily routine,
  - Avoid institutional care for people with mental health disorders, except for severe psychotic episodes,
  - Propose practical activities for people in distress to help control their anxiety (for example, explain to the victims of a cyclone how to protect their homes and families, etc.).
- Inform vulnerable people about the different services available.
- Ensure the activities on offer are accessible and adapted to the needs:
  - Use channels of communication that can be accessed by all people with disabilities,
• Find alternative solutions for people with extremely limited,
• Set up activities adapted to the specificities of the affected populations.

Strengthen bonds within the community:
• Facilitate the implementation of activities which are accessible to people with disabilities in order to reinforce social bonds (for example: safe and inclusive child-friendly spaces15),
• Facilitate vulnerable persons' inclusion in the community, in particular people with disabilities (including people suffering from mental health disorders).

Facilitate the participation and involvement of community organisations and disabled people's organisations as early as possible in the process when implementing the activities to ensure the sustainability of the actions put into place.

Psychosocial activities may also constitute a way of promoting people's rights and raising the target populations' awareness of different key themes (for example, understanding and social representations of disability).

Below is a comprehensive list of activities which can be implemented in emergency situations. They are set out according to the different service levels and intervention phases.

Please note that the last section of this guide is made up of practical files outlining how each activity can be put into operation. It should also be noted that not all the activities can be integrated into every project. The exact content will of course depend on the context, situation and existing services.

The suggested phased implementation is by no means set in stone and the strategy and activities implemented will be different in each different context.

<table>
<thead>
<tr>
<th>Level</th>
<th>Activities</th>
<th>1st month (acute emergency)</th>
<th>2–6 months (post-emergency)</th>
<th>+ 6 months (early recovery)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic services and security</td>
<td>Awareness-raising and information</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identification and coverage of basic needs</td>
<td>✔</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td></td>
<td>Advocacy</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td></td>
<td>Protection kits and adaptations</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Non specialised services</td>
<td>Family mediation</td>
<td></td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td></td>
<td>Focus group</td>
<td></td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td></td>
<td>Support group</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Parental guidance group</td>
<td></td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td></td>
<td>Training of reference persons</td>
<td></td>
<td>❌</td>
<td>❌</td>
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<tr>
<td></td>
<td>Safe spaces</td>
<td></td>
<td>❌</td>
<td>❌</td>
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<tr>
<td></td>
<td>Psychological first aid</td>
<td></td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td></td>
<td>Referral</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Specialised services</td>
<td>Community self-help group</td>
<td></td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td></td>
<td>Multi-disciplinary team meeting</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td></td>
<td>Clinical supervision</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td></td>
<td>Analysis of professional practices</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td></td>
<td>Individual and family interview</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td></td>
<td>Personalised social support</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
</tbody>
</table>
Furthermore, there are two fundamental cross-cutting activities which affect all intervention levels and at all phases of the emergency: referral (see technical file) and advocacy for inclusion (see first section of this document).

<table>
<thead>
<tr>
<th>Transversal activities</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Advocacy for inclusion</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
</tbody>
</table>

These are the key activities. It is important to take the time needed to look at the links which explain how these activities should be implemented. The following table sets out how the objectives for each activity can be set across the different emergency phases.

**Table summarising the specific objectives for key activities across the three emergency phases and according to the service typology**

<table>
<thead>
<tr>
<th>Level</th>
<th>Activities</th>
<th>Specific Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic services and security</td>
<td>Awareness-raising and dissemination of IEC (Information, Education and Communication) materials</td>
<td>− Inform the population about the services available (food, health, shelter, water, etc.). − Put into place resources to promote family reunification. − Inform the population about the services available (food, health, shelter, water, etc.). − Raise the populations’ awareness of the symptoms of distress which might develop following a traumatic incident, and of how these can be managed. − Raise the community’s awareness of possible means of protection. − Make sustainable improvements to security and protection conditions by raising awareness of the broader dangers some people face. − Increase the inclusion in the community of vulnerable and isolated people.</td>
</tr>
<tr>
<td>Identification of basic needs</td>
<td>Set up a system for identifying basic needs which takes into account the context, culture and specificities of vulnerable or isolated people, in particular people with disabilities.</td>
<td>− Ensure the basic needs of the most vulnerable and isolated people are covered.</td>
</tr>
<tr>
<td>Support to cover basic needs</td>
<td>Identify key cultural considerations which should be taken into account at food distributions or when providing other services. − Refer the most vulnerable people to the distribution points. − Support other actors during distributions to ensure the most vulnerable people have access to the services provided.</td>
<td>− Support actors providing services to cover basic needs and take into account an individuals’ specific needs. Refer them to other services where necessary. − Be aware of the possibility of improper use of the assistance provided and the risk of abuse or violence (offering to exchange food rations for sexual favours, for example).</td>
</tr>
<tr>
<td>Activities</td>
<td>Specific Objectives</td>
<td></td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Level</strong></td>
<td><strong>Phase 1</strong></td>
<td><strong>Phase 2</strong></td>
</tr>
<tr>
<td>Basic services and security</td>
<td>- Distribute protection kits and improve the populations' understanding of their use.</td>
<td>- Suggest adaptations to reduce individuals' isolation and vulnerability.</td>
</tr>
<tr>
<td>Protection kits and adaptations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation</td>
<td>- Find out about the procedures for replacing lost legal documents and the documents required to access humanitarian aid.</td>
<td>- Inform the population of the procedures for replacing lost documents.</td>
</tr>
<tr>
<td>- Inform people about how to protect their property.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocacy</td>
<td>- Identify the main challenges faced by vulnerable and isolated people.</td>
<td>- Report on the needs and problems faced by vulnerable people at coordination and cluster meetings to ensure the identified needs are taken into account.</td>
</tr>
<tr>
<td>- Report on the most pressing needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological first aid</td>
<td>- Listen to and refer the people worst affected by the situation.</td>
<td></td>
</tr>
<tr>
<td>- Support people suffering from severe psychological distress.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training community reference persons</td>
<td>- Identify the most relevant techniques and themes according to the needs and issues faced by the local population.</td>
<td>- Train reference persons in the identified techniques.</td>
</tr>
<tr>
<td>Family mediation</td>
<td>- Train support workers in the family mediation technique.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Identify the families which require support.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Offer family mediation sessions.</td>
<td></td>
</tr>
<tr>
<td>Level</td>
<td>Activities</td>
<td>Non-specialised services</td>
</tr>
<tr>
<td>-------</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Phase 1</td>
</tr>
<tr>
<td></td>
<td>Safe spaces</td>
<td>- Identify the people most at risk from acts of violence. - Identify a secure, accessible location which can accommodate the people requiring safe spaces. - Facilitate the implementation of focus groups of target people requiring safe spaces, in order to identify the types of activities to put into place (for example: Therapeutic mediation, games, recreational activities, micro-projects, etc.). - Set up accessible activities (purchase equipment, delegate tasks and responsibilities).</td>
</tr>
<tr>
<td></td>
<td>Personalised social support</td>
<td>- A restricted social anthropological study must be carried out for activities implemented as of phase 2. - Training in community-based social work (home, street, specialised centre, the importance of “reaching out”).</td>
</tr>
<tr>
<td></td>
<td>Therapeutic mediation group</td>
<td>- Build resilience. - Reduce the level of psychological distress. - Contain negative affects.</td>
</tr>
<tr>
<td></td>
<td>Psychotherapy</td>
<td>- Empower people suffering from severe psychological distress in order to build their coping capacity.</td>
</tr>
<tr>
<td></td>
<td>Analysis of practices (group)</td>
<td>- Develop critical awareness of the situation within its external context (political, economic, cultural). - Develop analytical abilities amongst peers with different professional styles (managing emotions, expressing feelings, positions). - Develop processes for analysing situations/cases which make it possible to identify and address complex issues. - Develop the ability to lead groups and skills for identifying group dynamics.</td>
</tr>
<tr>
<td></td>
<td>Multi-disciplinary team meeting</td>
<td>- Develop the skills of health care teams. - Improve work coordination.</td>
</tr>
</tbody>
</table>
### Activities

<table>
<thead>
<tr>
<th>Level</th>
<th>Specific Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1</strong></td>
<td><strong>Phase 2</strong></td>
</tr>
<tr>
<td><strong>Individual and family interview</strong></td>
<td>Identify the most vulnerable people who need support.</td>
</tr>
<tr>
<td><strong>Clinical supervision</strong></td>
<td>Work on professional issues (positions, values, representations, power balance, counter-transference, impotence, aggression, situations of anxiety) that the carer might find difficult to broach in front of their peers.</td>
</tr>
</tbody>
</table>

### Monitor and evaluate

During the intervention it is important to set up a system for prioritising support. Indeed, some people may find themselves in a critical condition and require immediate referral to the appropriate medical services.

