



Mental Health and Psychosocial Support Guideline

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Foreword

MSF first delivered mental health and psychosocial support (MHPSS) activities from 1989 in response to the Armenian earthquake of December 1988. Since then, the number of MHPSS activities delivered has increased, particularly over the last decade. Mental health (MH) is now an important part of programming in every region where MSF works. This evolution has come as a result of the recognition of the key role that MH plays in humanitarian interventions. This guide is a response to that change.

This guide is specifically aimed at MSF contexts. It contains practical recommendations specific to the assessment, planning, implementing and monitoring of MHPSS interventions. While this is not a clinical tool it does provide a clinical overview and it links to other resources for more in-depth treatment approaches. The content included is in accordance with MSF's Intersectional Mental Health Policy 2015¹, the inter-agency standing committee guideline (IASC)², the mhGAP Intervention Guide version 2.0³, the mhGAP Humanitarian Intervention guide⁴, and [other](#) international and World health Organisation (WHO) guides and tools.

This guide targets:

- MH activity managers (MHAM) and MH supervisors directly managing MHPSS activities.
- Project medical referent and medical coordinators responsible for MHPSS activities at project and mission level.
- Other non-MH team members involved in delivering and improving MHPSS responses.

The guide is divided into three sections:

- **Part A** describes the general concepts and principles of MHPSS interventions. It explains how to carry out a context assessment, design an operational strategy, put in place and monitor components necessary for all MHPSS activities.
- **Part B** elaborates specific context-related interventions and provides more explicit operational guidance for MHPSS activities relevant to those contexts.
- The **annexes** include or link many of the specific tools and interventions, both operational and clinical, that are required to deliver MHPSS activities.

The evidence base for mental health interventions continues to grow rapidly and cover a vast range of subject areas across many disciplines. There are notable gaps, for example in palliative care, where there is as yet insufficient MSF experience to provide a consistent framework. As such, the guide is not exhaustive and is expected to evolve. For any gaps identified, guidance can be sought from the MH advisors of each MSF operational centre.

The authors would be grateful for any comments to ensure that this manual continues to evolve and remains responsive to the reality of the field. Comments should be addressed to the MH advisor in your MSF operational section.

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Acronyms and abbreviations

AIDS	Acquired immune deficiency syndrome
ASD	Acute stress disorder
CHW	Community health worker
CO	Clinical officer
C-PTSD	Complex post-traumatic stress disorder
EPDS	Edinburgh postnatal depression screen
EMDR	Eye movement desensitization and reprocessing
FGD	Focus group discussion
GAD7	Generalized anxiety disorder 7
GHQ 28	General health questionnaire 28
GP	General practitioner
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HCW	Healthcare worker
HIV	Human immunodeficiency virus
HP	Health promotor
HR	Human resources
HSCL 25	Hopkins symptom check list 25
HTQ	Harvard trauma questionnaire
IASC	Inter-agency standing committee
IDPs	Internally displaced people
IES	Impact of event scale
(I)NGO	(International) non-governmental organization
IPD	In-patient department
JP	Job profile
ME	Monitoring and evaluation
MH	Mental health
MHAM	Mental health activity manager
MHC	Mental health certificate
MHPSS	Mental health and psychosocial support
MoH	Ministry of Health
MSF	Médecins sans Frontières
NCDs	Non-communicable diseases
NET	Narrative exposure therapy

OPD	Out-patient department
PE	Psychoeducation
PFA	Psychological first aid
PHQ9	Patient health questionnaire 9
PMR	Project medical referent
PSS	Psychosocial support
PTE	Potentially traumatic event
PTSD	Post-traumatic stress disorder
PSEC	Patient support, education and counselling
SGBV	Sexual and gender-based violence
SMART	Specific, measurable, achievable, relevant and time bound
SMDs	Severe mental disorders
SRH	Sexual and reproductive health
SRQ 20	Self-reporting questionnaire 20
STI	Sexually transmitted infection
SUD	Substance use disorder
SV	Sexual violence
TB	Tuberculosis
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

General introduction

Mental health and psychosocial needs in humanitarian settings

Mental disorders affect men and women of all ages worldwide and have a high impact on public health. Together with neurological and substance use disorders they account for 13% of the global burden of disease¹ and are the cause of 1 in 5 years lived with disability. The economic consequences of these health losses are equally far-reaching². Almost three quarters of the global burden of neuropsychiatric disorders is in countries with low and lower middle incomes³. People living with severe mental disorders are more likely to face other physical health problems (e.g. HIV, TB, non-communicable diseases) and have a reduction in life expectancy of 10-20 years³. Furthermore, suicide accounts for 800 000 deaths/year, and is a leading cause of death in young people⁴.

There is a clear gap in effective health care for people affected by mental disorders^a and psychosocial problems^b worldwide - and a global recognition of the need to improve the mental health (MH) of whole populations⁵. This gap in effective mental health care is wider in humanitarian settings. In 2019 WHO launched The WHO Special Initiative for Mental Health (2019-2023) as part of the Universal Health Coverage Initiative. The goal of the WHO Special Initiative for Mental Health's 5-year plan is to increase treatment coverage for mental health conditions and ensure access to mental health care for 100 million more people by 2023.

Between 76% and 85% of people with severe mental disorders (SMDs) in low- and middle-income countries receive no treatment for their disorder, while the gap is between 35% and 50% in high income countries². An additional difficulty is the poor quality of care for those who do receive treatment⁶. In order to address this gap and provide an effective response it is important to understand the contexts where increased MH needs exist and the factors that contribute to mental disorders and psychosocial problems.

MH estimations in conflict settings

Table 1 - Projections of mental disorders in adult populations affected by conflict (adapted from UNHCR and WHO^c)^{7,8}

	Before an emergency: 12-month prevalence	After an emergency: 12-month prevalence	Point prevalence in conflict settings (WHO 2019 data)
Severe disorders^d	2% - 3%	3% - 4%	5.1%
Mild or moderate mental disorders^e	10%	15% - 20%	17%
Normal distress/ other psychological reactions (no disorders)	No estimate	Large percentage	Large percentage

a In this guideline, the term 'mental disorders' refers to diagnosable mental health conditions as described in DSM and ICD.

b In this guideline, the term 'mental disorders' refers to diagnosable mental health conditions as described in DSM and ICD.

c UNHCR: United Nations High Commissioner for Refugees; WHO: World Health Organisation.

d For example, psychosis, severe depression, severely disabling form of anxiety disorder.

e For example, mild and moderate forms of depression and anxiety disorders, including mild and moderate PTSD.

Recent WHO estimates indicate a higher prevalence of SMDs in conflict settings than in earlier studies: point prevalence estimates are currently about 5.1% whereas previous 12-month prevalence estimates were 3–4%. For mild to moderate mental disorders the point prevalence is approximately 17% in the revised estimates compared with a 12-month prevalence of 15–20% in previous estimates.

The gap in mental health care in humanitarian settings

MSF frequently works in settings where provision of care for mental disorders and psychosocial problems is extremely low. This is especially the case during crises such as natural disasters and disease outbreaks, war and violence, migration, forced displacement and for people facing other forms of adversity such as forced detention, torture and sexual violence. Mental disorders and psychosocial problems are also common among people affected by communicable diseases, such as HIV^f, tuberculosis and hepatitis C, as well as non-communicable diseases including cancer and cardiovascular disease. People with SMDs are particularly likely to face a gap in treatment availability, and very often experience additional severe human rights violations, discrimination and stigma.

Risk factors contributing to mental disorders

The MH of each person is affected by a complex array of factors. These should be carefully considered when assessing and treating patients, as well as when designing and implementing programs. Risk factors for developing mental disorders can be considered as a result of multiple, inter-related aspects. These include:

- **Biological and genetic factors** – potentially including family history of MH disorders and suicide, the impact of physical ill-health such as stroke.
- **Life stages** - with particular risks during developmentally sensitive periods of infancy, childhood and adolescence, and increased vulnerability with advanced age.
- **Social determinants** – including the presence or absence of family, social and community support, the impact of poverty and employment, level of education attained, and access to effective healthcare. Exposure to violence, trauma and loss at individual and community levels are important additional social factors.

Principles of effective MH care

The principles of quality MH and psychosocial care remain the same no matter the context.

- Respecting human rights: people with mental disorders especially those with severe mental disorders and psychosocial disability, are at particular risk of human rights violations especially during humanitarian crises. Violations can include abuse, neglect, social exclusion and discrimination. Care delivered must ensure equal access, respect the dignity and autonomy of each person, and consider advocacy and empowerment for them with their family, community and other key stakeholders.
- Ensuring confidentiality and safety of the patient.
- Placing patients at the centre of their care and implementing strategies to promote recovery. Recovery means ‘gaining and retaining hope, understanding of one’s abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. It is important to remember that recovery is not synonymous with cure’⁹.
- Delivered by healthcare workers who have skills, training and supervision to effectively assess and treat patients.

^f HIV: human immunodeficiency virus

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Part A

General concepts and principles of MHPSS interventions

Chapter 1: MHPSS assessment

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1.1 Introduction

The aim of a mental health and psychosocial support (MHPSS) assessment is to determine the population's needs, resources available, gaps in care provision, socio-cultural context and coping mechanisms. This information is used to define an operational strategy to address any unmet needs. In addition to the MSF documents referenced below^{2,3,5}, the main document that should be consulted before carrying out an assessment is the WHO-UNHCR, *Assessing mental health and psychosocial needs and resources: toolkit for humanitarian settings, 2012*¹.

A formal structured assessment is required before starting any MHPSS activity. This chapter describes a structure and various data collection methods for initial and regular MHPSS assessments. It is the responsibility of the project and coordination teams to carry out regular assessments in order to adjust activities to the changing needs. Assessment reports should include formal recommendations for MHPSS activities.

During acute emergencies, a rapid assessment is done while MHPSS activities are being set up. This requires an organized approach and an assessment methodology that yields the most important information in a short period of time (this can be done in as little as 2-3 days).

Usually most of the information collected during an assessment comes from people or organisations in positions of power, it is therefore crucial to actively seek information from under-represented and less-powerful groups populations, e.g. minorities, people with severe mental disorders (SMDs) or disabilities.

1.2 Methodology²

MHPSS assessments should adopt multi-method approaches to collect data from various complementary sources. While it is impossible to cover all methods, triangulation (the use of multiple methods in combination) allows substantiation of the information obtained from different sources.

Data collection methods are often divided into ‘quantitative’ and ‘qualitative’ methods.

- Quantitative methods provide objective, measurable data about populations and groups, including information such as prevalence of mental disorders or numbers of people in important risk groups e.g. estimated number of unaccompanied minors, etc.
- Qualitative methods provide information about the subjective perceptions of individuals in a population e.g. ways of expressing distress, health seeking behaviours, coping mechanisms and other sources of relief. Qualitative methods give information about the range, depth and meaning of people’s experiences.

It is important to collect information from both qualitative and quantitative sources. Many approaches do not fit neatly into ‘quantitative/qualitative’ categories and some sources of information (e.g. reports), may include both types of information.

1.2.1 Desk review

The first step in an assessment is to carry out a desk review. Much of this can be done through internet research, headquarter resources and previous clinical data that may be available. Specific sources of information include:

- **Literature review:** review existing background literature (e.g. on history or anthropology) as well as previous assessment reports by other organizations. Also review MHPSS literature specific to the context/program e.g. refugees, children etc. as well as the national mental health (MH) policy, or MH action plan or any other related documents.
- **Healthcare data and mental health statistics:** health posts, clinics or hospitals are the easiest source of clinical data. Check data from MSF, ministry of health and other health facilities in the area e.g. number of patients with mental disorders in outpatient departments (OPD), number of patients with possible psychosomatic complaints in OPD. It may also be possible to obtain population statistics from central government, other project coordinators or local government (in particular the prevalence of SMDs and suicide). These data provide a quick overview of the documented medical and mental disorders in a population as well as any noticeable changes. Often however, this type of data is unavailable or is of limited/poor quality and therefore does not reflect the true needs. Look into the availability of psychotropic drugs in the country and in each health facility. Consult the relevant data in the WHO ATLAS^a.
- **Relevant reports:** previous MSF field reports, as well as reports from government and non-government agencies and international organizations, as well as sources in the country, are sometimes available depending on the context^b.

a The Mental Health Atlas series is a comprehensive resource on global information on mental health and an important tool for developing and planning mental health services within countries and regions.
https://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/

b Indicative internet resource sites: WHO MH atlas (prevalence of mental disorders per country, region etc.) and MHPS.NET

- **Dictionary of terms:** during the assessment, specific terms, definitions, expressions, symbols, explanatory mechanisms and rituals related to mental disorders and psychosocial problems can be described in a designated file. This process can be started during the desk review.

1.2.2 Data collection on location

In addition to continuing the desk review the following approaches should be considered on arrival at the location of the assessment.

- **Structured or checklist observation:** first-hand observation of the area of intervention to validate data collected from other sources. The goal of each visit and the information sought should be clearly defined before the visit. This assessment method may involve visiting health facilities, community organisations, other actors present, markets, food distribution sites, etc. All observations should be recorded.
While interviewing can provide information about what people think and say, observation will provide information about what people do. It also provides information on the context surrounding events and actions e.g. in a health structure observe the number of psychiatric drugs available in the pharmacy, number of people in waiting areas, number of beds.
- **Mapping:** the relationship between people and their environment is important to consider in assessments and interventions. There are different types of mapping:
 - Physical/geographical mapping: investigate available services and other actors.
 - Participatory mapping: can be used to discover how individuals perceive certain issues such as social dynamics. It is also helpful in the identification of social, spiritual and moral resources and resilience mechanisms. Potential beneficiaries are key sources of information about the way their community is structured such as social mapping and hierarchy mapping.
- **Focus group discussions (FGD)** is a qualitative technique to facilitate discussion about a pre-defined and limited topic among a selected group of participants. FGDs are a quick way to collect data from several people simultaneously. They help gain insight into people's perceptions, beliefs, attitudes, opinions, behaviour and experiences. This methodology is used in both rapid and more in-depth assessments. For more information, see the FGD guidelines³.
- **Key-informant interviews:** key informant interviews are another important source of qualitative information. Key informants are people considered likely to have knowledge of the identified topic. A key informant can be a community leader, government official, healthcare worker (HCW), teacher, social worker, village elder, religious leader, member of local or international non-governmental organization, member of informal groups and, in some cases, parent or a teenager (for questions addressing children's experiences and psychosocial well-being).