The most urgent cases are:
- People suffering from psychosis without access to their medication,
- People who develop mental health disorders in reaction to an event,
- People who are considered to be a high suicide risk,
- People who are violent or aggressive who may do themselves harm,
- People with violent or abusive tendencies who have a high risk of doing harm to others.

An improvement or deterioration in these people’s conditions may depend on whether they are left alone or given support; whether they can move about freely or not; and whether they have access to services or not.

A detailed written record of the results of the initial assessment, the intervention principles and the different actions carried out should be kept throughout the intervention. This ensures the best possible follow up is provided throughout the support process, especially if the support workers involved change regularly. Indeed, in some contexts, staff may be hired for short periods of time depending on their availability and access to funding.

A comprehensive follow-up system also ensures that any problems which arise and the results can be easily identified according to pre-set indicators.

At the end of the support intervention the complete file, or an executive summary of this file, should be handed over to the beneficiary as it contains personal data which belongs to them.

All this information is highly confidential and should only be shared between members of staff working directly with the beneficiaries and the beneficiaries themselves. In the office, these files should be kept in a locked storage facility.

Furthermore, an interim and final project assessment should be carried out to investigate whether the objectives have been met and measure its medium-term impact (positive or negative). This assessment should be both qualitative and quantitative in order to ensure it is truly representative of the work carried out. To this end, suggested output and outcome indicators are set out in the technical file for each activity, provided in this guide.

The assessment also provides the opportunity to compare the observations of practitioners in the field with the perceptions of the beneficiaries.
Recruit and train

It is important that members of the community, more specifically, the affected community, and in particular people with disabilities are recruited to the intervention teams. These individuals will have a more personal understanding of the issues and challenges beneficiaries face and more impact on social networks. It also makes it much easier to mobilise the community and consolidate the social fabric. It can be helpful to recruit volunteers to help implement the activities. They can work on aspects such as awareness-raising and the inclusion of people with disabilities in the community, in schools and in institutions, etc.

Further training is often required to raise staff members' awareness of the psychosocial approach, specifically symptoms of psychological distress, and of the intervention principles for emergency settings. The recruitment of mental health and psychosocial support specialists should also be considered. In this field of activity it is vital that the teams are closely supported and supervised. The perspective of a specialist is also crucial to avoid harming the affected populations.

It can also be beneficial to find local people who can translate the training materials into the local language with respect for local culture. Where required, sign language interpreters and Braille training supports should also be provided.

Support and supervise

Psychosocial interventions in emergency settings expose teams to complex, emotionally charged situations. Support workers can be affected by this constant, repeat exposure to trauma and suffer from burn-out.

There are certain early warning signs which indicate that someone may be reaching burn-out:
- Asthenia (chronic fatigue),
- Professional demotivation,
- Lack of empathy towards other people,
- Negative attitude towards the beneficiaries and/or work colleagues,
- Impatience, irritability, blaming, moralising, cynicism, minimisation of the difficulties experienced by others, detachment, emotionally cold and distant.

If these symptoms are observed, it is important to take preventive action and offer a forum for expression, discussion, and entertainment to support the whole team (expatriate and national staff) and to provide them with psychological support.
<table>
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<th>Page</th>
</tr>
</thead>
<tbody>
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<tr>
<td>Identifying and covering basic needs</td>
<td>42</td>
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<td>Advocacy</td>
<td>44</td>
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<tr>
<td>Protection and adaptation kits</td>
<td>45</td>
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<tr>
<td>Family mediation</td>
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</tr>
<tr>
<td>Focus group</td>
<td>48</td>
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<td>Support group</td>
<td>50</td>
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<tr>
<td>Parental guidance group</td>
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<tr>
<td>Training of focal/reference people</td>
<td>53</td>
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<td>Safe spaces</td>
<td>54</td>
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<td>Psychological first aid</td>
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<td>Referral</td>
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<td>Community self-help group</td>
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<td>Multi-disciplinary team meeting</td>
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<td>Clinical supervision</td>
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</tr>
<tr>
<td>Analysis of professional practices</td>
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<tr>
<td>Individual and family interviews</td>
<td>65</td>
</tr>
<tr>
<td>Personalised social support</td>
<td>67</td>
</tr>
</tbody>
</table>

**NB:** The files are organised in terms of objectives and indicators which relate to the activities themselves, not the projects they may be part of.
Awareness-raising and information dissemination

**Why?**

**Main objective**
Awareness-raising and information dissemination activities in emergency contexts aim to pass on general information to reduce populations’ vulnerability.

**Specific objectives**
- To provide the affected population with information about the emergency situation: legal rights, victim’s rights, laws or other specific information on or for people with disabilities, public health laws, property rights linked to reconstruction and positive coping methods.
- To keep track of information published by governments, local authorities or humanitarian stakeholders, in particular information about programmes concerning relief efforts and humanitarian responses.
- To provide specific information on different existing services.
- To provide the population with information about the different possible reactions that distress may cause in crisis situations.
- To suggest recommended actions that might reduce psychological stress (psychological first aid, for example).

**Expected results**
- Populations have more information and a better understanding of the services available and of their rights.
- People in situations of distress understand and are equipped with coping methods.

**Output indicators**
- Number of messages disseminated.
- Number and different types of media used (radio, leaflets, drawings, support groups, etc.).

**Outcome indicators**
Surveys: people questioned feel better informed about their rights and the available services.

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**For Whom?**

The dissemination of information, even when it targets a specific audience, should remain broad-based and of general interest. The aim is to spread the information widely.

**How?**

**Before implementation**
- Analyse the context through cultural immersion (socio-anthropological studies).
- Target a population.
- Define a theme.
- Determine the objectives and resources required.
- Study and understand the representations and beliefs of the target population (KAP study).
- Ensure there is a sufficient budget to see the action through to its conclusion.
- Create a specific time chart for awareness-raising activities.
- Create an attractive message, a slogan as well as a visual identity for the equipment.
- Choose simple, appropriate supports to disseminate the necessary information (brochures, media, posters, debates, theatre, etc.).
- When making radio broadcasts, remember to distribute radios to vulnerable people who do not have access to this type of media. For example: isolated people with limited mobility (see Protection kits).
- If there are pre-existing key messages (promoted by other stakeholders), ensure that the messages are disseminated in a way that is accessible to people with disabilities.
Implementation

- Ensure that at least two different methods of communication are used and that they are accessible to people with different types of impairments, notably, hearing, visual and intellectual.
- If there are specific registration requirements and forms for access to certain services (for example: identity cards for access to humanitarian aid, or specific documents to prove the status of a person with disabilities), remember to pass on this information, through theatre sketches for example. Remember to help people who need it to meet registration requirements or to complete the forms.
- Create a prototype.
- Test the communication tool on a sample of the target population and ask them to complete an evaluate questionnaire about it.
- Modify the tool if necessary.
- Create the final tool.
- Carry out a final evaluation of the impact of awareness-raising according to the objectives.

Attitudes during the activity

- Be careful when and where media broadcasts or communications are made.
- Observe and follow public debates, television shows, training courses, etc.
- Continually develop messages in line with developments in the situation.

Skills required

- Project management.
- Setting up and leading a network of professionals.
- Creating and managing Information, Education, Communication and Behaviour Changing tools.

When?

Phases 1, 2 and 3.

Monitoring tools

Activity report.

Reference documents

Identifying and covering basic needs

**Why?**

**Main objectives**
- To integrate (mainstream) specific psychological and social aspects (gender relations, vulnerable people’s need to be supported and to have access to services while retaining their dignity) into the response to basic needs (food, essential items, site planning, shelter, water and sanitation, etc.)
- To reduce the anxiety of those affected by helping them to access humanitarian aid.

**Specific objectives**
- To raise awareness amongst stakeholders about cultural practices (for example, cultural norms, gender relations and important domestic roles, etc.).
- To raise awareness amongst stakeholders about the specific needs of different categories of vulnerable people.
- To support distribution stakeholders in the field.
- To provide a check-list of the most important recommendations to be integrated into the programmes.
- To support and/or refer vulnerable people to ensure they access humanitarian aid.

**Expected results**
- Services for basic needs are set up with particular attention paid to the socio-cultural context and to the situations of vulnerable people.
- The anxiety of vulnerable people is reduced by improving access to humanitarian aid.

**Output indicators**
- The number of training certificates awarded to distribution actors.
- The number of people helped to access humanitarian aid schemes.

**Outcome indicators**
- Rapid evaluation by beneficiaries of the services using a satisfaction survey.
- Proportion of people with disabilities whose basic needs are covered.

**For Whom?**

Affected populations, notably the most vulnerable people.

**How?**

**Before implementation**
- Look at any socio-anthropological studies explaining the specificities of the local context which have already been carried out in the intervention zones.
- Begin a study into the specificities of certain social aspects (local beliefs, healing systems, power relations, gender, domestic roles, etc.)
- Study the basic and specific needs of vulnerable people (food, shelter, water, sanitation, mattresses, blankets, cooking utensils, technical aids, etc.) using evaluations already carried out in the field.
- There are several basic rapid evaluation tools available on the internet, created by different organisations such as CARE, UNHCR, IFRC, etc.
- Establish a check-list of the most important recommendations according to the socio-cultural aspects and contextual specificities.
- Prepare training for distribution stakeholders so that they can adapt their interventions.

**Implementation**
- Take every possible measure to prevent abuse and abusive practices, including within the scope of humanitarian workers’ practices. For example, do not isolate vulnerable and marginalised people, but place people with disabilities close to services, encourage the team to adhere to the dedicated policies (Protection of beneficiaries from exploitation and sexual abuse and, Protection of children).
- Support vulnerable people in accessing humanitarian aid: this support might include helping a person to access aid and helping the stakeholder providing the aid to understand how best to include them.
Field visits, during which you must be alert to abusive practices and set up preventative actions in relation to these practices.

**Attitudes during the activity**
- Provide clear and simple information.
- Do not swamp vulnerable people with too much information.
- Listen to the needs of vulnerable people.
- Provide accurate information on access to services.
- Do not promise anything that cannot realistically be done.

Skills required
- Understanding of basic needs in emergency situations.
- Ability to cope with stressful situations.
- Good understanding of the possible psychological reactions of people that have been through a natural disaster or a conflict, particularly of vulnerable people with disabilities.
- Good ability to communicate information about a country’s culture.
- Good ability to transfer skills.
- Good listening skills and empathy.

When?
- At the design stage of the first humanitarian actions.
- Phases 1, 2 and 3.

Monitoring tools
- Monitoring file.
- Training report.
- Contact report.
- Field Visit report.

**Possible recommendations**
- Reinforce local infrastructure management.
- Create safe community spaces that are accessible to people with disabilities.
- Remember to include those who are isolated and excluded from distributions—find creative solutions to include them (door-to-door distributions, support, separate queues, etc.)
- Remember to include vulnerable people, in particular people with disabilities, in the different cash for work projects.
- Lobby humanitarian stakeholders to include affected groups in implementing the actions they will benefit from (i.e. use volunteers from the affected community to prepare a distribution site)—this is a way of increasing psychosocial well-being.

Reference document
- All guides about needs assessment in emergency contexts are available on: [http://www.parkdatabase.org](http://www.parkdatabase.org)
Advocacy

**Why?**

**Main objective**
To influence decision-makers, governments and stakeholders to ensure that they include people with disabilities in intervention programmes and public action policies.

**Specific objectives**
- To feed back on the main issues affecting vulnerable people, notably people with disabilities to government stakeholders and international and local organisations.
- To recommend making psychosocial and protection projects accessible to people with disabilities, and support stakeholders in implementing this recommendation.

**Expected results**
- State actors, local and international organisations take the issues of vulnerable people into account and have the necessary tools for adapting their interventions.
- Vulnerable people have access to services provided by State actors, local and international actors.

**Output indicators**
- Participation rate in clusters and working groups.
- Number of meetings with governmental stakeholders.
- Number of meetings with international and local stakeholders.
- Number of training sessions dispensed.

**Outcome indicators**
- Number of documents adapted to improve the inclusion of vulnerable people.
- Recommendations are integrated into laws, and humanitarian intervention programmes.
- Awareness-raising programmes are carried out by other stakeholders in order to combat discrimination.
- Disability is genuinely taken into account in the interventions of partners, or other NGOs, working in the zones.

**For Whom?**

Governmental stakeholders, stakeholders from national and international organisations, clusters mediators.

**How?**

**Before implementation**
- Gather information on policy (public or internal actor policy):
  - Understand the political context,
  - Understand the community’s concerns,
  - Identify the policy-related causes of poverty and discrimination,
  - Understand the perception of disability in the community,
  - Identify the stakeholders and the institutions involved in drafting public policy, as well as those capable of mobilising and influencing decision-makers,
  - Analyse the distribution of political power between the main stakeholders,
  - Understand the formal and informal decision-making processes.
- Gather information on the humanitarian stakeholders:
  - Who does what?
  - Identify key stakeholders that are open to suggestions for adapting their activities.
- Evaluate the risk:
  - Plan for themes which have a risk of violence,
  - Plan for the political trends, notably any contextual developments that could change the advocacy targets.
- Create strategic relationships:
  - Establish links with decision-makers,
  - Work with other humanitarian aid organisations.
- Establish credibility:
  - Gather supporting evidence: reviews, studies, etc.,
  - Create an evidence-based argument in order to convince politicians,
  - Develop our expertise to establish credibility with decision-makers, policy-makers and humanitarian stakeholders,
Protection kits and adaptations

Why?

Main objectives
- To reduce the incidence of violent acts and abuse carried out on vulnerable people and people with disabilities.
- To reduce the anxiety of children in psychological distress by providing them with ways of expressing their emotions and affects.

Specific objectives
- To provide equipment to increase the protection of vulnerable people and/or people with disabilities through kits made up of adapted equipment.
- To provide means of expression and adapted entertainment for vulnerable people and/or people with disabilities.
- To provide isolated and particularly vulnerable people with access to information on humanitarian aid.

Expected results
Vulnerable people (especially those with disabilities) benefit from equipment and relevant information which enables them to prevent situations of violence and abuse.

Output indicators
Number of kits and/or items distributed.

Outcome indicators
Evaluation with beneficiaries to study the usefulness of the kits provided.

For Whom?
Vulnerable people and people with disabilities in need of supportive equipment (whistle, radio, light, etc.).

Attitudes during the activity
- Be objective and trustworthy.
- Establish trusting relationships with the different stakeholders (political, humanitarian and community).
- Be diplomatic and persuasive.

Skills required
- Having valid information about the subject in hand.
- Being recognised as a reliable source of information.
- Being comfortable when speaking.

When?
Phases 1, 2 and 3.

Monitoring tools
- Activity report.
- Action plan.
- Logical framework.
- Evaluation form.

Reference document
How?

**Before implementation**

- Study the greatest risk factors within the context concerned.
- Adapt the kit to the country’s culture.
- Identify the most vulnerable people at risk from abuse and violence.

**Implementation**

- Train those who will distribute the kits (the approach to adopt, problems that may arise, etc.).
- Distribute the kits.
- Train the beneficiaries to use the kits.
- Evaluate the usefulness of the kits with the beneficiaries.

**Attitudes during the activity**

- Speak clearly and simply.
- Analyse the local factors (individual’s environment) that may increase the incidents of abuse and violence.

**Skills required**

- Common sense.
- Ability to raise awareness and to inform others.

**When?**

Phases 2 and 3.

**Monitoring tools**

- Donation Certificate.
- Evaluation form.

**Examples of items to be included in the kits**

- Radios to access information on the humanitarian response, or any new crisis, in particular for isolated people, with limited mobility.
- Whistles or bells to warn their friends and family of danger, of abuse or of violence (for example, in a crisis situation the whistle could be used by someone to indicate that they are stuck, or even that they have been left stranded somewhere).
- Toys for children, and games for adults.
- Musical instruments.

**The content of the kits should be adapted to the needs of the most vulnerable people** (for example, appropriate toys for children—no scissors for children who might injure themselves, balls with different textures for children who have difficulties grasping objects, toys with sounds for visually impaired children, etc.).
Family mediation

Why?

Main objective
To construct or reconstruct a family relationship damaged by a rupture or separation.

Specific objectives
- To restore communication, support participative discussion within the group and, more specifically, within the family.
- To support the family in defining an action plan to initiate change and in finding its own solutions to the situation.

Expected results
The family feels empowered and takes responsibility for overcoming difficulties linked to the ruptures experienced.

Output indicators
- Number of visits carried out.
- Number of action plans completed with different families.

Outcome indicators
- A change in the attitude of members of the family regarding how they manage difficulties (empowerment).
- Each member of the family feels more empowered.

For Whom?

For suffering families that are facing a rupture.

How?

Before implementation
- Identify members of the team with the skills to carry out family mediation (social workers, psychologists, leaders, people with an important role in the community).
- Prepare and train, if necessary, the selected team members in family intervention techniques and in the role and function of a family mediator.

- Prepare and adapt monitoring tools with these team members.