Main considerations:

- Key informants should represent the views, experiences and opinions of different groups in the community including ethnic/religious groups, women, men, and varying age groups - not their own views. Often those chosen as key informants are the more vocal, better off, better educated and more powerful members of the community, which can introduce a bias in the information collected.

- Time and effort should be spent in identifying key informants who are representative of vulnerable groups such as women, unaccompanied minors, older people, etc. Time permitting, an increased number of individual interviews can be conducted to give a wider range of opinions. There are different types of interviews¹.
 - **Structured interviews:** questionnaire with open and/or concealed/ “closed” questions and usually with coded responses.
 - **Semi-structured interviews:** framework of questions/themes to be explored with the interviewer adding or omitting questions according to need.
 - **Open-ended/undirected interviews:** one or two issues are covered in great detail; questions are based on what the interviewee says.
- Before any interview or focus group be aware of sensitive and/or taboo topics.
- **Workshop:** it is useful to organize a workshop with interested parties to discuss the assessment. During the workshop a facilitator (mental health activity manager or project medical advisor) should be present to provide assessment results, analyse the relationship between problems (the problem tree) and what needs to be done (the intervention). This is also a good opportunity to discuss how changes and results can be observed and measured as indicators of success.

Remarks

In some cases, specific instruments such as structured interviews and formal symptom checklists can be used for the large-scale appraisal of MHPSS needs in closed (camp) and open (community) settings.

Before considering carrying out any large-scale quantitative appraisals, it is important to recall that the prevalence of mental disorders in populations at baseline and in emergency and post-emergency settings has already been well researched. Instruments used for the surveys are not always locally validated. Population level MH surveys are rarely of practical value – and are challenging to conduct in a meaningful manner.

Specific quantitative population-level methods to assess MHPSS needs, such as questionnaires, symptom checklists or self-completion questionnaires require the guidance and involvement of an MSF epidemiologist and MH advisor and require the prior approval of the national and MSF ethical review boards, as well as local validation.

Use WHO data projections of the estimated prevalence of mental disorders to plan a response when other reliable data is not available. These figures are described in the general introduction.

1.3 Ethical considerations

Assessment in humanitarian contexts is a sensitive and delicate activity that requires careful planning (knowledge of other surveys in progress to not overwhelm the population, etc.) and ethical considerations during implementation.

- Population surveys and questionnaires are not recommended in the first weeks after an emergency³. Safety is always paramount for interviewees and interviewers.
- Information about the assessment, objectives, procedures and the time investment must be clear to all participants.
- The participants are always free to end their participation. Ending or refusing participation will have no consequences (they will continue receiving the same quality care as others, etc.).
- The possible use of data/findings and the possible consequences for the individual should be explained (verbal/written consent procedures).
- Information collected can be confidential depending on the source and how sensitive it is. Information provided by patients, e.g. vulnerable beneficiaries, should be recorded anonymously. Information about the context may be sensitive and must be recorded anonymously too.
- The potential benefits of the assessment for the community should be communicated (It is not always possible to assume benefit as it cannot be guaranteed MSF will implement an activity at the time of assessment).
- Train the translator in the assessment methods to be used and rehearse beforehand, if possible.

If working on the assessment with a translator (who is almost always someone from the affected community), be alert to their reactions and emotional well-being. In contexts such as post-disaster or displacement, hearing others' stories can awaken their feelings about the traumatic event. Make sure there is time for the assessment team to discuss and ventilate emotions at the end of each day (see [Section 2.9](#), Chapter 2).

1.4 Structuring and reporting an assessment

To decide on the need for an MHPSS activity and then plan the implementation, it is first necessary to gather information on the following points listed below⁴. Specific methods for collecting information are described above in [Section 1.2](#). This list can also be used as a template when writing the assessment report:

1. **General context:** briefly describe the emergency/context and how it affects the location and population(s). Identify actual and expected population movements, if anticipated.
2. **Description of the affected population^a:** estimated numbers, estimated distribution by gender and age, estimated number of orphans, unaccompanied minors, female head of households, older people, people with disability (split into psychosocial and physical) etc. Include information about: social stratification, family structure, marriage, child education, gender roles, status, religion, ethnicities, migrants/displaced populations, etc.
3. **MH needs:** identify and rank the leading causes of mortality and morbidity among the population specifically affecting the MH and psychosocial well-being of the population:
 - Prevalence of physical morbidities potentially linked with mental disorders and psychosocial problems (e.g. generalized body pain, gastro-intestinal complaints, sleeping problems, headaches, people with HIV^b, people with NCDs^c, sexual violence and torture survivors/victims, etc.) and changes in this prevalence since the crisis began.
 - Check the consumption of psychiatric drugs in health facilities e.g. prescription of the antidepressant amitriptyline may be high, but no patients diagnosed with depressive disorder. This can be seen for example in OPD data.
 - Mental disorder statistics and suicide rates.
 - Interviews with medical staff and key community members (community leaders, religious leaders, traditional birth attendants, traditional healers, etc.) that may highlight the burden of MH and psychosocial needs.
 - Breakdown and analysis of the category of 'other' in morbidity lists (medical data tool). Ask primary HCWs what is included in this category and identify any potential link with mental disorders and psychosocial problems.
4. **Events exposure:** briefly describe and rank the main traumatic events experienced by the affected population which may be causing or exacerbating mental disorders and psychosocial problems.
5. **Socio-cultural background:** identify main characteristics related to culture, religion, socio-political organisation of the affected country and communities and relevant differences with the host community.
6. **Traditional responses to mental disorders and psychosocial problems:** describe how people are dealing with the consequences of the crisis at individual, family and community levels. Describe local perceptions of distress and illness (including expectations/requests

a Particular focus is given to identifying the needs of vulnerable or marginalized groups. Vulnerability of groups is defined in terms of morbidity (presence of symptoms), mortality (suicide, etc.), exclusion from care, human rights abuses, denial of the beneficiary's dignity and specific conditions that increase vulnerability (psychiatric institutions, etc.).

b HIV: Human immunodeficiency virus

c NCDs: non communicable diseases

related to a potential future MHPSS activity) and positive/negative coping mechanisms e.g. How are people in the community affected by the situation? How do they express their emotional suffering? How do you know someone is sad or afraid? How do children express this? What do you do to feel better when you are sad or afraid? Identify community resources and how they are affected by the current situation. An in-depth assessment includes cultural information regarding habits, behaviour and practices, beliefs and values, spirituality, rituals (birth, death, etc.) and language (ways to express emotions, etc.).

7. **National and local MHPSS:** verify existing national MH policies and action plans (including MH-related laws), existing psychiatric hospitals or facilities (and the quality of care provided) and national MH clinical guidelines or other guidelines used in the country. Identify MH personnel (including paraprofessionals) and other related resources within the refugee/displaced/survivors and host communities (teachers, social workers, traditional healers, women's associations, community leaders, active local/international relief agencies, etc.). Map the response of other actors/agencies and highlight gaps and unmet needs. Inquire about psychotropic drugs and prescribing:
- What drugs are available on the Ministry of Health's list?
 - What drugs are available at mission and project level?
 - Are there complications related to drug importation?
 - Which health professionals are legally allowed to prescribe, or feel comfortable prescribing? What drugs can each category prescribe?
 - Are there medical doctors/nurses/clinical officers trained in mhGAP?

Inquire about the extent and availability of a workforce who are trained and able to provide talking therapies:

- Are there psychologists or counsellors in the country? Does psychology/counselling training include an adequate clinical component?
- Are there psychiatrists in the country?
- Does psychiatry training include an adequate psychotherapeutic/counselling component?
- Are psychologists/counsellors salaried in the Ministry of Health workforce?
- Are there any regulations around who can provide individual counselling or psychological consultations?

1.5 Criteria for MHPSS activities

Before recommending an activity, it is important to take into consideration where and how an activity will fit in with the general humanitarian response, its coordination with the Ministry of Health and other actors, and how it will fit in and relate to the broader MSF activity. It is likewise important to consider the criteria for adjusting or ending any proposed MHPSS activity.

Criteria for starting an MHPSS activity

Request for an initial MHPSS assessment is likely to have arisen as a result of gaps suspected or identified at mission and HQ level. Based on the assessment, an intervention could be proposed for a variety of reasons including:

- Contexts where the affected population is likely to experience distress after direct or indirect exposure to a potentially traumatic event (PTE).
- Unmet MHPSS needs in the target population, including psychiatric needs, due to gaps in the provision of care provided by local, national or international organisations.
- Pre-existing MSF activities with needs and gaps in MHPSS (see [Part B](#)).

As with any other assistance programme, acceptance and engagement with the community are key before implementing MHPSS activities.

Criteria for adjusting or ending an MHPSS activity

Reassessment of the target population's needs is an on-going process and should follow the assessment framework laid out in [Section 1.4](#). Aim to continuously adapt the implemented activities to meet these needs. Criteria for ending or readjusting activities may include:

- Needs are observed to be covered by the Ministry of Health or other non-governmental organizations. MSF ceases to intervene when other agencies have enough resources to adequately respond to the needs of the affected population.
- Needs have significantly decreased or changed, as observed by the number and type of cases reaching the MHPSS activity facilities.
- Handover to other actors (MSF considers that other organizations can take over the activities).
- Lack of access to the target population because of unmanageable changes in the context, security situation or organizational set up.
- Change in operational priorities, as determined by the coordination team and headquarter.

1.6 Recommendations

The assessment report should include the sub-headings listed in [Section 1.4](#) followed by consideration of the criteria for the activity. This should be followed by formal recommendations for development of an activity that responds to the identified gaps and needs of the affected community and specific vulnerable groups.

For detailed information on pertinent activities and specific interventions that could be suggested in the recommendations, see [Chapter 2](#) as well as the specific chapter(s) that may be relevant to the population or context (e.g. disaster, disease outbreak, sexual violence, nutrition).

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2.1 Introduction

During emergencies the prevalence of mental disorders roughly doubles¹, usually resulting in a worsening gap in the provision of appropriate care. If the population's mental health and psychosocial support (MHPSS) needs are not being met, appropriate interventions should be initiated as soon as possible. A rapid supportive multi-layered response, addressing the needs of different groups, helps people deal with acute stress, detects and treats people needing specific mental health (MH) care, and prevents the appearance of long-term psychological problems.

MHPSS activities are implemented according to priority needs, available resources and identified gaps in care. Activities are described as either:

- Horizontal when integrated into a broader medical activity.
- Vertical when delivered as a stand-alone MHPSS activity or project.

MHPSS activities can also be conceptualized on a continuum from minimum up to comprehensive packages.

It is important to consider existing care, local resources, local regulations (i.e. who can prescribe, mental health act laws) and culturally appropriate ways of dealing with emotional distress before implementing MHPSS activities. When considering establishing an MHPSS response it is crucial to consider other MSF activities or those of other actors, whether planned or already implemented, in order to seek potential opportunities to integrate MHPSS into them.

MHPSS activities specific to various contexts and situations, e.g. disasters, protracted crises, excluded/marginalized populations, medical programs and psychiatry are elaborated in the corresponding chapters (see [Part B](#)).

2.2 Intervention pyramid and MHPSS activities

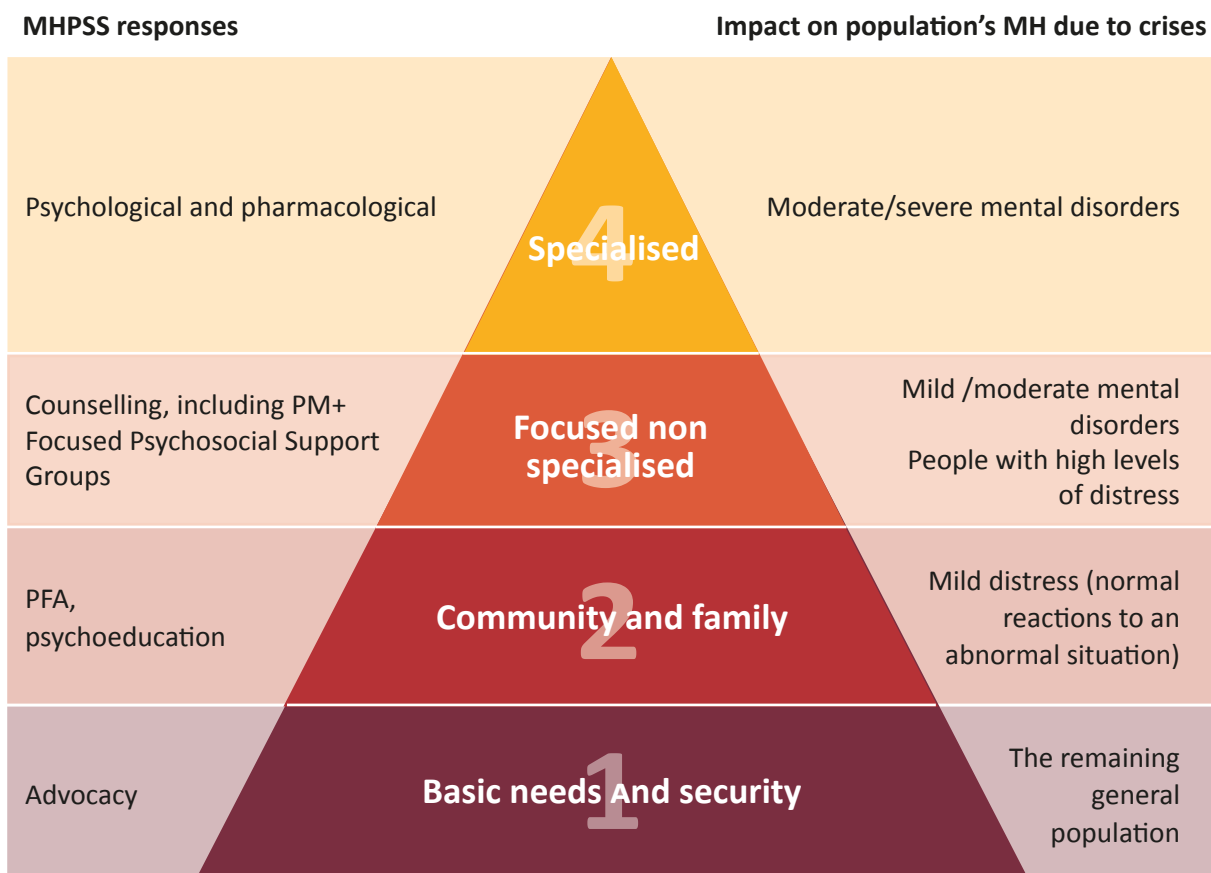
The MHPSS intervention pyramid was first described in the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings published in 2007². It is a conceptual and organising framework used by all actors implementing MHPSS activities in humanitarian settings.