Implementation
- Introduce the selected team members to the family.
- Explain the meeting objective.
- Explain the role and function of the mediators.
- Explain the limits of the mediator’s role (a mediator is not an adviser or an educator. They do not judge and do not take sides in conflicts. They are not therapists, although the activity can be seen as therapeutic).
- Fix the framework for interventions (place, date, time and duration, confidentiality, consent, methods for promoting participative discussion, etc.).
- Understand what the family wants and what motivates them.
- Understand how a family works:
  - What are the roles of the different members of the family?
  - How do they communicate?
  - Who are the leaders? Who has influence within the family?
  - What are their most frequent defense mechanisms?
- Help the family to identify obstacles/difficulties that prevent them adapting to situations.
- Support people who express the most distress and difficulty within the family:
  - Allow all members to express negative affects,
  - Encourage the family to build on positive factors and family resources.
- Provide feedback to the family on what has been said (reformulation) to put their experience into different words.
- Support the family in its action plan:
  - Identify actions to be put in place in order to facilitate change occurring,
  - Discuss deadlines with the family.
- Support the family in the actions that each member wants to put into place:
  - Discuss the family’s main difficulties,
  - Support them in finding their own solutions.
- Evaluate the intervention in the last session.
Attitudes during the activity
- Objectivity and impartiality.
- Knowing how to create a framework for discussion and to ensure the family respects it where necessary.
- Containing the family's suffering.
- Being aware of the expectations the family might have regarding the moderator's position.

Skills required
- Ability to analyse family dynamics.
- Ability to be unbiased and not to judge a member of the family (impartiality).
- Ability to reformulate emotions and thoughts.
- Ability to summarise.
- Ability to maintain a working framework that operates independently from external authorities (justice, public order).

When?
Midway through phase 2 and phase 3.

Monitoring tools
Intervention reports from the moderator.

Focus group

Why?

Main objective
To ensure the credibility of an intervention using the information received and participants' contributions to a focus group.

Specific objectives
To gather qualitative information drawn from real-life experiences through targeted discussion over a relatively short time-frame with a group of people.

Expected results
A better understanding of people's expectations and perceptions in terms of a specific reality.

Output indicators
Focus group report covering the most significant results.

Outcome indicators
- The intervention is accepted or validated.
- Level of involvement of the participants in constructing a joint project.

For Whom?
People from the community: key stakeholders (community leaders, community decision-makers), people with disabilities and vulnerable people.

How?

Before implementation
- Define the theme to be discussed.
- Identify group members: 6 to 12 carefully chosen participants—limiting the number leads to a better understanding and improved management of the information communicated. The restricted number of participants guarantees group cohesion because each member is able to express themselves freely. For focus groups on the theme of sexual violence, it is recommended that the groups are homogeneous in terms of age and gender.
Decide on a location for the meetings that is accessible to people with disabilities.

Create an interview guide with 5 or 6 questions including the interview objectives and the information to be collected. This guide should be flexible enough to allow any areas of interest broached during the focus group to be explored. To optimise both contact with the group, and information collection, it is recommended that two facilitators conduct the interviews: the first to lead the group and the second to take notes.

**Implementation**
- Approach the themes in a flexible manner.
  - Avoid targeting very sensitive subjects that could create difficulties for the participants (these subjects could be kept for the individual interviews).
- Stimulate and moderate the interaction, without giving an opinion.
- Observe the participants' reactions.
- Take notes or record the interview (audio or video if permitted).
- Note any institutions cited, terms used, people's different perceptions, the issues raised by group members, etc.
- Several people should analyse the data to avoid bias.
- Provide feedback on the results obtained.
- Develop any areas of interest using other survey methods if necessary.

**Skills required**
- Ability to lead discussions, allowing each person to speak.
- Ability to stimulate discussion and re-focus it on the theme in hand.
- Listening skills.

**When?**
Phases 1, 2 and 3.

**Monitoring tools**
Activity report.

**Reference document**
  - Data-collection: Qualitative methods.

**Attitudes during the activity**
- Be careful to ensure the least forthcoming members of the group take their turn to speak.
- Ensure the rules established at the beginning of the session are respected.
- Re-focus the discussion if participants stray too far from the subject.
- Encourage everybody to participate, give their opinion and react to other people's opinions.
Support group

**Why?**

**Main objective**
To improve the mental health of vulnerable people through their participation in a peer group that encourages a group dynamic, interaction and connections between participants.

**Specific objectives**
- To build people’s capacities to take action.
- To reduce the level of psychological stress.
- To contain negative affects and representation.

**Expected results**
- Vulnerable people's level of distress has been reduced.
- Individuals face up to the trying situation they find themselves in.

**Output indicators**
- Levels of participation and attendance (or justified absence).
- Meeting frequency.
- A follow-up form for each participant.
- Satisfaction survey: participant feedback.

**Outcome indicators**
- Confrontation of opinions/representations
- The rules established are adhered to.
- Changes in individual and collective attitudes.

**For whom?**

Vulnerable people of all ages, all cultures (particularly in contexts where social fundamentals have been shattered, for example, isolation, guilt, loss of bearings, etc.).

**How?**

**Before implementation**
- Plan for at least two facilitators.
- Have a fixed location for each session that is accessible to people with disabilities and guarantees confidentiality.
- Plan the group's life cycle (number of sessions).

**Implementation**
- Create a group with the same participants each session (6 to 10 participants).
- At the first session, establish the rules with the members of the group:
  - Frequency and length of meetings,
  - Listening to what each person says, what is said in the group stays in the group,
  - Respect what each person says, there are no right or wrong answers,
  - Do not make categorical moral judgments about what other people say,
  - Set up an analytical policy to manage absences, i.e. an absence is analysed in terms of both the issue the person is dealing with and the group dynamic.
- Provide participants with feedback or a summary after each session.
- Keep a record of participants’ feedback after each session.
- Plan individual time for each participant at the last group session.

**Attitudes during the activity**
- Be convinced of the value of the process undertaken by the group, in order to be able to motivate participants.
- Be able to structure group meetings.
- Ensure the rules established with the group at the first session are respected.
- Be flexible, capable of adapting according to what the group brings, while remaining a sufficiently stable influence for the group.
- Be capable of coping with diverse inter-personal interaction: aggression, passivity, etc.
- Be capable of putting one’s own opinions “on stand-by” in order to let others express theirs.
Parental guidance group

Why?

Main objective
To enable participants to rediscover a certain balance within the family through their contact with people living in similar situations.

Specific objectives
- To support parents/teachers in discovering resources.
- To help parents to discover different methods for dealing with difficult situations.

Expected results
Parents acquire new methods for handling crisis situations and have rediscovered a certain balance within the family.

Output indicators
Good attendance.

Outcome indicators
- Group dynamic.
- Parents’ perceptions have been challenged and changed.
- The perceptions children have of the protective capacity in their surroundings.

For Whom?
Parents of children with disabilities, who are often overwhelmed and suffering.

How?

Before implementation
- Identify the people who will lead the parental guidance sessions according to the Skills required for the activity.
- If necessary, prepare complementary training sessions for the session leaders on parental guidance techniques.
- Prepare the monitoring and evaluation tools for the activity (presence sheets, evaluation sheets, etc.).

Skills required
- To have been trained in the method.
- To have good working knowledge of the illustration/mediation used (if there is one).
- To know the specific issues of the group members.

When?
Phases 2 and 3.

Monitoring tools
- Follow-up form/session form.
- Evaluation of the value added to the group dynamic and its development.

Reference documents
Form a group made up of parents/teachers to develop a common issue. Try to make the group as diverse as possible.

Determine a neutral location for meeting.

**Implementation**

- Present the framework for the activity:
  - The session objective,
  - The frequency of meetings,
  - The duration of each session.

- Establish the rules for the group:
  - Respect for what other people have to say (do not judge their opinions),
  - Respect the confidentiality of what is said, anything said or heard should not be passed on to anybody outside of the group,
  - Listen to what other people say.

- Collect information on future participants’ expectations regarding the scheme (it is possible to hold individual interviews with each future participant).

- Set objectives with the group (experience sharing, information on the disease, etc.).

- Remind participants about each session.

- Leave time for feedback at the end of the session.

- Plan a project evaluation at the end of the cycle.

**NB:** Recreational activities could also be set up, for example, a group could be formed for a “cooking together” session.

**Attitudes during the activity**

- Remind the group of the framework during the first sessions.
- Do not make value judgments or moralise.
- Listen to each person’s story and experience.
- Encourage the participants to share their experience rather than their advice.
- Let the group develop in terms of the needs and issues that arise.
- Observe participants in their entirety (non-verbal communication, presentation, signs of emotion etc.).