Why is the MHPSS intervention pyramid so important?

In emergencies, people can be affected in different ways, have different coping mechanisms and require different kinds of support. The layers of the pyramid represent the MHPSS interventions for different individuals and groups– ranging from basic shelter and security required by everyone in the community at the bottom of the pyramid, moving up to specialised mental health care required by a much smaller group of people at the top of the pyramid

This tool is used to prioritise needs and organise the roll out of MHPSS activities. See [Figure 2.1](#).

Figure 2.1 - Intervention pyramid for mental health and psychosocial support in emergencies² (adapted).



It is essential that project managers, team leaders and coordination managers understand the different layers of support represented in the intervention pyramid. It is used to describe which MHPSS needs are already covered and which remain to be met and thus communicate and

coordinate an adapted response with other actors. The intervention pyramid is a universally used framework that is a useful tool to explain MHPSS activities operationally because it is easily understood and explained.

One of the main difficulties when using the pyramid is that, although the framework is used by all humanitarian organisations, there is no agreement between actors yet on exactly which activities are provided in which layer. It is therefore important to clarify the layer and type of activity that is being referred to.

What do the layers of the pyramid represent?

The varying support layers depicted in [Figure 2.1](#) are designed to meet the needs of different groups of affected people: basic services and security should be provided to all people in a manner that is safe and protects their dignity; community and family supports are designed for communities and families to maintain their psychosocial well-being; focused, non-specialised supports are necessary for those who may require more focused individual, family or group MHPSS interventions by trained and supervised MH workers; and finally specialised support for those who are suffering more severe symptoms and have impaired daily functioning.

The decision to implement one or more activities depends on the context, needs and resources of the target population (for more information see [Section 1.5](#), Chapter 1). Activities can be run by staff with different professional and educational backgrounds, ranging from community health workers (CHWs) to lay counsellors and clinical officers to doctors, nurses, psychologists and psychiatrists.

All the layers of support represented in the pyramid are important and should ideally be set up concurrently whether by MSF or other actors. Activities and their specific implementation require some degree of flexibility.

MSF classifies MHPSS activities in the pyramid as follows:

✓ LAYER 1. Basic services and security

During an MHPSS assessment and/or ongoing activities, security concerns or a lack of basic services such as shelter, and food may be identified. If MSF is not involved in providing these services, it can contact the actors covering these activities and advocate for a response. MSF teams, including MH team members, can document the negative impact of failures in basic services and security on the MH of the population.

✓ LAYER 2. Community and family psychosocial support

The second layer represents the psychosocial responses required for a smaller number of people who can maintain their mental health and psychosocial well-being if they receive help in accessing key community and family supports.

The objectives of these activities are to help people reduce their suffering, maintain their well-being and reduce the risk of developing a mental disorder. These activities mainly involve the identification and strengthening of individual/family/community positive coping skills (spending time with other supportive people, establishing a routine, community memorials or rituals, social activities as sports or gardening).

Interventions at this level of the pyramid are often implemented by CHWs, community MH workers, counsellors and lay counsellors, though they can also be implemented by more specialised MH professionals when needed. Typical interventions in this layer include:

– **Psychological first aid (PFA)**

PFA is an intervention involving calming and reassuring the individual, particularly following a traumatic event but also after any stress (natural or man-made disaster, sexual violence, illness etc.), and linking them to needed services. It is an intervention that all members of the medical and MH team should be trained to deliver. PFA typically involves normalizing a reaction to an abnormal event. It takes place in the community as well as in health facilities and is particularly relevant in the aftermath of a disaster³.

– **Psychoeducation (PE)**

The objective of psychoeducation is to explain psychological reactions to a humanitarian disaster specific to the context and promote healthy coping mechanisms. PE is an intervention that can be delivered to large numbers of people through targeted group sessions led by counsellors and CHWs. It involves raising awareness of culturally appropriate coping mechanisms and providing information on how and where to obtain further help including from an MH program (if available) or any other community resource. It can be done at all levels, beginning with community settings and extending to out-patient waiting areas and in-patient wards. Visual materials such as posters or brochures with pictures of culturally appropriate figures experiencing MH symptoms are particularly helpful as a complementary tool when delivering PE messages (see [Appendix 4.1](#), [Appendix 4.2](#), [Appendix 4.3](#) and [Appendix 4.4](#)).

– **Psychosocial stimulation**

Psychosocial stimulation is part of the rehabilitation of the malnourished child. The objective is to promote the caregiver-child relationship and facilitate the child's development. Often nutrition assistants in inpatient therapeutic feeding centres ensure provision of daily psychosocial stimulation. Psychosocial stimulation is also relevant for people experiencing chronic illness and long hospitalizations, such as patients recovering from traumatic injuries or illnesses such as tuberculosis and visceral leishmaniasis. For more information see [Chapter 13](#) and [Chapter 14](#).

– **Child friendly spaces**

The objective of activities in a child friendly space is to provide a safe space for children and stimulating activities that are fun and culturally appropriate. For example, some children might enjoy a space to play football; other children might like art activities. These activities restore a semblance of normal life and a sense of safety for the children. Play supports and promotes developmental skills in children.

– **Recreational activities**

Depending on the context, structured and organised recreational interventions can be developed and delivered for adults. Examples of this can include knitting, coffee ceremony, card playing, sports, etc., which can take place among women's groups and youth clubs. People in detention centres, or patients admitted to hospital for long periods of time also benefit significantly from stimulating recreational activities that engage them cognitively and physically.

– **Other psychosocial support activities**

These can be implemented directly with individuals, in groups or collectively. Community support activities can include collective memorial ceremonies, (such as lighting of candles) or collective community actions such as clean-up activities. Group psychosocial support activities may include group discussions of people with a common concern, e.g. a group of women whose husbands have disappeared. This offers a communal experience with an emphasis on reactivating community coping mechanisms and traditional practices.

Individual psychosocial support activities may include peer support activities. Individuals with lived experience of a mental disorder or injury provide support by sharing their experience and demonstrating their recovery to others. Peers can be identified, trained and supervised to provide specific limited psychoeducation and psychosocial support related to the event or disorder which makes them a peer. They have the additional benefit of credibility since the support comes from someone with first-hand experience of the stressor, disorder, injury or disability. Usually peer support activities are included in layer 2. However, when peers provide counselling this activity will be considered in layer 3, in which case they will be hired as lay counsellors and require ongoing supervision.

✓ LAYER 3. Focused non-specialised supports

The third layer represents the necessary supports for people who have high levels of distress or mild or moderate mental disorders that require more focused individual, family or group interventions by trained and supervised workers. Activities at this level of the intervention pyramid are provided in health facilities or at community level. Counsellors, lay counsellors, psychologists, social workers, clinical officers, nutrition assistants, nurses and other health staff participate in various activities according to their job descriptions and training. All staff should be able to provide layer 2 support such as PFA, and certain staff should be able to provide specific forms of psychoeducation. At level 3, basic non-specialised skills, such as active listening can be strengthened, and new skills such as structured problem solving can be introduced. Activities include:

– Individual therapeutic counselling

Individual therapeutic counselling is a core MH activity with the objective of decreasing an individual's MH symptoms and increasing their functionality. Individual counseling is an MH activity in which individuals can explore their feelings, beliefs, behaviors and memories in a safe, caring and confidential environment. Counseling focuses on identifying and supporting the person's positive coping skills. Depending on the person's availability for sessions, and the presence of lay counsellors or trained psychologists, counselling includes different types of interventions including for example:

- Multi-session supportive counselling⁴, for example the WHO "Problem Management Plus" (PM+) intervention: this is a low intensity psychological intervention for adults impaired by distress in communities who are exposed to adversity, it is implemented by counsellors and lay counsellors over 7 sessions⁵.
- Structured problem solving: clinicians, including doctors and nurses, can be trained in basic problem-solving skills which they can integrate into their routine clinical care.
- Single session low intensity counselling intervention⁶. This activity requires training and continued structured supervision of the counsellors by specialised MH clinicians (e.g. psychologist, psychiatrist, clinical social worker, psychiatric nurse).

– Group therapeutic counselling

Group therapeutic counselling may be useful when several people or a community share the same experience (for example loss or stress after a natural disaster, during or after experiencing armed conflict, etc.). The goal may be to create a sense of belonging thus improving a person's ability to share and cope with their experience(s). Therapeutic groups are closed groups, with the same participants for each session, have a fixed number of sessions with an agenda and clear objectives^a.

This activity requires trained staff and continued structured supervision by a specialised MH clinician (e.g. psychologist, psychiatrist, clinical social worker, psychiatric nurse).

a In contrast, group discussions are open groups with varying participants and changing objectives.

– **Focused psychosocial support activities**

These interventions target people with psychological distress, as opposed to people identified with specific mental disorders. They are useful to decrease distress and promote coping.

An example of this are focused psychosocial support group interventions. They have generally been developed pragmatically to meet conditions in humanitarian settings i.e., settings with overwhelming needs and few resources, e.g. structured parenting skills group interventions, structured interventions on coping with anger/stress, etc.

Psychosocial stimulation can also be in layer 3. For example, a structured intervention of 5-6 sessions performed by trained and supervised staff. Note that exceptionally some psychosocial support activities described in layer 2 can also be in layer 3. This will depend on the level of staff skill, only staff with more advanced training and ongoing supervision can deliver psychosocial support activities included in layer 3. If we are referring to psychosocial support provided by any health care professional trained in MHPSS generalities it will be considered layer 3 support. However, if nurses or general practitioners are trained in psychosocial support for sexual violence survivors and receive ongoing supervision it will be in the upper level (layer 4).

✓ **LAYER 4. Specialised support**

“The top layer of the pyramid represents the additional support required for the small percentage of the population whose mental suffering, despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning”². This care can be provided by different staff (including psychiatrists, mhGAP trained general practitioners, psychiatric nurses, clinical psychologists, and professional counsellors) that offer treatment for moderate to severe mental disorders with professional counselling, psychological care and when needed psychotropic medication. Activities at this level of the intervention pyramid take place in health facilities or at community level.

– **Care of patients with severe mental disorders (SMDs), including with psychotropic medications**

Patients with SMDs and psychosocial disabilities require a multidisciplinary approach including pharmacological and psychosocial interventions such as psychological care, social support and community integration. All this together is sometimes called «psychiatric care». Pharmacological treatment can be prescribed by either a psychiatrist or other prescribing clinician (doctor, clinical officer, medical assistant or nurse, depending on the country. For its implementation it is essential:

- All prescribing clinicians be trained according to the mhGAP intervention guide.
- Appropriate psychotropic medications are included in the project’s international medical order so that they are readily available when needed, see [Chapter 15](#).
- Ongoing regular supervision by a psychiatrist (on site or remote) is ensured.



Pharmacological treatment is never a stand-alone intervention.

– **Psychological care, psychotherapy and professional counselling activities**

The objective of this group of activities is to provide professional talking therapy interventions for patients with moderate to severe mental disorders. Terminology differs due to the different educational backgrounds of the professionals implementing the activity. These activities can only be implemented if trained and certified professionals are available and when supervisors are present in the project to provide formal supervision. The MH advisor must be contacted before implementing any of these interventions.

The term 'psychotherapy' covers a range of approaches and methods. They all involve a psychological (as distinct from medical, social or pharmacological) treatment for a range of psychological, emotional and relationship difficulties and disorders⁷, e.g. supportive psychotherapy, WHO Group IPT (Interpersonal Therapy) for depression^b. In MSF, specific interventions such as Eye Movement Desensitization and Reprocessing (EMDR) and narrative exposure therapy (NET) (outlined in Appendix 6) can be considered only if trained and certified professionals as well as supervisors, are available in the project. The MH advisor must be contacted before implementing psychotherapy activities.

Professional counselling, as distinct from psychological care, is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals. Counsellors work with patients on strategies to overcome obstacles and personal challenges that they are facing.⁸

Sometimes the MHPSS intervention pyramid is correlated with mental disorder prevalence (e.g. linking SMD prevalence with layer 4 of the pyramid). This is not ideal as they do not correspond exactly. We have adapted the IFRC's^c MHPSS pyramid to be able to see the link and describe MSF's approach.

b WHO Group IPT for depression and PM+ have been developed as low intensity psychological interventions. According to the authors they can be implemented by supervised non specialists. In this sense both could be in layer 3. However, in MSF we consider that a group psychotherapeutic intervention for people with moderate/severe depression is already quite specialized and more complex intervention than PM+. This is why we consider it as a specialized support and place it in layer 4. Sometimes PM+ may be delivered by trained psychologists and in MSF we would consider it as layer 4 in this case.

c IFRC: International federation of the Red Cross

2.3 MHPSS intervention packages

Once the decision has been taken to implement an MHPSS intervention, the project team should consider a package of care ranging from minimum to comprehensive. Sometimes a minimum package can be implemented at the start of a project, then a more comprehensive range of activities implemented after a few months.