**Skills required**

- To be trained in leading groups and analysing group situations.
- Participation in supervision groups, analysis of professional practices.
- Possible candidates: psychologist, social worker, educator, youth leader, etc.

**When?**

Phases 2 and 3.

**Monitoring tools**

- Participant monitoring form.
- Session report.

**Reference document**


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In Haiti, parental guidance groups have been set up for the mothers of children with cerebral palsy. Thanks to these forums for exchange, these mothers were able to share their experience as parents/carers and develop new skills for supporting their children.
Training of focal/reference people

Why?

Main objective
To train reference people from the local population on various themes and techniques in order to increase their caring skills and their knowledge of mental health/psychosocial support.

Specific objectives
- To identify the most relevant techniques and themes according to the needs and issues of the local population.
- To train and supervise reference people in the identified techniques.

Expected results
The reference people are able to support vulnerable people, in particular those with disabilities.

Output indicators
- Rate of participation in training seminars (or justifiable absence).
- Number of people successfully trained.
- Questionnaires to measure the effectiveness of the training/supervision.

Outcome indicators
- Evaluation of the skills and knowledge acquired during the training in the areas of mental health and psychosocial support.
- A study shows the new skills have been appropriated through peer-to-peer support activities.
- Practical application of newly acquired skills via the setting up of self-help groups of resource people within the community.

For Whom?

Volunteers, focal and reference people, and, more broadly, all non-professional people in the community active in the sector of mental health and psychosocial support.

How?

Before implementation
- Identify the reference/focal people (religious or association leaders, traditional healers, social activists).
- Create and distribute a pre-training questionnaire.

Implementation
- Ascertain which skills and aptitudes need to be acquired.
- Understand their background and motivation.
- Evaluate their standing in the community and their ability to create networks of collaborators.
- Create a time chart for the different training sessions.
- Determine the skills to be acquired and create appropriate training courses.
- Inform and clearly explain programme and activity objectives.
- Pass on a certain number of theoretical and practical case studies.
- Use different types of media to enliven the training (films, interventions from professionals, role play, etc.).
- Schedule time for debate/questions.
- Ask participants to complete a questionnaire in order to evaluate the training at the end of the session.
- Supervise the participants.

In Myanmar, the team noted that training sessions led by people with disabilities were more effective than those led by the members of Handicap International’s team without disabilities. First-hand accounts of the daily life of people with disabilities were a good way of sparking interesting debates and discussions.
Attitudes during the activity
- Create interactive training (start with each person's experience, their opinions, take into account each person's knowledge, work on their positions, etc.) and adapt it to people's actual understanding.
- Act as a mediator and facilitator for discussion.
- Ensure the framework is respected.
- Encourage participants to come to training on future themes (establish a training schedule).

Skills required
- Ability to pass on knowledge.
- Listening skills.
- Ability to motivate and build the participants' resources.
- Ability to moderate training sessions.

When?
Mid-way through phase 2 and phase 3.

Monitoring tools
- Satisfaction survey.
- Evaluation of knowledge, attitudes and practices.
- Project monitoring tools (evaluation form and follow-up form).
- Knowledge updates at regular intervals.

Reference document
  Supporting persons living with trauma by rebuilding social and community links: an example of a community-based mental health approach after the Rwandan genocide of the Tutsis.  

Why?

Main objective
To promote safe inclusive transitional spaces for the most vulnerable people in order to build their self-esteem and reduce the risk of abuse and violence.

Specific objectives
- To strengthen socialisation within a safe space by offering adapted cultural activities.
- To encourage participants to express their emotions and creativity.
- To limit the risk of abuse and violence against the most vulnerable people during the emergency period.
- To inform people about means of protection in emergency situations.
- To provide information on the places where aid can be accessed and the different services available in the community.
- To make the space physically inclusive and welcoming for people with disabilities.

Expected results
The participants feel safer and their feeling of distress has been reduced thanks to the information received in the safe space, social connections between participants are also reinforced.

Output indicators
- Number of activities on offer.
- Number of participants per session.

Outcome indicators
- Improved understanding of the issues relating to the prevention of violent abuse.
- Questionnaire on perceptions of safety in the surrounding environment.

For Whom?
For people of any age who are unsupported in an emergency period, with a focus on the most vulnerable, including people with disabilities.
How?

**Before implementation**
- Set up focus groups with community members and community leaders to identify protection issues and ensure they support the establishment of safe spaces with conviction. Ensure that representatives of people with disabilities participate in the focus groups.
- Through discussion, identify those most at risk of being victims of violence and abuse within the community.
- With community members, explore the existing protection mechanisms, notably for people with disabilities.
- Together with the community members and community leaders, identify a safe space that is accessible to everybody and easily identifiable.
- Recruit group leaders, educators, or managers who can facilitate the activities. If possible, recruit people with disabilities.
- Train the teams on leading groups.
- Train the teams on the principles in the internal policies on child protection and protection from sexual exploitation and abuse.
- Train the teams on the theme of disability and related risks of violence on a continual basis.

**Implementation**
- Explain the aims of safe spaces to all members of the community, and, in order to avoid any confusion, state explicitly that they in no way replace schools.
- Explain to participants how safe spaces work (times, place, frequency).
- Clearly explain the limited duration of the activities in safe spaces.
- Present and explain the rules to participants:
  - Respect other people’s opinions,
  - Respect the emotions expressed during the activities,
  - Give everybody the opportunity to participate in the activities,
  - Ensure people with disabilities participate in the activities set up.
- Facilitate discussions with the safe spaces’ target groups in order to identify which activities should be set up (examples: therapeutic mediation activities, games, recreational activities, micro-projects, etc.).
- Set up accessible activities (purchase equipment, share tasks and responsibilities).
- Follow up and evaluate the activities under way.
- Lead awareness-raising and community information activities to promote the protection of vulnerable people, in particular the protection of people with disabilities at risk of acts of violence.
- Lead awareness-raising activities which aim to include people with disabilities in the community.

**Attitudes during the activity**
- Ensure the established framework is respected.
- Listen to comments, criticisms and feedback from participants to adapt the activities to people’s needs and situations.
- Be very careful with regards to behaviours or activities that might create a risk of violence and pay close attention to the social climate.

**Skills required**
- Ability to lead a group of children, adolescents or adults.
- Good command of the tools for leading a group.
- Ability to adapt to the specific needs of a group.
- Ability to make activities inclusive.
- Ability to optimise the use of each participant’s resources.
- Ability to recognise the risks of violence and abuse in the different activities set up.
- Sense of creativity.

**When?**

Phase 2 and potentially in phase 3, depending on the situation.
Psychological first aid

Why?

Main objective
To offer immediate support to people that have been exposed to one or more potentially traumatic events.

Specific objectives
- To listen to and refer the people most affected by the situation.
- To support people in severe psychological distress.

Expected results
- People have the information required to be able to access the services that they need.
- People no longer constitute a danger to themselves or to others.
- People are calmer and can take decisions for themselves.

Output indicators
Number of people having received psychological first aid.

Outcome indicators
Subsequent evaluation by the person having received the support (the person is able to manage their stress and confront the difficult situation).

For Whom?

Any person in a state of distress potentially exposed to a traumatic event (adults and children). In particular, seriously injured, people who might hurt themselves or others, people unable to look after their children because of their distress, those separated from their families or who have lost members of their family, and displaced people.

Reference documents


Monitoring tools

- Number of participants in the activities set up.
- Activity reports.
- Evaluation of changes in the level of distress.
- Evaluation of participant satisfaction.
How?

Before implementation

- Identify the members of the team able to provide this type of care.
- Train caregivers in psychological first aid, notably the ethical principles.
- Identify a safe place offering sufficient privacy to protect confidentiality and people's dignity.
- Understand the impact of the event that took place.
- Know which different services are available and operational and pass this information on.
- Understand the main issues linked to the safety and protection of individuals.

Implementation

- Identify the people who urgently require services to meet basic needs.
- Identify people suffering from severe distress.
- Introduce yourself and explain your role.
- Be clear about the support that can be offered.
- Provide information about available services.
- Listen to those in severe psychological distress who need and want to speak (do not force them to speak).
- Reassure each person that they are safe.
- Offer breathing relaxation techniques if the person feels sufficiently safe.
- Respect the person's culture, age and beliefs.
- Support individual, family and community coping capacity (family reunification, etc.).
- Explain that even if the person refuses aid now, they can always come back and receive support or aid later.
- Try to help the person reconnect with the present.
- Refer people to specialised services for their needs.
- Strengthen peoples' positive coping mechanisms.
- Prevent people in severe distress from harming themselves or others.
- Help each person to calm down.
- Help each person define their priorities.
- Always inform people when you leave a given location.
- Introduce them to another colleague if you need to leave.

Attitudes during the activity

- Be empathetic and listen to each person.
- Interject periodically whilst the other person is speaking to show them you are listening.
- Keep a calm tone of voice.
- Do not force them to tell their story.
- Do not judge their story, feelings or actions.
- Respect the confidentiality of each person's story.
- Be honest about the aid and support on offer.
- Respect each person's right to freely make their own decisions.
- Do not make false promises or give false information.
- Do not use technical or specialised language.
- Do not leave people in severe distress alone.

Skills required

- Listening skills.
- Sense of observation.
- Organisational skills.
- Desire to help those in distress.
- Ability to remain calm and patient, even in chaotic situations.
Important note

Avoid specific psychological interview (such as psychological debriefing), aimed at encouraging someone to speak about the event that caused the distress. Psychological debriefing is not recommended in emergency contexts. It is very controversial due to the fact that it is not proven to be effective and may contravene the principle of “do no harm”.

When?

As soon as sufficient information is available, during phases 1 and 2.

Monitoring tools

Intervention reports.

Reference document


Why?

Main objective

To set up a scheme for referring vulnerable people to different services (health, education, basic needs, specialised mental health services, etc.), in order to increase their ability to cope with the situation and to reduce their level of psychological distress.

Specific objectives

- To map the different available services.
- To refer vulnerable people to these services.
- To ensure that the service proposed meets the needs of the beneficiary.

Expected results

- Vulnerable people have benefited from services that can increase their ability to cope with the situation and reduce their level of psychological distress.
- People with severe mental health disorders have access to care and specialised services.

Output indicators

- Number of referrals made.
- Number of people having benefited from the services they were referred to.
- Map of services created.

Outcome indicators

Satisfaction survey of those referred to measure the quality of referrals (including the quality of the services that they were referred to).

For Whom?

Vulnerable people, including those suffering from mental health disorders in need of specific services or care: health, food, shelter, hygiene kits, protection kits, specialised mental health services, etc.).
**How?**

**Before implementation**
- Train the teams to properly identify people in psychological distress.
- Create tools for following-up referrals.
- Create a list of the different services available in the intervention area (health, nutrition, shelter, education). Please note: this list may have already been created by groups working in mental health and psychosocial support, or even by another Handicap International project or service.
- Check that the map includes services offered by local organisations (community-based organisations, disabled people’s organizations, etc.).
- Check the conditions for accessing each service offered with the service provider (age, gender, conditions linked to family status, geographical area, etc.).

**Implementation**
- Contact the organisations to find out the requirements for accessing the service in question (identity card, referral form, telephone call).
- Identify the referral network and how to access the different services (quality of access to the services and quality of the services), so as to avoid referring people to non-existent or inaccessible services.
- Constantly update the mapping.
- Create a system for following up on referrals according to the level of urgency. For example:
  - Follow-up after 24h if the situation is very urgent,
  - 48h if the situation is quite urgent,
  - 72h if the situation is slightly urgent,
  - Automatic follow-up after one week.
- Listen to each person to determine their needs.
- Clearly explain the procedure and requirements for benefiting from the service in question.
- Where required provide support to ensure the person in question can access the service required.
- Ensure that each person has received the service.

**Attitudes during the activity**
- Pay careful attention to the highest priority needs of vulnerable people.
- Be empathetic in your approach.

**Skills required**
- Good communication skills.
- Ability to summarise needs.
- Ability to analyse a situation.
- Organisation.
- Ability to map.

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**Important note**
Ensure that members of the team are particularly well-trained in identifying the red flags for referring people to specialised mental health services.

**When?**
Phases 1, 2 and 3.

**Monitoring tools**
Monitoring file.

**Reference documents**
Numerous—contact the technical adviser for detailed references!
Community self-help group

Why?

Main objective
- To support the recovery of vulnerable people in severe psychological distress.
- To improve the mental health of members of the Community Self-help Groups (CSG) by helping them make the most of their economic, social and community resources to meet their own needs/wants.

Specific objectives
- To learn to live with others by working on a joint project.
- To know how to make a plan based on the analysis of strengths and opportunities in the environment (social, community, family).
- To be capable of setting up and managing a project (economic, cultural, social, etc.).

Expected results
- The psychological distress of the CSG is reduced.
- The needs/wants of the members of the CSG are met.
- The members of the CSG are able to participate in social life of the community, i.e. are able to invest and be creative within their environment.

Output indicators
- Participation rate and punctuality (or justified absences).
- Meeting frequency.

Outcome indicators
- The participants have adopted the mediation actions.
- The rules are followed.
- Attitudes change as the group develops.
- Improvement in the ability to set up and manage projects.

How?

Before implementation
- Create a group (8 to 12 people) in which the participants are always the same, or discuss rules for joining or leaving if the group is to remain permanently open to the community. This group should evolve from a support group.
- Decide on a location that is accessible to people with disabilities.
- Prepare tools for monitoring and evaluating the activity.

Implementation
- Communicate about the group to attract participants and inform other professionals.
- Explain the activity objective.
- Explain the working framework:
  - Duration of each meeting,
  - Location of sessions,
  - Frequency (for example, once a week),
- At the first session, create rules with the members of the group:
  - Confidentiality of information,
  - Respect for what other people say,
  - Create a clear policy for managing absences so that they can be taken into account in the analysis of the group dynamic and the psychological issues of the absent person.
- For the first sessions, define the themes and a method (income generating activities, theatre, singing, drawing, sport, photo-language, etc.) according to the audience and the objectives defined within the group.
- For subsequent sessions, prepare them beforehand.
- Provide the materials required (room, supplies) as well as competent professionals.
- At the end of each session, analyse the problems raised by the group and look for possible solutions with the participants.

For Whom?

Vulnerable people suffering psychologically who need support. This approach is recommended for people who have difficulties expressing their discomfort verbally.
Have a debriefing meeting with the group leaders after each session.

Attitudes during the activity
- Be flexible, able to adapt according to what the group brings, whilst providing a stable influence for the group.
- Do not judge other people.
- Encourage people to speak, act as the group mediator.
- Observe participants in their entirety (non-verbal communication, presentation, signs of emotion, etc.).
- Be able to question yourself at all times and to self-analyse, with the help of the debriefings.

Skills required
- To have been trained in this method and in the chosen type of mediation.
- An understanding of group dynamics.
- Set up evaluation scales for the mediation according to the agreed objectives (development, behavior, etc.).

When?
Phases 2 and 3.

Monitoring tools
Patient follow-up form/session form.

Reference documents

Multi-disciplinary team meeting

Why?

Main objective
To ensure coordination between different teams (social and community workers, rehabilitation technicians, physiotherapists, psychologists, etc.), in order to provide better follow-up care for vulnerable and excluded people and to share professional practices.

Specific objectives
- To develop the teams' skills.
- To improve work coordination.

Expected results
The teams will have developed their skills and understanding of the treatment and care of vulnerable people thanks to the sharing of professional practices.

Output indicators
- Participation rate (or justified absences).
- Frequency of team meetings.
- Number of action plans set up.

Outcome indicators
- Participants know each other and recognise each person's work and contribution.
- Development of psychosocial skills.
- Better coordination, effective networking.

For Whom?
Professionals focus and reference people working in the same centre or on the same team.

How?

Implementation
- Contact professionals who might be interested.
- Set up a group with the same participants and leader each session (10 to 15 people).
- Find a calm available location (if possible outside the institution).
Have a meeting to set up the scheme (explain the objectives, methodology, etc.):
- Determine the frequency and duration of sessions (1 or 2 hours),
- Establish the internal rules with the group participants at the first session (respect what each person says, what is said in the group stays in the group, etc.),
- Set up a policy for handling absences.
- Discuss one or two real cases to identify the best possible ways for supporting the beneficiaries.
- Debrief at the end of each session.

Attitudes during the activity
- Accept everyone's differences.
- Compromise, use phrases starting with “I” to avoid conflicts about values.
- Cooperate, be open to new ideas and innovations.
- Respect the group members.
- Be able to question yourself at any time.

Skills required
- Good team management skills.
- Ability to moderate.

When?
Phases 1, 2 and 3.

Monitoring tools
Session form.

Clinical supervision

Why?

Main objective
To provide support for each team member individually to work on their relationship to the situations the vulnerable people they interact with find themselves in, in order to consolidate their professional autonomy.

Specific objectives
- To work on professional issues (positions, values, representations, power relationships, counter-transference, impotence, aggression, anxiety) that the carer might find difficult to broach in front of their peers.
- To allow team members to question their attitudes, words, perceptions, emotions, the actions and ethics of their work in order to better define their working style.
- To manage the risks of professional exhaustion or burn-out.