2.3.1 MHPSS minimum package

A MHPSS minimum package is suited to a context where, for example, each layer of MHPSS support is being met by other actors. It can be care can be implemented without the ongoing presence of an MH activity manager (MHAM), however it is strongly recommended to have a qualified supervisor available at least for the first 3 months to ensure initial training and supervision. If not available, a qualified supervisor, activity manager or equivalent position should then be appointed. The following services are included:

- **PFA** (see [Section 2.2](#)).
- **MHPSS awareness raising activities**, also called **psychoeducation**. Psychoeducation topics can include:
 - Information about common reactions to traumatic events.
 - Positive coping mechanisms tailored to specific contexts and cultures.
- **Psychosocial support (PSS) integrated into other medical activities**: PSS should be set up if the project has a medical activity where the condition impacts the psychosocial well-being of a specific group e.g. SRH, SV, nutrition, HIV, TB, etc. These PSS activities can be carried out by a nutrition assistant, health educator, lay counsellor or nurse. In some situations, these activities may be provided by another organisation, in which case a referral pathway should be established (see below). In humanitarian disasters and outbreaks these activities are considered part of the comprehensive package because they are a priority activity.
- **Care of people with SMDs**: if the project has an activity delivering any form of medical care then the activity should ensure the clinicians can identify and treat SMD. Support for clinically challenging cases can additionally be provided through the telemedicine platform when required. In some situations, this activity may be provided by another organisation, in which case a referral pathway should be established (see below).
- **Referral pathways to other care providers** should be established once the quality and capacity of their services has been assessed by clinicians.
- **Advocacy** for basic services that are safe, culturally appropriate and protect dignity.

All clinical staff in these activities should receive training by the MHAM, supervisor or other qualified professional in:

- PFA⁹
- Identification of psychological distress and mental disorders
- Communication skills integrated into patient consultations

2.3.2 MHPSS comprehensive package

The comprehensive package includes a broader array of activities from community/family support to specialized care which targets both individuals and communities. These activities are carried out by MH professionals (counsellors, psychologists, psychiatrists, general practitioners trained in mhGAP, psychiatric nurses) and/or staff identified and trained locally (lay counsellors, peer educators, community MH workers, etc.).

The comprehensive package requires the presence of an MHAM and/or MH supervisor to provide training and on-going clinical supervision to ensure the quality of the following list of activities, which co-exist in addition to those of the minimum package:

- **Individual, family and group counselling or psychological care activities.** Counselling and psychotherapy require clinicians who have completed formal training (e.g. clinical counselling or clinical psychology degrees), or previously untrained staff who are intensively trained and supervised in counselling activities by the MHAM or MH supervisor. The intensity of the training and supervision will depend on the pre-existing skills of the clinicians recruited for the position. Regular structured supervision of the clinicians by qualified professionals must be scheduled.
- **Care of patients with SMDs** using psychotropic medications and basic PSS delivered by a psychiatrist or general practitioners/clinical officers trained according to mhGAP Intervention Guide⁷. Depending on the size of the activity, supervision and training can be provided by a psychiatrist working with the team, or for very small-scale activities it can be done remotely such as through the telemedicine platform.

2.4 MHPSS activities and interventions for children

Proactively seek to identify psychosocial stress and mental disorders in children, rather than reactively waiting for parents or others to identify suffering. Always consider the child as part of their family system. Involving parents and trustworthy caregivers is essential in the recovery process. Introduce techniques for interacting in a manner that allows children to express themselves comfortably and in a way that is consistent with their developmental stage (play, drawing, etc.).

It is especially important that parents/caregivers have a clear understanding of the child's presenting problem and how to intervene in the home setting with this problem. Parents/caregivers may require intervention for their own problems, both mental and medical, before they can focus on their child's needs and problems.

MHPSS activities for children include:

- **Psychoeducation:** help children understand their reactions to a traumatic event and how to calm themselves. Parents also should be informed about usual/expected reactions in their children and how to help them. See psychoeducation briefing paper for children in [Appendix 2](#).
- **Other psychosocial group activities:** recreational, cultural, sports and other child-specific activities. Play is vital to the healthy development of children. It is their way of coping with what has happened, of relaxing and relieving tensions and assimilating what they have experienced. These activities aim to improve the physical, mental and social well-being of children and promote resilience and self-help by allowing them to ventilate their traumatic experiences and engage in social activities. They help children learn how to function within the family and the community. Organize child friendly spaces or collaborate with other agencies that have already developed these spaces.
- **Support of caregivers:** support parents and trustworthy adults/caregivers by enabling them to support their children (and unaccompanied minors) and/or identify other children/minors in need of MHPSS inside the family.
- **Peer support groups** offer opportunity to talk about problems and ways of addressing them. It is important a child understand they are not alone and that they are not responsible for what has happened.
- **Individual/family counselling:** individual counselling can provide a safe environment for a child to communicate their feelings.
- Encouraging **school activities and training for teachers** (identification of children in need of MHPSS – as their clinical expression is different from adults, etc.).
- **Referring children** to agencies that can reunite them with their families and or ensure protection as quickly as possible.

Psychotropic medication for children

In MSF activities, psychotropic prescription for children should be considered as an exception¹⁰. There are very few occasions when psychotropic medication is necessary for treatment of children in MSF projects.



It is mandatory to contact a psychiatrist before prescribing psychotropic medication for children/adolescents under 15 years of age. If there is no psychiatrist at field level, the MHAM or the project medical advisor should consult a psychiatrist via the telemedicine platform. If there are frequent cases of psychiatric disorders identified in children, the mission should consider requesting a field visit by a specialised psychiatrist to provide training and supervision of the clinical team.

2.5 Activity planning

Activity planning takes place in every field project following assessment and prior to start-up. Each participating specialty (MHPSS, water and sanitation, medical, etc.) develops objectives and activities in accordance with the overall strategy of the project. The log frame gives the overview of the project's objectives, expected results, activities, and indicators. It is a helpful tool in clarifying what an MHPSS activity needs to do and accomplish. Usually it is an appendix of the mission/project annual plan.

The development of an MHPSS activity proposal takes the assessment findings (see [Chapter 1](#)) and translates them into action. Some key elements within an MHPSS activity proposal include chronologically:

- Background information on the context, population and specific target population
- Objectives of the intervention
- Activities (with chronogram)
- Monitoring methods, including indicators
- Human resources, trainings and materials needed (e.g. medications and other materials such as toys, pencils, paper)

When making the proposal, always think about integration within other MSF activities and engagement and integration with other actors that may be present (e.g. Ministry of Health, other agencies). It is important to think about an exit strategy even during the assessment.

Apart from this guide, there are various documents that should be consulted when considering the project's MHPSS strategy and where it fits with respect to the context. The operational centre's strategic plan and priorities should be considered first. The WHO mhGAP Operations Manual¹¹ is an additional document that can be helpful. This manual is designed to provide practical, step-by-step guidance for district health managers and others responsible for integrating mental and physical health services.

Each year there is a revision of the project's annual plan, this is an opportunity to analyse the indicators and propose changes accordingly.

2.6 Human resources

The number and type of MHPSS profiles recruited depend on the extent, length (time and space), type of intervention and available resources. Always consider gender equity and balance within the team and ensure appropriate representation of key cultural and ethnic groups.

For implementing a comprehensive MHPSS package there is a need of minimum one MHAM per project. However, where there may be a lack of resources and or competing priorities, a MHAM could be shared between two projects in the same country. For some specific profiles such as psychiatrist, consider the possibility of an intersectional position (e.g. country flying psychiatrist). In missions and countries with an important volume of MHPSS activity, and or where there is a need for highly specialised care, a MHPSS specialised coordination position (i.e. Deputy Medical Coordinator, Mental Health Coordinator or Medical Coordinator with MH profile) should be considered.

Standardized MHPSS job descriptions (JD) are described in the MSF International Field Reference Function Grid (IRFFG) and can be found on the intersectional MSF IRFFG website¹². With human resources (HR) and advisor validation, the JD can be adapted to the project and context. Ds should be adapted by adding roles and responsibilities to the 'Section/Context Specific Accountabilities' section of the JD, rather than adding them to the 'Accountabilities' section.

MHPSS staff should be aware of the core competencies required for their positions – as detailed in their job description. It is important the responsibilities assigned to each member correspond to their job description.

To ensure quality interventions, team management includes appropriate training for staff and the type of intervention. The implementation of comprehensive package activities requires clinical supervision. See [Chapter 4](#) for details concerning mandatory routine scheduled training and clinical supervision by a qualified professional.

2.6.1 Staff ratios

Each counsellor or psychologist can provide an average of five to six counselling sessions or consultations/day^a. Psychiatrists and mhGAP trained clinicians can provide an average of eight to 12 consultations/day depending on the severity and complexity of the cases.

Determining the estimated number of counsellors needed for a target population is based on^b:

- Estimated total number of people requiring MHPSS services: this is up to 24% of the target population (according to WHO projections of mental disorders in adult populations affected by emergencies⁶ and IASC intervention pyramid).
 - Most people will improve with simple low-intensity interventions such as PFA, psychoeducation and basic psychosocial support activities. Depending on the context, some of these activities will often be partly provided by other organisations.
 - People with SMDs require more intensive intervention. Estimates for numbers of people who require management of SMDs is approximately 2%, increasing up to 5% in emergency situations. This layer of care is very frequently not provided by other actors.

a Considering workload includes other psychosocial activities, supervision, training, annual/sick leave, etc.

b Example needs to be adjusted to each context. Estimation is tailored to program activities.

- Number of working days per week or month (5-6 working days/week).
- Estimated number of follow up sessions for each patient: on average, in acute settings, this could be 3 to 6 though it depends on the patients' conditions and contexts. People experiencing chronic or severe trauma, torture, or chronic psychiatric conditions such as schizophrenia, require longer term care, and estimating staff needs may require advice from the MH advisor.
- The project scope, size, budget and available HR resources need to also be considered.

Social workers and CHWs will have different variables to estimate their HR needs, based on the tasks assigned. They are recruited based on the project's activities and target population.

2.6.2 Code of professional conduct

All MHPSS staff must adhere to the highest standards of professional behaviour and in accordance with MSF guidelines and policies. They should be briefed on MSF's charter and principles, including the code of professional conduct of MH professionals^{13,c}.

The code of professional conduct addresses issues related to the work's specific nature and the unique relationship with patients. MH professionals must respect interpersonal boundaries with beneficiaries both in the immediate present and following the termination of the intervention (confidentiality^d, refraining from intimate relationships, etc.).

The document should be translated into the local language. Members of the MHPSS team should discuss it to guarantee common understanding and acceptance of all principles. It is meant as a supplement and not a replacement of other MSF codes of ethical and responsible behaviour, such as the Research Ethics Framework Guidance document, November 2013¹⁴.

For further recommendations, contact the MH advisor of the implementing operational centre.

2.6.3 Psychosocial care for MHPSS staff

Burn-out and vicarious trauma in MSF staff are serious conditions common in missions. Burn-out results when stress becomes overwhelming. Symptoms develop gradually and can include fatigue, decreased quantity and quality of work, difficult interpersonal relationships and gradual progression to encompass symptoms of exhaustion, depression and anger.

It is the responsibility of each team member to follow good self-care practices. A personal toolbox of stress reducing activities might include meditation, spiritual rituals, exercise, watching movies, reading, listening to music, events/activities with individual's social/support network, family etc.

When training lay people, always include the importance of self-care in their training, including basic self-care activities such as relaxation techniques. A positive team dynamic can mitigate serious consequences of stress, see [Chapter 4](#). Regular MHPSS clinical meetings and/or clinical supervision that facilitates experience sharing and concerns within the team, helps to prevent harmful consequences for the staff^e. Pay particular attention if local staff are part of the affected population.

c The code of professional conduct for MH professionals is not an internationally validated document within MSF. It is implemented per MSF operational centre.

d MHAMs and supervisors enforce the respect of confidentiality within the MHPSS team. The MHPSS team can share confidential information with other MSF HCWs when necessary to deliver appropriate care.

e Staff include interpreters, translators, cultural mediators, etc.

The MHAM and MH supervisor should be alert to distress reactions and overwhelming feelings within the MHPSS team. Concerns for individual staff members should be discussed with the medical coordinator, project medical advisor or field coordinator.

The care of beneficiaries and the care of MSF staff are two distinct interventions for professional and ethical reasons. The MHPSS team is not responsible for the psychosocial care of MSF staff. Providing therapeutic services to work colleagues can affect job roles, quality of work, team dynamics and interfere with the confidentiality of the affected colleague.

Each operational centre has a psychosocial care unit or advisor to provide support to staff in need. Some projects have an approved referral source for local staff requiring an intervention in their own language.

Sometimes, exceptions can be made for provision of MH care of staff. In these situations, please consult with the medical coordinator and the operational centre's psychosocial care unit.

2.7 Activity monitoring

Monitoring is a continuous and systematic process of collecting, measuring, analysing and communicating information throughout the project.

Monitoring and evaluation (ME) assesses whether a project or activity is achieving its desired results. ME uses information to demonstrate positive, negative, direct/indirect changes that have occurred and targets that have been reached or not. ME also provides lessons for consideration in future work and is necessary for contextualisation, adapting programs and accountability¹⁵. Monitoring aims to:

- Describe and analyse the intervention and activities of a program;
- Support the program and adjust its focus or end the activity based on findings, if necessary;
- Assess the overall impact of the program;
- Ensure the quality of the intervention.

MHPSS activities have a data collection system to facilitate activity monitoring, including:

- Patient files (first and follow-up visits).
- Health information systems or database^a.
- MH monthly reports integrated in the project situational report or in the monthly medical report.

In designing an MHPSS activity, clear and objectively verifiable indicators need to be defined. Indicators are selected using the “SMART” criteria: specific, measurable, achievable, relevant and time bound. Indicators are defined by the intervention area and time frame. They are adapted to activities.

MH indicators^b

All MSF operational centres reached consensus in 2018 on the indicators which must be reported monthly. See the table in [Appendix 18](#) with indicator definitions.

^a Data collection systems are currently different for each operational centre.

^b Developed by MSF MH working group. (Version 5.0 April 2018).

2.8 Advocacy and communication

Advocacy is an important aspect of all MSF activities. Bearing witness and speaking out is one of the key founding principles of MSF. MH teams are often thought to hear what is ‘really happening’ for beneficiaries. Humanitarian affairs and communication officers frequently approach counsellors and MHAMs in field projects to obtain information for advocacy efforts. They may request data and access to MH records, and identification by counsellors of patients who can offer “stories”. It is important to collaborate with humanitarian affairs and communications officers while not compromising core principles of MH work, particularly confidentiality. The guidelines “Advocacy action and MSF psychosocial and mental health programs (2012)” and “Code of professional conduct of mental health professionals (2016)” offer direction on what and how to share information. It is important to have read and be familiar with these guidelines.

Key points included in these guidelines are:

- A reminder to adhere to medical ethics (respect for autonomy, beneficence, non-maleficence, and justice) including in advocacy and communication situations.
- MHPSS teams should always discuss issues related to advocacy with their supervisor. All requests from advocacy managers/communication officers and other media demands need to be discussed with the project medical advisor/medical coordinator and field coordinator/head of mission.
- If the patient agrees to give information for advocacy/communication purposes, then obtaining their informed consent is mandatory. Consent should be obtained ideally away from anyone or any place associated with the delivery of MH care (and this includes avoiding requesting consent in the waiting area or the consultation room). The MH professional must ask the patient’s consent to be contacted by the communication/advocacy colleague, who will then themselves seek consent for the communication. Sometimes however, the MH professional is the person best placed to assess consent. Be aware of the power imbalances that are present and clearly explain the options available. Avoid asking patients under high levels of mental distress because their capacity to consent may be impaired.
- If patients wish to come forward spontaneously to talk about their experience with external parties, the counsellor should facilitate this and after asking the patient’s consent, share with their line managers.
- Some patients that have suffered very painful experiences may express to the counsellor their anger, sense of helplessness and frustration at their situation. In some situations, speaking out can in fact empower the individual and reduce their suffering. In cases where the patient does want to speak publically, general information about MSF’s advocacy role can be provided to the patient in writing or by someone other than their counsellor.
- The patient should be offered counselling support during and after the process of speaking out.
- Only the counsellor, patient and supervising MH staff should have access to the patient’s file.

Disclosure of anonymous information or aggregate data may be used where there is a clear purpose and plan for the use of the information. Approval from headquarters (operations/medical director) is always required before release. Operational research findings can be used for advocacy purposes. MH related operational research follows the same procedures as any other health related research. See 'An Ethics Framework for MSF-Medical Ethics and beyond'¹⁶ and the MSF Research Ethics Framework Guidance document¹⁴.

2.9 Working with interpreters

Interpreters have an important role in many of MSF's humanitarian activities. MHPSS teams often provide care in settings where the clinical team may not all share the same language and culture as the patients and families they work with. Interpreters are crucial in these contexts.

Interpreters can also be translators of a culture as they (ideally) share with patients the same culture. In some situations, teams may specifically recruit an Intercultural Mediator whose role can include interpreting for clinicians.

Interpreters are full members of the MH team. The MHAM is required to ensure that clinicians and interpreters know how to work together. The MHAM is also required to consider and plan their specific needs for basic training and continued supervision.

Understanding the MH interpreter's role

Interpreters have the same responsibility as other team members to conform to MSF's professional code of conduct (see [Section 2.6.2](#)). They have the same responsibility as clinicians to maintain patient confidentiality. Interpreters are required to give an accurate translation. The interpreter's role includes:

- The therapist knows the technique required to treat the patient; the translator knows the language and often the culture of the patient: the professional relationship is an exchange of knowledge.
- The interpreter is an additional person involved in the therapeutic relationship (alongside the patient and the clinician). They are not invisible in this interaction and have significant weight in the therapeutic relationship.
- The need in a therapeutic relationship is to build a trustful relationship between the three persons involved. It is important for the therapist and interpreter to work together to create a setting that will allow the patient to explain their story with the least difficulty possible.
- Any personal opinion about the patient can be discussed later, after the session with the therapist. Time for the interpreter to discuss the session is advisable because it will enable them to express their own feelings and thoughts and so they can be prepared for the next appointment with the patient. Interpreters' feelings are important for the therapist but during the session they cannot be shown.
- The key to continuously improving the technique of translation is a discussion after the session between the therapist and the interpreter. Knowledge of one another is key to an effective therapeutic relationship.
- The interpreter is not a counsellor. During the therapy session, the translator cannot add anything from their side. They must clarify the meaning of the words used by the therapist and the patient.
- The interpreter should not see themselves as holding a position superior to the patient because they work with the clinician. It is crucial to recall that the patient is the expert of their personal situation.

Information for clinicians required to work with interpreters

Not all team members will have experienced working with an interpreter. The MHAM must illustrate how the team and clinicians can work efficiently with the interpreter in order to make the best use of the added value of the interpreter-cultural mediator in the therapeutic process. Recommendations to clinicians working with interpreters:

- Language used must be clear and simple: avoid professional jargon, ambiguous remarks, abstractions and idiomatic expressions. Ask questions that are short and keep your commentary brief, pause frequently; break statements down into short sections, if long explanations are necessary.
- Make a list of technical terms that come up often in consultations and make sure that the interpreter knows them, and keep in mind that certain expressions may not exist in a given language.
- Do not forget that the interpreter needs time to establish a relationship with the clinician and to develop cooperation with both the patient and clinician. They have their own feelings and expectations and can feel often torn between the clinician and the patient and sometimes may feel more comfortable with the patient than with the treating clinician.
- The clinician should explain their work and expectations, support the translator before and after the sessions (see below).

Provision of training and supervision for interpreters

As part of the clinical team, interpreters require training, supervision and access to psychosocial care. Interpreters will often have little or no knowledge of MH symptoms and disorders. Therefore, participation in routine team clinical training is important. Knowledge development will also be facilitated through integration of the interpreter within the clinical team meetings and discussions.

In most settings, candidates for interpreter roles have little or no formal training in interpreting. Specific training for interpreters should be provided and can cover:

- Recommendations for best translation
- Basic education and information about mental problems and disorders
- Specific preparation and instruction when working with certain patient groups, for example children, patients who have faced severe trauma, or those who may have disturbed behaviours or speech patterns such as patients with psychotic symptoms.

Supervision should be provided formally and informally. Clinicians should also consider support to interpreters after a session as part of the therapeutic process. MHAMs and clinicians should keep in mind that:

- Interpreters and/or their families may have shared the same events as the patients.
- Interpreters have not automatically developed the skill of protecting themselves from the emotion of difficult consultations. It is important for the clinician to foster expression of feelings, particularly after difficult sessions (horrific stories, etc.) or at the end of the day.
- Interpreters often build a close relationship with international staff who will leave the field after a few months. Even if MSF international staff turnover is inevitable, newly arrived international staff must respect their reactions to the loss.

2.10 MSF mental health certificate and mental health files

An MSF mental health certificate (MHC) is an MSF medical certificate that is established after a MH/psychological consultation by an MSF clinician (usually a qualified psychiatrist, or psychologist). It is necessary to obtain the advice of MSF's intersectional legal department regarding which professional is eligible to issue the document, and to understand if there are any national requirements for the document to be considered valid in the country where it is being written. The MHC:

- Attests to and reports the symptoms suffered and/or described by the patient. It can also attest to the link between the results of the medical and mental health examination and the descriptions given by the patient. The report should also include diagnosis and treatment if applicable.
- Is a stand-alone document protected by medical confidentiality? It can be provided in addition to a medical certificate attesting to violence or sexual violence (but cannot be merged with other certificates).
- In some cases, such as a victim of torture or other violence, it is mandatory to draft an MHC and offer it to the patient according to recommendations in the medical legal toolbox¹⁷. If the patient does not wish to accept the MHC the original and the copy should be kept by MSF.
- As well as documenting what the patient themselves reports, an MHC can be based on the contents of the medical file, it is therefore important that MH files be as clear and complete as possible.^a
- Can be used by patients for various administrative purposes (asylum and non-refoulement to third party countries, proving criteria for services such as accommodation). It can also be used during judicial proceedings, particularly if the symptoms/disorder can be linked to events as recounted by the patient. Different templates are available for children and adults. If the consultation is not directly carried out by the psychiatrist/psychologist, it is based on information obtained from the MH file and signed by the psychiatrist/psychologist on an additional template.
- Should be stored in a secure cabinet separately from the patient's medical file. The MHC contains the patient's name and other identifying information, whereas the patient's medical file identifies the patient only with their unique patient code: storing the two together would identify the patient in the medical file, which would defeat the purpose of using a unique patient code. In the event of the project's closure, the MHC and medical file must be for archived together. Check the Medico Legal toolbox for the templates and guidance on these issues¹⁷.

This certificate is a legal document and it must be differentiated from a referral document. A referral document is a summary of the main clinical information related to a patient that it is written when a patient is referred to another service for the continuation of their treatment.

^a In such cases, draft the medical certificate in 2 copies + archive them separately from the patient's medical file. MSF can also give the patient in such cases a document informing them of their right to later request a certificate and how to obtain it.

The MHC must be provided directly to the patient or with patient consent to their legal representative, when requested. With respect to providing MHCs to minors:

- An MHC cannot be given to an unaccompanied minor except with prior advice from MSF’s legal department.
- An MHC can only be given to a legal guardian/accompanying person after checking:
 - His/her relation to the minor?
 - His/her relation to the alleged perpetrator?
 - Does s/he have the capacity and willingness to act in best interest of the child?

MH files must be anonymous and must be kept in a locked cupboard. MH files may have sensitive content that can put the patient or MSF at risk. MH files must be sent to the mission capital office each year. They should be kept by MSF for several years. Each patient has the right to have access to their MH files. When a patient requests this, it is usually the MSF MHAM/MH supervisor who drafts a summary of the MH file with the main clinical information.

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Chapter 3: Patient assessment

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3.1 General approach to patient assessment and follow-up

The first step for mental health care is to conduct a patient assessment. All the information collected during the assessment, first consultation and follow-ups will be embedded in the clinical file. Proper clinical documentation is essential for good quality of care. Therefore, in MSF the mental health (MH) clinical files are standard and they are an important source of data collection. Hence, it will allow to monitor the patient's care and it will help to monitor the mental health and psychosocial support (MHPSS) activities in the project.

3.2 Clinical assessment of adults

The specificities of patient assessment in specific contexts are detailed in the relevant chapters of [Part B](#) of this guide. Initial patient assessment may vary depending on the:

- Age of the patient
- Nature of the activity
- Time available
- Clinical/therapeutic approach being taken.

Topics covered in an initial assessment include:

- **Presenting complaint**

Explore why the patient has come for help: the symptoms, thoughts, emotions, stressors they describe, and their understanding of the situation. Identify what steps the patient has taken to try and help themselves, and what they expect from treatment.

Asking about activities of daily living and the patient's functionality can also help assess the severity of the presenting complaint (ability to eat, sleep, do daily tasks, take care of children, interact with others, independent living skills, etc.).

- **History of mental disorders**

Ask the patient whether they have experienced similar problems in the past or whether they have a history of other mental disorders. What happened on those occasions? Did anything help or make their situation worse?

- **Family history of mental disorders**

Ask if there is any family history of MH problems or suicide.

- **General health history**

Does the patient have any medical problems? Are these being treated? What is their level of adherence to medical treatment: consider use of tools such as the Morisky medication adherence scale or 0-10 Likert scale to indicate how much of each medication has been taken over a specific period of time ([Appendix 3](#))^a.

- **Use of alcohol and other substances**

Determine the pattern of use of any substances, including alcohol, caffeine, cigarettes or other drugs.

- **Social situation and social support**

Gain insight on the patient's social context: living conditions, support and responsibilities, employment, level of financial security, and presence or absence of other social networks are examples.

- **Strengths and other resources**

Gain insight on the patient's sense of their own strengths – either internal personal characteristics, or external protective factors helpful to them.

- **Personal History**

To be aware of major life events the person has passed, such as educational attainment level, relationship history (current and past important relationships, marriage, divorce).

^a Pill counting is discouraged.

– Mental state

Observation and recording of the patient's current appearance, hygiene, behaviour, speech, mood, thought form (the structure of the person's thoughts – including logic) and content (the themes of the thought – which, in unwell people, can include delusions, persecutory themes, excessive depressive thoughts etc.), perception disturbance (including hallucinations), and insight – can give useful objective information about the severity of the person's suffering.

Patient follow-up

To monitor the patients' progress, their MHPS status should be re-assessed and compared to the status found in the initial assessment.

If any screening and monitoring tools (for example scales such as Clinical Global Impressions (CGI) scale, self-reporting questionnaire 20 (SRQ 20), Hopkins symptom checklist 25 (HSCL25), patient health questionnaire 9 (PHQ9), trauma screening questionnaire and generalized anxiety disorder 7 (GAD7)) have been used during the first assessment they can be used again in order to monitor changes. Due to the diversity of symptoms, choose tools that include a large range of symptoms and are culturally appropriate. See [Appendix 3](#).

Remarks

For patients who have experienced a potentially-traumatic event (PTE), the following principles should also be kept in mind during clinical assessment and follow-up:

- Ensure the safety of the patient and MH care provider.
- Respect the patient's wishes. Trust can be difficult to gain due to the individual's confrontation with horror, helplessness and loss of control. They may not want to share personal details, not want them written down (concerns about privacy/confidentiality), etc.
- Respect the patient's pace. Do not rush into details of the PTE when taking the history of complaints and precipitating events.
- Focus on the here and now. All details do not need to be known to help. For example, "I would like to know what you consider is important for me to know to help your problems/feelings today."
- Do not diagnose normal reactions too rapidly. First, understand the context and cultural ways of understanding, reacting and coping.
- Provide information to help patients regain control and understand why they are experiencing symptoms of distress.
- Assess and support coping strategies to empower individuals through their personal resources and family support^b.