Expected results
- The team member/carer is capable of questioning their relationships to others within the scope of their professional activities and, in particular, of their own personal experience.
- The team member/carer provides support according to the representations and values of the person being supported, while optimising personal development, not necessarily to meet a specific norm but improve the person's mental health.
- The team member/carer mobilises others' abilities to invest and construct within their environment.
- The team member/carer is able to accept other people's situations (without judgment and with empathy).
- The team member/carer is able to remain grounded in themselves.

Output indicators
- Clinical supervision participation rate.
- Number of support sessions carried out.
Outcome indicators
Evaluations midway through and at the end of the professional development cycle.

For Whom?
Psychologists, social workers, and counselors.

How?
Implementation
- Find a place where meetings can be held privately, ensuring confidentiality is respected.
- Create an intervention framework:
  - Explain where the team meetings will take place, the duration and frequency of meetings.
  - Explain the confidentiality of the information shared.
  - Clearly assert each participant’s right to speak.
- Intervention proceedings:
  - Clear presentation of the situation,
  - Presentation of the relationship dynamic between the person intervening and the individual concerned,
  - Reflection on the specificities of the relationship dynamic,
  - Reflection on the experience of the person intervening in relation to this situation,
  - Analysis and interpretation.

Attitudes during the activity
- Listen carefully to what is said.
- Do not judge what is said or each person’s interpretation.

Skills required
- Intervention experience.
- Good understanding of the issues and experience in the field.
- Experience in professional support.
- Good analytical capacities.
- Experience of deep thinking and reasoning.
- Listening skills.
- Know how to act in retrospect and to confront people in a respectful manner.

When?
Phases 1, 2 and 3.

Monitoring tools
Supervisor’s report.

Reference documents
  http://www.youtube.com/watch?v=VjooeaEmmbo
Analysis of professional practices

**Why?**

**Main objective**
To allow professionals to reflect on their practices with their peers and to find practical resources relating to the difficulties they may encounter. This activity also aims to prevent professional exhaustion or burn-out.

**Specific Objectives**
- To develop critical awareness of their situation, notably in context (political, economic, cultural).
- To develop analytical capacities amongst peers with different professional styles (emotions management, expression of feelings, positions).
- To acquire the reflex of analysing situations and where possible to take a step back from complex issues and provide support.
- To develop the ability to lead groups and skills for detecting group dynamics.

**Expected results**
- Team members/carers acquire the ability to analyse individual and group problems.
- Team members/carers develop critical awareness of their situation.
- Team members/carers know how to be self-critical in terms of their professional practices.

**Output indicators**
- Participation rate (or justified absences).
- A follow-up form for each participant.
- Level of participant satisfaction.
- Sustainability of the scheme.

**Outcome indicators**
- Development of critical awareness and analytical capacities between peers with different professional styles.
- Solutions are found to the problems raised.
- Ability to be self-critical in terms of professional practices.

**For Whom?**
Professionals who provide counseling, for example, psychologists, social workers.

**How?**

**Before implementation**
- Identify the person who will be in charge of analysing practices.
- Create tools to follow-up the activity.
- Identify a work space.
- Set a fixed time and place for each session.
- Contact professionals who might be interested.
- Create a group of professionals or of people that remains the same (10 to 12 people).

**Implementation**
- Have a meeting to set up the scheme (explain objectives, methodology, etc.).
- Ensure regular meetings are held (one meeting per month minimum).
- Establish the internal rules with the group participants at the first session (respect what each person says, what is said in the group stays in the group, etc.).
- Set up a policy for managing absences, i.e., go beyond mere follow-up and give a meaning to any absences that can be integrated into analysis of the group dynamic.
- Pre-training forms on the participants’ expectations and concerns.
- Discuss practices, experience and real cases encountered.
- Debrief, i.e. at the end of each session go back and follow the thought processes through what was said during the session.

**Attitudes during the activity**
- Be flexible, able to adapt according to what the group puts forward, whilst remaining a stable resource for the group.
- Do not make judgments or take sides during discussions.
- Ensure the rules established in the first session are followed.
Individual and family interviews

Why?

Main objective
To provide clinical support and an evaluation of the most vulnerable people's condition in order to provide psychological support.

Specific objectives
- To identify the most vulnerable people who need support.
- To offer adapted support.
- To refer psychiatric cases in need of medical care.

Expected results
The most vulnerable people have been identified, supported and/or referred to specialised services.

Output indicators
- Participation rate (or justified absences).
- Number of people having had one or more interviews.
- Number of sessions.

Outcome indicators
- Participant satisfaction survey.
- Results of evaluation carried out by the support worker.

For Whom?

People showing symptoms of severe psychological distress.

How?

Before implementation
- Identify team members who are able to conduct an individual interview.
- Provide training in techniques for individual interviews if necessary.
- Create follow-up tools (for example, interview framework, follow-up report, etc.).

Skills required
- To have been trained in this practice.
- Be a psychologist or psychosocial group leader.
- Have an understanding of group dynamics.

When?

Phases 1, 2 and 3.

Monitoring tools
- Follow-up form/session form.
- Semester debriefing with the group.
- Annual satisfaction questionnaire.

Reference documents
Find a calm space which guarantees confidentiality and is accessible to people with disabilities.
Ensure interpreters (languages, sign language, etc.) are present if necessary and brief them on how the interview will proceed.

Implementation
- Make contact.
- Present the framework for the interview (accessible space, length of one hour at most unless necessary, frequency of meetings, rules about confidentiality, etc.).
- Set up a scheme for managing absences.
- Create an action plan together, with goals to attain (always choose easily attainable goals so as not to be discouraging, and remain open to uncertainty and change).
- Decide whether the interview requires a meeting with the person's family and friends (collective interview).
- Fill out the follow-up form explaining how the interview has gone.
- Observe each person as a whole (non-verbal communication, presentation, signs of emotion, etc.).
- Provide emotional support.
- Provide advice when people are disorientated.
- Be able to refer each person to other professionals if necessary.
- Allow each person to express themselves to a carer during formal discussions with mutual trust.

Attitudes during the activity
- Use open questions that allow the person to confide.
- Adapt the methods according to the person, and the specificities of the meeting.
- Stay neutral and be kind.
- Keep to the prescribed times for support sessions so as not to create a relationship of dependency.

Skills required
- Training in individual interview practices.
- Understanding of how to carry out specific tests.
- Ability to identify specific needs.
- Ability to make a diagnosis.
- Ability to make referrals.

When?
Phases 2 and 3.

Monitoring tools
Follow-up form/session form.
Personalised social support

**Why?**

**Main objective**
- To improve vulnerable people's social participation and living conditions through outreach programmes providing social support adapted to each individual's needs and resources.
- To build their self-confidence and confidence in their abilities.

**Specific objectives**
- To identify each individual's needs and resources.
- To set up an individualised support programme to strengthen each individual's abilities.

**Expected results**
Each vulnerable person starts to draw on their own individual and environmental resources to improve their ability to act for themselves and with others.

**Output indicators**
- Number of visits/meetings.
- Action plan drafted with the person supported.
- Evaluation after support (satisfaction survey).
- Participant's presence at meetings and appointments.

**Outcome indicators**
Survey to show the improved skills and knowledge of the people being followed.

**For Whom?**
Vulnerable people in psychological distress and their families.

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**How?**

**Before implementation**
- At the start of this activity, it is essential to carry out a socio-anthropological study in order to adapt the intervention methods.
- Identify people who are able to implement personalised social support.
- Provide training on social support in the community (home, street, specialised centres, the importance of reaching out i.e. reaching out to others rather than waiting for them to come to you).
- Prepare tools for monitoring and evaluating the activity with the team members.

**Implementation**
- Create a network, a team of professionals with whom projects can be set up, or who can be consulted for medical opinions.
- Make contact: first interview.
- Define the duration of the interview: on average, forty minutes in a safe space that is accessible for people with disabilities.
- Explain the visit objective and the intervention process: explain the intervention framework (location, frequency of visits, length of sessions).
- Create a trusting professional relationship that encourages individual responsibility.
- Define each person's needs together.
- Meet other family members if necessary.
- Analyse the data collected (possibility to contact those close to the person concerned).
- Build a plan together, an action plan and a time chart.
- Formalise each stakeholder's commitment to the process, explain the conditions and involvement (contractual).
- Support each person in terms of their fixed objectives:
  - Give them the means to do things for themselves. Do not try to make them fit in a mould.
  - Make constant adjustments according to the person, their social environment and their development throughout the support.
  - Optimise each person's abilities, see potential and not just incapacity.
Facilitate different steps, without replacing the person involved.

Adapt to the realities and difficulties in the field.