^b Coping mechanisms that may initially appear ill adapted or negative may have an adaptive and positive value in these contexts. Not wanting to share what has happened can be an adaptive way of maintaining control and not being overwhelmed with sadness or anxiety, for example.

3.3 Clinical assessment of children

3.3.1 Specific considerations for children

Children make up more than half of the beneficiaries seen in MSF field projects. These children and their families experience natural and man-made disasters, displacement, food insecurity, chronic illnesses as well as all the problems associated with difficult life situations. Many have experienced disruption of family and parent loss. They can suffer from illnesses requiring lengthy or lifelong treatments, and frequently face malnutrition. Their parents/caregivers are stressed and can experience both mental and physical illnesses which compromise the caregiving of their children. These psychosocial stressors impact a child's developmental progress¹.

A common misconception of healthcare workers and caregivers is that children (including infants) do not feel the impact of a stressful event and easily 'bounce back'. Children may lack adequate security, access to psychosocial support, recreational activities and school for months, sometimes years. Moreover, in such vulnerable situations, children can also be the targeted of various forms of violence.

How children react to a crisis and cope with their reactions of stress, distress, etc., depends on their age, developmental stage and the way caregivers and other adults interact with them. Even if a child is playing and smiling, they can be experiencing manifestations of distress which may be hidden or not so obvious (such as rapid heart rate, etc. or visible signs that do not immediately appear related to stress, such as subtle changes in sleep, eating or play patterns).

Children and adolescents may or may not experience similar distress reactions as adults. The symptoms manifest through behaviour rather than words. Additionally:

- Young children may not fully understand what is happening around them. They may return to earlier behaviours (for example, bedwetting or thumb-sucking), cling to caregivers, reduce their play or use repetitive play related to the distressing event.
- School-age children may believe they caused bad things to happen, develop new fears, become less affectionate, feel alone and be preoccupied with protecting or rescuing people in the crisis.
- Adolescents may feel "nothing", feel different or isolated from their friends, or display risk-taking behaviour and negative attitudes.

Communication, explanations and the type of support needed must be adapted to their age. For further explanation on how children express distress according to age and development, refer to MHPSS for children, MSF 2016 and see [Appendix 1](#) and [Appendix 2](#).

3.3.2 Child clinical assessment

The assessment of children requires evaluating different areas of child development and interaction. It is also essential to assess, via the caregiver or other legal guardian, any alteration in the child's emotions and behaviours.

Key elements to assess include²:

- Developmental problems (use of milestones chart in [Appendix 1](#))
- Inattention or over-activity
- Emotional reactions or difficulties. If an adolescent, evaluate for moderate to severe depression.

- Behavioural disturbance: repeated defiant, disobedient, and aggressive behaviour
- Presence of other priority mental disorders
- Family and social environment, including the home
- School environment
- When necessary refer for medical assessment (e.g. acute or chronic infectious illness, including ear infection and HIV/AIDS, tuberculosis, anaemia etc.).

Figure 3.1 - Child and adolescent mental and behavioural disorders²

Common presentations of child and adolescent mental and behavioural disorders	
<ul style="list-style-type: none"> • Child/adolescent being seen for physical complaints or a general health assessment who has: <ul style="list-style-type: none"> – Any of the typical presenting complaints of emotional, behavioural or developmental disorders. – Risk factors such as malnutrition, abuse and/or neglect, frequent illness, chronic diseases (e.g. HIV/AIDS or history of difficult birth). • Carer with concerns about the child/adolescent's: <ul style="list-style-type: none"> – Difficulty keeping up with peers or carrying out daily activities considered normal for age. – Behaviour (e.g. too active, aggressive, having frequent and/or severe tantrums, wanting to be alone too much, refusing to do regular activities or go to school). • Teacher with concerns about a child/adolescent <ul style="list-style-type: none"> – e.g. easily distracted, disruptive in class, often getting into trouble, difficulty completing school work. • Community health or social services worker with concerns about a child/adolescent <ul style="list-style-type: none"> – e.g. rule- or law-breaking behaviour, physical aggression at home or in the community. 	

For more specific information on child assessment, please refer to MHPSS for children, MSF 2015, and mhGAP Intervention Guide V2, 2016: child and adolescent mental and behavioural disorders².

Table 3.1 - MHPSS communication reminders for children

Dos	Don'ts
Do participate in an activity with the child.	Do not use direct questioning method.
Do sit on the same level as the child.	Do not sit at a different level to the child.
Do use open-ended questions.	Do not use leading questions.
Do start talking about general subjects of interest to the child.	Do not repeatedly ask about the same issues.

3.4 Cultural considerations

A cultural consideration approach emphasizes understanding of mental distress according to the social, political, economic, spiritual, cultural and moral worldview of the beneficiaries. When framing MH conditions/diagnosis in a culturally sensitive way it is critical to understand:

- What are the local idioms of distress and common ways of expressing distress within a culture or community^a?
- How do people explain and make sense of their symptoms or illness^b?
- Where do people seek help? The first-line helper in many non-western cultures is commonly the traditional healer.

MHPSS providers need to continuously balance evidence-based interventions alongside cultural beliefs and traditions. They must be sensitive and aware of the patient's explanatory model and, simultaneously, explain the patient's symptoms and diagnosis from a Western-medicine point of view. A trustful patient/healthcare worker relationship is essential to accomplish this.

When and if local explanatory models of MHPSS treatment lead to harmful practices by traditional healers, family and/or community, openly and honestly communicate with family members/community about the potential negative impact of these harmful practices^c or negative coping behaviours (drinking, aggression, isolation, etc.). Suggest alternative ways of addressing the issues.

Non-harmful traditional practices can be used alongside psychological and pharmacological treatment after careful assessment. Positive coping mechanisms, such as religious and spiritual beliefs and practices and community traditions, need to be recognized and supported.

a For example, in Zimbabwe the idiom for depression is *kufungissia* which means *thinking too much*.

b For example, psychosis may be explained as being possessed by a jinn or evil spirit.

c For example, beating or burning a patient to "chase out" the jinn is not helpful to a psychotic patient and may worsen the condition

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Chapter 4: Clinical supervision and training

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4.1 Introduction

The main job responsibilities of mental health activities managers (MHAM) and supervisors include providing supervision and training to ensure the delivery of quality care. They support the staff's clinical work and individual professional development. Absent or insufficient supervision leads to poor and/or harmful outcomes for beneficiaries, clinicians (burn out, vicarious trauma, etc.), and eventually the entire project.

MHAMs and mental health (MH) supervisors have 2 main responsibilities:

- Hierarchical (manager and employee)
- Clinical (clinical supervisor and supervisee)

Striking the right balance between these two sometimes conflicting responsibilities is essential for a successful mental health and psychosocial support (MHPSS) activity. Monitoring and appraising the performance of staff requires management competencies. Staff should receive the necessary support and clinical supervision in a safe environment while carrying out the core responsibilities of their job profile.

4.2 Clinical supervision¹

Clinical supervision refers to professional guidance by a senior MH professional. Professional guidance does not require a hierarchical relationship between supervisor and supervisee. At MSF however, the supervisor is almost always in a hierarchical relationship with their supervisees, unless the supervision is provided from outside the project, for example by an external consultant.

Clinical supervision is a shared reflection between the supervisor and supervisee(s), focused on the supervisee's clinical work in order to enhance their skills and capacity and which promotes their professional independence. It is expected that patients will benefit from the supervisee's improved competence².

The supervisor must ensure a confidential, safe and respectful environment. Supervisees need to feel protected from personal attacks and unconstructive criticisms.

Main functions of supervision:

1. **Educational** (developing the skills, understanding and abilities of the supervisees) to:
 - Understand the patient better.
 - Become more aware of the supervisee's reactions and responses.
 - Understand the dynamics of the interaction.
 - Analyse how they have intervened and the consequences.
 - Explore other ways of working.
2. **Supportive** (validate and ventilate):
 - Recognize how the distress, pain and patient's presentation affect the supervisee.
 - Guide the supervisee on how to deal with these emotional reactions.
3. **Evaluative**
 - Assess the supervisee's performance.
 - Identify areas to improve.

Categories of problems discussed in clinical supervision

1. Case-concept: difficulties in understanding/approaching the case.
2. Emotional impact of the case on the counsellor:
 - Empathic enmeshment/too much empathy (for example, finding the right distance between the counsellor and patient, feelings of helplessness, lack of progress, anger in the MH professional).
 - Empathic repression (for example, mechanical, distanced approach, lack of empathy).
3. Other problems: handling aggression in a patient, ethical problems, etc.

4.3 Types of supervision

4.3.1 Clinical observation

A very common way to supervise wherein the supervisor observes the capacity of a counsellor (psychologist/psychiatrist) to:

- Relate with patient.
- Use appropriate language (including questioning, language adjusted to patient, body language, etc.).
- Use non-verbal communication (respect, attentive listening, use of silence, empathy, etc.).
- Encourage the patient to express emotions, feelings, thoughts, beliefs, etc.
- Identify features and coherence between verbal and non-verbal communication of the patient.
- Identify, understand and analyse the patient's problems (current situation, coping mechanisms, etc.).
- Define treatment objectives with the patient.
- Define, set up, follow up and adapt (if needed) intervention strategies.
- Provide information and implement counselling/psychotherapeutic techniques.

4.3.2 Shadowing/modelling

Halfway between supervision and training, the supervisor directly observes the supervisee during a counselling session. Usually applicable for:

- Complicated cases where the counsellors/psychologists/psychiatrists request support.
- Cases where counsellors/psychologists/psychiatrists perceive difficulties to establish a suitable relationship with a specific patient.

In both cases (clinical observation and shadowing) the role of the supervisor during the session is agreed upon beforehand with the counsellor (psychologist/psychiatrist) to minimize the potential disruption and confusion during the session. The patient should be informed and give their consent regarding the supervisor's presence before the beginning of the session.

As language may be a limitation, the use of a translator is feasible if explained to patients^a. If the counsellor is translating for the supervisor, regularly interrupt the session to allow translation.

4.3.3 Clinical case discussion (individual or group)

Clinical case discussion is a designated interaction between two or more practitioners, in a safe and supportive environment, which enables a reflective process of critical analysis of care to ensure quality services.

While individual case discussion may stimulate the supervisee to bring up the emotional impact of the case, group case discussion allows for mutual support, a large variety of reactions/feedback and the possibility for role play.

At the beginning of the supervisor's assignment, start with individual supervision in order to get familiarized with the individual team members, the culture and context.

^a Whispered simultaneous translation.

Case discussions need to be prepared in advance and structured and usually include:

- Key personal data about the patient: age, sex, key social information, education/occupation, key family facts, current living status, etc.
- Reason for consultation
- Key life events
- Main problems perceived by the patient and by the counsellor
- Symptoms and category of major problem (and diagnosis if pertinent)
- Severity of problems and functionality
- Resources and coping mechanisms
- Intervention plan / strategies / techniques
- Counsellor’s feelings and perception about counselling and relation with patient
- Difficulties encountered and doubts in case management
- Questions and requests for support (as clear and detailed as possible)

Group case discussions should be scheduled at least once per week. These discussions facilitate the learning and sharing of experiences by team members. The role of the supervisor is to facilitate the case discussion in a safe and non-judgmental environment. Ensure the supervisee receives the clarification, support and answers to the questions they present, as well as other relevant feedback from the supervisor.

4.3.4 InterVision (peer to peer facilitation)

The role of the facilitator is assumed on a rotation basis by one of the team members. The group must consist of experienced MH (para-) professionals that understand how the process of facilitation works. They must receive appropriate training. InterVision is an organized conversation between people combining work with learning. The purpose of InterVision is to improve expertise through common understanding and professional development and learn from each other by exploring situations, problems and questions from each participant’s work context. The time frame for each session should be around 30-40 minutes.

Structure for InterVision session³

Phase	Minutes	Procedure
I	7	The case presenter describes his/her problem situation. The colleagues listen in silence. The case presenter formulates a question to be discussed.
II	2	The colleagues spontaneously formulate their emotional reactions.
III	5	The colleagues ask questions to clarify the details and understanding of the problem.
IV	8-10	The case presenter listens in silence while the peer colleagues discuss the situation described. The colleagues formulate assumptions/hypotheses about possible causes and implications of the problem.
V	2	The case presenter selects those of the formulated hypotheses that seem to fit best.

Phase	Minutes	Procedure
VI	10	The colleagues consider which approaches to solutions they can think of for the hypotheses selected by the case presenter.
VII	3	The case presenter reflects on the three questions: Where do I stand? What do I understand differently now? What will my next steps be?

4.3.5 Review of clinical files

Clinical file review is a complementary method of supervision. It enriches the supervisor's knowledge of the supervisee and can be used as a follow up tool of individual/group supervision of a specific case. Clinical files are an administrative tool and used as part of the therapeutic process. Particular emphasis is given to the treatment goals and plan, ensuring they are appropriately followed and documented. This review gives the supervisor a better understanding of the beneficiaries' problems as well as specific needs (training, etc.) of the MHPSS team.

Also, the supervisor must check if the files are well organised and stored in a secure place. Files should be classified as open or closed. Check if there are files that are still open that should have been closed.

4.3.6 Review of clinical data

Analysis of collected clinical data gives the supervisor an indirect picture of the quantity and quality of work of each counsellor and the team as a whole. Take care when interpreting data. Points to consider include:

- Patient progress as assessed by an outcome score of improvement/deterioration
- Duration of therapy (number of sessions required for improvement)
- Number of open files (check files are closed in a timely manner)
- Workload
- Rate of default (potentially an indirect measure of patient satisfaction)

4.3.7 Program monitoring with the team

Very often monitoring methods are limited to databases, quantitative indicators and analyses of the general context related to the project. Organize team meetings on a monthly basis to discuss activity developments and project goals for potential redefinition and to find more adapted strategies, if needed. Include the discussions (challenge identification and solution proposals) in the monthly report. When the team is involved in these discussions, they also are more engaged in the project.

When patients suffer from multiple medical conditions or their treatment involves several health professionals, multi-disciplinary team meetings and case discussions are essential. The aim of this type of "supervision" is to make sure all specialists agree on the treatment plan and are informed of who is doing what and when.

These discussions should be led by a supervisor, MH supervisor/MHAM or another health supervisor.

4.4 MHPSS training

Supervision and training are two of the MHAM's main responsibilities.

The MHAM is required to regularly assess and report on the training needs of their team. The needs assessment takes into account previous training and identifies gaps in knowledge observed during supervision, observations and according to project objectives. **A minimum of two weeks intensive preparatory training** is recommended prior to direct patient contact particularly for team members with little or no previous experience as lay counsellors. Topics should be discussed beforehand with the project medical advisor. The following are examples of training topics for MHPSS staff and medical staff:

Topics for an MHPSS team:

- Listening and communication skills
- Psychological first aid
- Role of counsellors and basic counselling skills
- Principles of supportive counselling
- Identification of main problem and MH symptoms
- Referral criteria
- Protocols and guidelines
- Integration of MHPSS in primary health care settings
- Reporting

Topics for medical staff⁴:

- Communication skills
- Breaking bad news
- Integration of MHPSS in other programs
- Identification of cases in need of MHPSS care
- Referral criteria
- Psychological first aid (PFA)

All MSF staff could benefit from training in:

- Psychological first aid

Training methodology includes a variety of tools and methods such as presentations, discussions, case studies, group exercises, role plays and clinical simulation. Formal training sessions include a pre and post-test evaluation of participants using a standardized form. Ensure sufficient time is allocated (specifically when translation is required) to allow staff participation. For delivery of training for counselling skills see the MSF guideline⁵ or WHO's Problem Management Plus guideline⁶.

Before facilitating any training – regardless of whether it is a one-hour 'on-the-job' training or a lengthier workshop, a training plan should be drafted that includes:

- Goals/learning objectives/purpose
- Outline of content and its connection to the goals/objectives/purpose
- Description of methodology
- Structure/time
- Formal pre and post training evaluation

External (non-MSF) courses are available for staff and can be found in the training brochure of each operational centre. Application to such courses should be discussed with the medical coordinator for approval and support.

There are also some MSF MHPSS training courses available for MSF staff:

1. MH intersectional course: face to face training for MHAM and MH supervisors.
2. Training on diagnosis and management of mental disorders: intersectional, face to face, leads by Operational Centre Amsterdam.
3. Online training on diagnosis and management of mental disorders: Operational Centre Amsterdam.
4. Online MH induction training: Operational Centre Barcelona.
5. Online PFA training: Operational Centre Barcelona.
6. Ad-hoc mission mhGAP-IG training: all Operational Centres.

There are also other free online trainings that may be relevant such as:

1. WHO-PAHO, Psychological First Aid (PFA) in disaster management in the Caribbean – 2019.
<https://www.campusvirtualsp.org/en/course/psychological-first-aid-pfa-disaster-management-caribbean-2019>
2. WHO-PAHO, Alcohol Use, Women’s Health and Pregnancy: Comprehensive Approaches to Preventing Problems Associated with Prenatal Alcohol Exposure.
<https://www.campusvirtualsp.org/en/course/alcohol-use-womens-health-and-pregnancy-comprehensive-approaches-preventing-problems>
3. WHO-PAHO, Virtual Course on AUDIT-SBI: The Alcohol Use Disorders Identification Test.
<https://www.campusvirtualsp.org/en/course/virtual-course-audit-sbi-alcohol-use-disorders-identification-test-solo-se-creo-este>

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Part B

Specific context-related interventions

Chapter 5: Humanitarian disasters

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5.1 Introduction

The United Nations reports that at the end of 2019, over 79 million people worldwide had been displaced by war, armed conflict or persecution^{1,2}. In 2016 violence related displacement was reported at a 20-year high and the number of internally displaced persons (IDPs) was at its highest level in more than 50 years³.

“Every year natural disasters kill around 90,000 people and affect close to 160 million people worldwide.”⁴

The impact of armed conflicts and natural disasters on the mental health (MH) of a population is influenced by the:

- Nature of the conflict or disaster – Context in which the violence or disaster occurs^a
- Availability of immediate and effective emergency relief
- Extent of health consequences associated with or resulting from displacement, loss, social isolation, etc.

During armed conflict and natural disasters, mental health and psychosocial support (MHPSS) activities are implemented as rapidly as possible to alleviate suffering, to prevent the development of mental disorders and psychosocial problems and to foster individual and community resilience^{b,5}.

a Impact depends on infrastructure, government, economic development, culture, etc.

b An MHPSS needs assessment is not mandatory to justify an MHPSS intervention. Begin as soon as possible. An assessment can be carried out while simultaneously adapting/refining implemented activities. See [Chapter 1](#).

5.2 Risk factors to mental disorders and psychosocial problems

Many disasters do not have a single cause. Complex humanitarian emergencies is a term used to describe settings in which multiple, often historically and politically determined, etiological factors predispose an area to disaster and mitigate its outcomes. In such multidimensional disasters, natural and man-made factors may be closely intertwined⁶.

Populations living through disasters may directly or indirectly experience:

- **Potentially traumatic events (PTE):** bombing/shelling, being wounded, being victims of violence, rape, imprisonment, relatives' death, loss of property, etc.
- **Displacement^a:** leaving their houses, escaping violence via difficult journeys, being alone with no protection, being separated from family, community disruption, loss of possessions, etc.
- **Lack of basic needs:** once safety is reached, difficulties may include overpopulated camps, lack of shelter and hygiene, limited access to water/food, adjustment to a new way of living (without previous routine, social connections, cultural institutions, etc.).

There are other conceptualizations of psychological trauma that should be considered such as the following definition of trauma and its key elements⁷:

Trauma is an experience:

1. That constitutes a threat to the physical or psychological integrity of the person. It is often associated with experiences of chaos and confusion during the event, fragmentation of memory, absurdity, horror, ambivalence or bewilderment.
2. Which has a character: unspeakable, impossible to narrate and incomprehensible to others who have not experienced it.
3. That breaks one or more of people's basic assumptions of the world, that constitute the benchmarks of human safety. It especially affects beliefs of invulnerability and control of life itself: trust in others, confidence in the controllable and predictable nature of the world.
4. That questions the perception of one self and the interaction with the outer world.

The impact of a PTE on a person depends on several factors including:

- The nature of the threat or injury: frequency and intensity, proximity, man-made or natural disaster (when perpetrated by man the impact is usually higher).
- Level of exposure to the PTE and degree of personal impact: peri-traumatic distress, human/material loss in families, injury, etc.
- Individual characteristics:
 - Coping skills and resilience
 - Past traumas
 - Previous history of medical and psychiatric illness (due to the additional stress, discontinuation of previous treatment, etc.)
 - Age (children and older people are particularly vulnerable)
 - Cultural explanations and level of known information (or lack of information), meaning given to the experience
 - Level of education and socioeconomic status (poverty, etc.)

^a Refugees and internal displaced persons due to conflict or natural disaster.

- Recovery environment: family/community support systems, etc. Usually these situations overwhelm the response capacity of the affected community and causes disruption and disintegration of the social fabric by prohibiting the survivors from functioning normally. However, there are usually some support systems that reactivate in the immediate aftermath of the PTE.

The groups at most risk of developing mental disorders and psychosocial problems in emergencies due to natural or manmade disasters are those with previous mental disorders, unaccompanied minors, violence/sexual violence victims/survivors, child soldiers, men and adolescents recruited by force, people who have lost relatives, injured people, detained, tortured, older people and children.

5.3 Clinical characteristics

After extremely violent events and natural disasters, affected populations can present with a wide range of reactions. Most people will stabilize and recover with time. They cope with these reactions over time and do not experience continued symptoms. This is attributed to resilience^a. Others will present with persistent symptoms and disorders⁸ and some may deteriorate in their symptomatology.

Reactions in the immediate aftermath of a PTE are considered “normal reactions to an abnormal event”. The first month following a disaster or a PTE is a period of adjustment.

The psychological consequences of exposure to natural or man-made disasters can impact physical, mental, spiritual and moral wellbeing. The possible reactions after a PTE vary and may include:

- **Physical symptoms:** hyperarousal, insomnia, fatigue, headaches, sweating, tachycardia, gastro-intestinal complaints;
- **Emotional symptoms:** shock, anger, sadness, helplessness, anxiety, panic attacks, despair;
- **Cognitive symptoms:** confusion, disbelief, detachment, self-blame, daze, stupor, inability to concentrate, traumatic memory;
- **Behavioural symptoms:** withdrawal, mutism, aggression, substance use, over activity or under activity, lack of appetite or excessive eating, shaking or ‘tics’, startle responses.

Some people may experience post-traumatic growth after one or several PTEs. This has been defined as a beneficial change in cognitive and emotional capacities beyond previous levels of adaptation, psychological functioning, or life awareness after trauma. It refers to a permanent change. This growth is not a direct consequence of PTE but the result from the struggle to cope with the event and find meaning. It is important for clinicians to be aware that this can happen and identify it⁹.

There are people that will have more severe symptoms and will need MH care (counselling, psychological support or pharmacological treatment). See the following criteria to refer to MH care for an assessment:

1. People with very severe and urgent symptoms such as:
 - Suicidal thoughts/attempts
 - Psychotic symptoms and behaviours
2. During the first month post-PTE there are warning signs and symptoms that require MH care:
 - Extreme reclusiveness and isolation
 - Insomnia for > 3-5 days
 - Refusal to eat for > 2 days
 - Intense sadness, irritability and/or survivor’s guilt
 - Emotional numbness or dissociation
 - Intense physical complaints without medical explanation (convulsive paralysis of limbs, etc.)
 - Excessive use of alcohol or other substances
3. When symptoms persist and interfere with daily functioning following the PTE.

a The American Psychological Association (2014) defines resilience as “the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress”.

Furthermore, possible disorders can include presentations of grief, depression and anxiety, as well as more severe mental disorders (SMDs) such as psychosis, severe depression, post-traumatic stress disorder (PTSD), complex PTSD (C-PTSD). World Health Organization (WHO) latest statistics estimate a 22%-point prevalence of mental disorders among people living in conflict settings (5.1% SMDs, 4% moderate and 13% mild mental disorders)¹⁰. See General introduction, [Table 1](#).

According to ICD-11, reactions and disorders specifically related to traumatic events include acute stress reaction (ASR), PTSD and CPTSD¹¹.

1. ASR¹¹

Transient reactions (physical, emotional, cognitive or behavioural) that are considered normal, usually subsiding within a few days after the event or after removal from the threatening situation. ASR is characterized by “autonomic signs of anxiety, being in a daze, confusion, sadness, anxiety, anger, despair, over-activity, inactivity, social withdrawal or stupor.”

2. PTSD¹¹

Symptoms persisting for several weeks following exposure to a traumatic event. A period of latency may exist between the traumatic event and post traumatic reactions. Do not diagnose PTSD immediately after a traumatic event. Full diagnostic criteria are not met until several weeks after the trauma(s), although onset of symptoms may occur immediately. PTSD is characterized by:

- Re-experiencing the event (flashbacks, nightmares, intrusive memories).
- Avoiding reminders of the event (trauma related thoughts, memories or feelings; external reminders of the trauma such as places, persons, situations).
- Feelings of a heightened threat altering arousal and reactivity (hypervigilance, irritability or aggression, risky or destructive behaviour, difficulty concentrating, difficulty sleeping, etc.).
- Negative alterations in cognitions and mood (overly negative thoughts and assumptions about oneself or the world, decreased interest in activities, feeling isolated, difficulty experiencing positive affect, etc.)⁵.
- Symptoms of dissociation (depersonalization, derealisation, dissociative amnesia).

3. C-PTSD¹¹

A new disorder included in ICD-11. It is a disorder that develops following exposure to event(s) “of an extremely threatening or horrific nature, most commonly prolonged or repetitive events^b from which escape is difficult or impossible (torture, slavery, prolonged domestic violence, repeated childhood sexual or physical abuse”) and characterized by symptoms causing significant impairment in important areas of functioning (personal, social, occupational, etc.):

- Severe problems with affect regulation;
- Feelings of being diminished, worthless and “shame and guilt related to the traumatic event”;
- Difficulties in sustaining relationships.

When MSF provides medical responses to disasters among the most frequent complaints (headaches, stomach-ache, back pain and other generalised body aches and pains) are symptoms often associated with underlying mental disorders and specific psychosocial stress, even though they are not always first identified as such. Look out for increased physical complaints, increased physical health disorders, and increased unhealthy behaviours.

^b C-PTSD can also occur within the first month after exposure to extreme trauma that is not necessarily repetitive (torture, etc.).

5.4 Clinical assessment

If patients display any severe symptoms, immediately complete an MH assessment and treat the patient. Diagnose potential psychiatric disorders to implement first-line treatment as soon as possible, if necessary.

Individual patient assessment involves covering, and recording in the patient file, all the key aspects listed in general principles of patient assessment (see [Chapter 3](#)), as well as considering the specificities described below.

In humanitarian disasters, there are various factors that will determine the type of interventions the individual may need:

- **History of current complaint:** nature of complaint, duration, severity, impact on daily functioning, person's belief about the problem, treatment.
- **Precipitating factors:** violence or non-violence related, type of violence (e.g. torture or sexual violence), losses, injury, death of loved ones, etc.
- **MH and medical history:** previous and present medications, availability of medications and family psychiatric history (e.g. relative with a diagnosis or symptoms possibly associated with a psychiatric disease).
- **Resources:** provision of basic needs, availability of family and social connectedness, positive and negative coping mechanisms. These factors can help the recovery process.
 - Sense of security and provision of basic needs.
 - Effective family and social support.
 - Opportunities to make choices about one's own life and take an active role in solving personal problems and in providing support for others.
 - A rapid return to a life that is as normal as possible.
 - Provide reliable information to survivors to help them understand the PTE, the present situation and anticipate the near future.
 - Timely psychological support and acknowledgement of suffering.