Carry out an evaluation/a midway assessment, ideally once a month, and adapt the action plan if necessary (examine the gap between the current situation and starting goals).

Finalise the support: exiting the scheme.

Carry out a satisfaction survey with the participants and their family and friends to obtain feedback on their experience of the process.

Attitudes during the activity

Participative approach: involving the person in the stages of the project.

Be aware of life stories, collect as much information as possible on different aspects to establish each person's baseline situation in order to offer something adapted to their circumstances.

Be empathetic.

Skills required

Knowledge of the social environment and how it works.

Ability to conduct interviews (individual or collective).

Ability to analyse disparities, when things go wrong and obstacles.

Ability to carry out a social diagnosis.

Ability to build a plan based on individual requests.

Ability to mediate.

Ability to work in a team, a network, or with the family and friends of the person being supported.

Knowledge of communication and behaviour mechanisms.

Good working knowledge of the disability creation process (DCP) and the tools for analysing its practical application.

When?

Phases 2 and 3.

Monitoring tools

- Evaluation form.
- Activity report.

Reference document

Appendices

ACRONYMS

BIBLIOGRAPHY

GUIDANCE ON UNDERSTANDING THE VARIOUS TYPES OF IMPAIRMENT

FOOTNOTES
Acronyms

DRR  Disaster Risk Reduction
FGD  Focus Group Discussion
HC   Humanitarian Coordination
HESPER The Humanitarian Emergency Setting Perceived Needs Scale
IASC Inter-Agency Standing Committee (= CPI)
IEC   Information, Education, Communication
INEE  International Network for Education in Emergencies
IOM   International Organization for Migration
KAP   Knowledge, attitude, and practice
MhGAP Mental Health Gap Action Programme
MHPSS Mental Health and Psychosocial Support
OCHA  Office for the Coordination of Humanitarian Affairs
ONSMP National mental health and vulnerability observatory (Observatoire National de la Santé Mentale et de la Précarité)
PSEA  Protection from sexual exploitation and abuse
UNHCR United Nations High Commissioner for Refugees
UNICEF United Nations International Children Emergency Fund
WHO   World Health Organization

Bibliography


Guidance on understanding the various types of impairment

Motor impairment
The term 'motor impairment' encompasses several causes of disability (non-exhaustive list):
- Congenital malformation or amputation, surgical amputation.
- Paraplegia, hemiplegia or tetraplegia: the partial paralysis of and lack of sensation in the body and the limbs resulting from traffic accidents, domestic accidents, strokes, cerebral palsy, infections, etc.
- Spina bifida: congenital malformation affecting the spinal cord resulting in a lack of sensation and/or paraplegia.
- Cerebral palsy: often caused by an in utero problem, while giving birth (the umbilical cord around the neck), a premature birth or when the child does not start to breath immediately.
- Neuromuscular disease: a general weakness of the muscles due to a genetic disease.

People with a motor impairment may have difficulty moving around. They can use a walking stick, a walking frame, a prosthesis, a pushchair, a barrow or other means of locomotion requiring the assistance of a third person, a manual wheelchair which enables them to move around on their own or with the help of a third party, a bike, a tricycle or any other means of locomotion which can be operated with the arms.

Hearing impairment or deafness
A person can be affected by a hearing impairment or be deaf from birth, on account of a genetic, viral or parasitic disease or as a result of an accident. The degree of hearing varies from one person to the next.
Visual impairment or blindness
According to the classification of the World Health Organisation (WHO), visual impairment is based on a measure of visual acuity over distance and a measure of the visual field, which is to say the portion of space perceived when the eye is open and mobile. A person can be affected by a visual impairment or be blind from birth, on account of a genetic, viral or parasitic disease or as a result of an accident. States of partial sightedness are very diverse and give rise to a variety of consequences in daily life. People with a visual impairment all perceive the environment differently from one another. Depending on their visual capacities and adaptations (glasses, etc), people can to a greater or lesser extent perceive static or moving objects and their environment in the light of day, under high luminosity or with no luminosity.

Intellectual disabilities
A person can be affected by an intellectual disability from birth, due to a genetic or viral illness or as a result of a head injury. The person learns more slowly and experiences comprehension difficulties. Consequences of this impairment vary enormously from one person to the next depending on their social situation, their family and community and the special learning services available. For example, a person with an intellectual disability may be able to operate perfectly well in a particular environment but requires a lot of assistance in another context.

Mental disabilities
Mental disabilities are linked to chronic or severe mental disorders (schizophrenia, manic-depressive disorder, depression, etc.). These disorders generally appear in adolescence or at the beginning of adulthood. Post-traumatic stress disorder, which is also considered to be a serious mental disorder, appears after being confronted with a situation during which the physical and/or psychological integrity of the individual and/or of his/her entourage is threatened and/or actually compromised (serious accident, violent death, sexual violence, serious illness, war, violent attack, violent flooding, etc.). Individuals with mental disabilities frequently suffer from paranoia, depression, anxiety, panic attacks and/or attention deficit, difficulties developing and following a plan of action and alternating states of calm and tension. They are perturbed in their relationships with themselves, with others and sometimes with their environment: withdrawing into themselves, behavioural disorders, a lack of sense of time and space, self-harm, violence towards others, etc. They become perturbed during sporadic 'crises' of greater or lesser duration. When experiencing a crisis, people suffering from mental disabilities have difficulty distinguishing between right and wrong in their relationships with others and they can easily place themselves in danger.

Psychosocial disabilities
Psychosocial disabilities are related to psychological distress, whatever the cause (migration, exile, natural disaster, poverty, homelessness, breakdown of family and/or social relationships, unemployment). The disabilities resulting from these situations should be acknowledged as such, as they adversely affect the social life of those concerned (incapacities in terms of behavior, language or intellectual activities) who lose their social skills and their ability to take care of themselves (incapacities concerning protection and assistance). The disabling situations resulting from psychosocial disabilities related to the surrounding environment, can be experienced by both adults and children. However, special attention must be paid to children and adolescents in vulnerable situations due to their upbringing: Emotional deprivation, physical abuse, precarious social environment, etc. We know that mental disorders presenting in adults are often rooted in childhood problems which have not been addressed.
Disabling diseases
In most cases, these are chronic diseases which affect the integrity or functioning of one or several organs and can result in functional restrictions (reduction in mobility, in the capacity to be independent, etc.). Without appropriate treatment or care, the disease can result over the longer term in irreversible motor, sensorial or mental disabilities. Such diseases can include cancerous tumours, cardiovascular diseases (including severe hypertension), endocrine diseases (particularly diabetes), diseases of the digestive system (kidneys, liver, intestines), diseases of the respiratory system (including asthma) and infectious or parasitic diseases (including HIV, leprosy, tuberculosis, lymphatic filariasis, the Buruli ulcer).

Footnotes

   http://www.who.int/hac/events/drm_fact_sheet_mental_health.pdf

2. For further information on the background to, and strategic positioning of, Handicap International’s mental health and psychosocial support projects, please see the corresponding policy paper: Pégon Guillaume (2010). Mental health in post-crisis and development contexts. Lyon: Handicap International.

3. Director of the French National Mental Health and Vulnerability Observatory (ONSMP).

4. Lyon Declaration, October 2011: Congress of the Five Continents—When globalisation drives us mad—Towards an ecology of social bonds (Article 2.8).

   http://lesrapports.ladocumentationfrancaise.fr/BRP/094000556/0000.pdf


8. As part of the UN reforms to improve the effectiveness of its emergency response mechanisms, a cluster system was set up in 2005 to improve coordination in nine key areas: Nutrition, health, water, sanitation and hygiene, emergency shelter, camp management and coordination, protection, early recovery, logistics and telecommunications. The Inter-Agency Standing Committee (IASC) for humanitarian aid named different lead agencies in each of these areas. Their remit is to clarify the roles and responsibilities of the UN and its non-UN partners in order to respond to specific emergency situations and simplify communication with the host government.


16. Learning to live with others can be assessed through a series of indicators to be decided according to sociocultural contexts such as: good relationships with others, ability to respect others, getting the best out of others, curiosity, the ability to face the unknown, desire for interpersonal relationships, ability to give and to receive, ability to nurture and repair relationships, ability to confide and not turn inwards in times of difficulty.

17. Adapted extracts from the technical files created by Guillaume Pégon and Sheila Warembourg (Handicap International) and used in the training of the social researchers involved in the pilot project 'The vulnerability of disabled children to sexual violence', 2011.
Credits

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This guide sets out the general principles of intervention with methodological advice and practical files on mental health and psychosocial support in emergency and post-crisis situations (the files here may also be used in a development context). This document is for any Handicap International professional responsible for developing, implementing or analysing this type of intervention.