Pay attention to people showing dissociative symptoms, disconnected from their surroundings and/or isolated. Careful patient assessment and close counsellor clinical supervision is necessary to avoid the risk of re-traumatisation.

While assessing individuals exposed to natural or man-made disasters:

- Ensure safety. Particularly in armed conflict settings, assess the risk of continued threats of further violence. Ensure the patient is protected by taking precautions in the management procedures of sensitive information. Ensure contact with the patient does not put them at risk of further violence (how contact with the patient will be perceived by others, etc.). Identify 'red flag'^a cases to discuss with the coordinators.
- Build a trustful relationship.
- In highly insecure and volatile contexts where future access may be compromised, consider that continuity of care is not guaranteed when considering prescribing psychotropic medications. One consultation may be the only contact with the patient.

a For example, patients with urgent protection needs; patients with very sensitive information that, if shared, could be a security risk for the patient or MH professional etc.

- Be proactive and identify the patient's main current problem/concern to help them find solutions/alternatives/improvement in this first consultation.
- Be cautious when assessing past exposure to a PTE and always explain to the patient that they only need to talk about issues that they want to discuss. They don't have to go into detail about what happened to them if they don't want to.

Remark

Do not only focus on trauma related problems and disorders when evaluating survivors of traumatic experiences. Maintain a broader view that includes consideration of other possible symptoms (such as grief, depressive, anxiety or psychotic symptoms and symptoms related to substance use) and different grades of impairment in social, occupational or other important areas of functioning. For further definitions, refer to the ICD-11^{b,6}. In addition, co-morbidities after traumatic event(s) are frequent. People with previously diagnosed disorders frequently relapse due to stress or unavailability of medications.

b International classification of diseases of mortality and morbidity statistics (ICD-11). Eleventh revision.
<https://www.who.int/classifications/icd/en/>

5.5 MHPSS assessment

For MHPSS assessment in humanitarian disasters, see [Chapter 1](#).

5.6 MHPSS activity planning

5.6.1 General principles

MHPSS activities address the needs of individuals, families and whole communities^a by focusing on the:

- Direct consequences of the armed conflict or natural disaster on the individuals' well-being.
- Stressors linked directly with displacement and loss.
- Daily stressors like family conflict and violence, loss of possessions, separation, lack of social support, etc.¹²

Care of disaster survivors involves many sectors and agencies. Understand who is doing what and where. Understand how to link beneficiaries with needed services. Identify gaps in these services (see [Chapter 1](#)) and establish a referral pathway including bilateral information sharing.

Individuals, families and communities affected by a disaster may have the resources to cope with the effects, particularly if supported. MHPSS activities can be considered in the following main dimensions:

- **Individual/family:** support and facilitate the individual's process of re-connecting with their environment, community and culture through individual or group counseling/psychological support. Reinforce their coping processes and support their bereavement/mourning process. Propose pharmacological interventions for SMDs.
- **Community:** create an environment that facilitates the reintegration of individuals or groups by strengthening the coping process and reinforcing the protective factors of the community. Stimulate mutual support (e.g. peer support groups, community leaders visiting vulnerable people at home, etc.). Encourage resuming cultural and religious activities (e.g. church, mosque services). Encourage those affected to play an active role and to take decisions in reconstruction and relief efforts, in order to help restore their sense of dignity and some control of the situation (e.g. leaders and other members of the community participating in reconstruction plans or participating in the decision-making in a refugee camp). Support previously formed groups (e.g. women who used to wash clothes together, men who used to gather to play chess at sunset, teenager volunteers, etc.). Promote maintenance of routine social activities. Give community networks resources to foster helping each other (e.g. enable a group of volunteers to visit the community's older people, people from the same community able to provide psychological first aid (PFA) when needed, etc.).

Integrate MHPSS activities into:

- General healthcare: mainly primary healthcare and other medical activities.
- Water, sanitation and hygiene: consider discussing social/cultural factors with the teams in charge when deciding where to put the latrines, water points, etc. These aspects can have an impact on protection, feelings of safety, etc.
- Other MSF interventions such as non-food items distribution: a key role of MH care is to advocate for these activities to be carried out with a maximum of consideration and attention to individuals. Try to encourage the active involvement of the community in these activities.

^a Particularly during armed conflicts, social and family fabrics are profoundly weakened.

5.6.2 Support interventions according to the timeframe after the event

In the first month (acute emergency) prioritize:

- PFA and single ‘one shot’ consultations¹³ if MH staff are available
- Psychoeducation
- Management of SMDs

Afterwards, when the team has received formal training, counselling and psychological interventions (one¹⁴ or more sessions) can be implemented. The timeframe decided on is specific to each context and depends on many variables including resources, etc.

Table 5.1 - Priority activities in relation to time

Phases	Acute emergency (1 st month)	Post-emergency (2-6 months)	Early recovery (> 6 months)
Interventions prioritized	<ul style="list-style-type: none"> • PFA • Psychoeducation • Management of acute SMDs • Referrals • Advocacy for basic needs^b <p>NOTE: psychosocial aspects should be considered during water and sanitation interventions and the distribution of NFI (culturally sensitive design of interventions, protection issues, etc.).</p>	<p>In addition to activities set up in the first month:</p> <ul style="list-style-type: none"> • Counselling and psychological support • Identification and management of SMDs • Community-based psychosocial activities (group activities for parents, recreational activities, safe spaces, etc.) 	<p>In addition to the activities previously described:</p> <ul style="list-style-type: none"> • Psychosocial activities for specific groups depending on the medical focus of the project (trauma and burn unit, nutrition, sexual and reproductive health, etc.) • Community-based psychosocial activities (teacher training, adolescent groups, etc.)

The minimum package^c can be implemented in the early stages of an intervention (post emergency). A more comprehensive package^d is implemented as soon as needs have been properly assessed and resources are available. See [Chapter 2](#) for detailed information.

5.6.3 Minimum package

The key activities included in the minimum package are:

1. Awareness raising activities or psychoeducation
2. PFA
3. Identification and management of **patients with SMDs**
4. Referral pathways to other actors where possible
5. Advocacy

For more information see [Section 2.3.1](#), Chapter 2.

^b Ensure the population is not put at risk of additional harm when implementing advocacy activities (see [Section 2.8](#), Chapter 2).

^c Minimum activities that should be set up in such a context which are implemented irrespective of the presence of a MHAM. If possible, it is always better to have an MHAM from the outset (see [Chapter 2](#)).

^d Depending on the complexity and volume of activities to be implemented, the presence of an MHAM is required to ensure effective management of a higher volume and more complex activity (see [Chapter 2](#)).

MHPSS activities should be systematically implemented in post-emergency. The presence of a mental health activities manager (MHAM), or other experienced MH professional, is recommended from the outset of an intervention to develop and guide these activities. If not present, a person needs to be appointed responsible for these activities. Ideally, all emergency responders (medical, paramedical, logistics, etc.) should be familiar with the principles and practice of PFA.

Key MHPSS activities to be implemented from the outset of the intervention include:

- Advocate with pertinent actors for food, water, shelter, medical aid, protection and security.
- Provide reliable information to the patients about what has occurred and what relief actions are being taken, by whom, where, etc. Provide means to communicate with relatives and friends (if possible). Access to information reduces unnecessary anxiety, rumors and distress by establishing a sense of mental control. Inform people about potential psychological reactions. Identify and reinforce culturally appropriate coping mechanism techniques to help them feel better.
- Take care of the dead: find and identify corpses, ensure proper and culturally appropriate burial and funeral ceremonies, etc.
- Social contacts: reinforce community interventions (see [Section 5.6.1](#)), advocate and/or refer to organizations providing assistance to keep families together, facilitate participation of isolated people in activities, etc.
- Emotional support: PFA, non-intrusive pragmatic care focusing on listening without forcing to talk, encouraging company from significant others, etc.
- Acknowledgment: recognize what they have been through and their pain with respect and empathy.
- Tools: use radio, newspapers, leaflets, social media, psychoeducation at collective gatherings, organized activities for children/adolescents, etc.

Table 5.2- Minimum package for humanitarian disasters

MHPSS minimum package (integrated)		
Expected Result	Activities	Who?
To reduce mental disorders and psychosocial problems in populations exposed to natural and/or manmade disasters	<ul style="list-style-type: none"> • PFA for patients with acute reactions. • General psychoeducation by health staff. • Identification of main MH reactions and common mental problems in primary health care. • Identification of SMDs for treatment or referral^e. • Advocate for provision of basic needs within MSF and with other agencies. 	Trained: General practitioners (GPs), clinical officers (COs), nurses, community health workers, health promoters
	<ul style="list-style-type: none"> • Basic assessment and management of MH conditions (specific psychoeducation, integration of basic counselling skills, psychotropic medication). 	Trained: Nurses, GPs, COs

A toolkit has been developed for the implementation of MHPSS minimum package activities in emergencies¹⁵.

^e In humanitarian emergencies there is usually nowhere to refer patients with SMDs.

5.6.4 Comprehensive package

An MHAM is required to develop the following activities:

The comprehensive package includes all activities in the minimum package and:

- **Individual, family and group counselling or psychological care activities:** it may not be possible to provide multi-session counselling (security reasons, geographical access difficulties, etc.). In this event, single session (“one shot”) interventions can be provided. Single session interventions focus on the most important concern and promote coping strategies that engage a person’s natural resilience and inner resources. Single sessions are delivered by trained MH staff ^{f,16}.
- **Care of patients with SMDs** using psychotropic medications and basic psychosocial support delivered by a psychiatrist or general practitioners/clinical officers trained according to mhGAP Intervention Guide⁸. Depending on the size of the activity, supervision and training can be provided by a psychiatrist working with the team, or for very small activities supervision can be provided remotely, for example through the telemedicine platform.
- **Psychosocial activities for vulnerable groups:** wounded, malnourished patients, patients with HIV/TB^g, female heads of households, victims of sexual violence, etc.
- **Community based psychosocial interventions** are particularly relevant due to the weakened social and family fabric resulting from the disaster (mainly violence, displacement, etc.) and are important in places where people gather (camps, shelters, etc.). Changes in family and social structures force new forms of social organization and affect the equilibrium of the community’s psychosocial well-being. Identify existing resources (leaders, structures, associations, etc.). Support and coordinate with them. Community mobilization, self-support activities (supporting traditional coping mechanisms, etc.), awareness raising activities and psychoeducation can be implemented. Safe spaces for children or community centres can be established to provide a safe environment in which to gather and share activities to enhance mutual support. Observe, understand, respect and promote community ways of coping with the situation.

Ensure there is at least one private consultation room that guarantees safety and dignity. Referral between the medical and MHPSS team is essential. Adapt and simplify data collection tools for emergency interventions.

Before implementation of a wider set of activities^h, assess if it is possible for patients and staff to move freely and safely outside healthcare facilities. Confidential information (patient files, etc.) must be stored in a locked cupboard.

There are some specific interventions for families of victims of forced disappearance, child soldiers and other populations. For more information, check with your MH advisor at headquarters.

^f For more details, refer to: a primer on single session therapy and its potential application in humanitarian situations and MSF operational centre Barcelona’s protocol on MHPS single session (2011).

^g HIV/TB: Human immunodeficiency virus/tuberculosis.

^h For example, counsellors in a mobile clinic team, psychoeducation sessions in the community, etc.

5.7 Specific challenges in armed conflict settings

Table 5.3- Challenges related to MHPSS responses in armed conflict settings¹⁷

Challenges	Recommendations	Activities
<p>Limited access to the population due to security constraints</p> <p>Limited time of direct contact with target population</p>	<ul style="list-style-type: none"> Consider ways the intervention may contribute to improving national and local capacity to respond. Establish good network with community leaders to mobilise population to access MSF facilities. Adjust strategies to offer the best possible response within a time-limited package. 	<ul style="list-style-type: none"> Training and supervision of national staff regarding MH support. Specific strategies adjusted to limited access: single session interventions, tele-counselling, tele-psychiatry, etc. Community MH activities: training of community health workers, raising awareness, etc. Regular meetings with key actors. Training key actors in community approach.
<p>Technical support in remote control settings</p>	<ul style="list-style-type: none"> Innovation Ensure technology that can guarantee confidentiality and data protection. 	<ul style="list-style-type: none"> E-learning Skype, phone meetings, video conference system (supervision and training) Inter-sectional clinical training and supervision available in some contexts
<p>MH support in contexts of on-going violence</p> <p>Access to population during acute massive violence</p>	<ul style="list-style-type: none"> Acknowledge limitations of results. Be prepared to respond during emergencies, forecasting all possible scenarios. 	<ul style="list-style-type: none"> E-Prep plan to include MHPSS. Provide appropriate training and guidelines to all staff (e.g. PFA)
<p>Providing MH activities when protection for victims of violence is not ensured</p>	<ul style="list-style-type: none"> Advocacy, lobby Mapping possible actors/shelters, etc. 	<ul style="list-style-type: none"> Advocacy strategies Collect 'témoignage': treat witness reports from MH patients with caution Meetings with key actors, international organizations, etc.
<p>Working with national staff who are affected as well by the disaster</p>	<ul style="list-style-type: none"> Availability of emotional support Clearly defined roles for everyone 	<ul style="list-style-type: none"> Provide appropriate tools and training. Support to staff by the Psychosocial Care Unit. Collaboration with other organizations and professionals for emotional support for national staff.
<p>MH stigmatization</p>	<ul style="list-style-type: none"> Community awareness Training of key actors, leaders, medical staff, etc. 	<ul style="list-style-type: none"> MH promotion, psychoeducation and raise community awareness. Meetings with key actors.

5.8 Specific challenges in natural disasters

Psychoeducation and psychosocial activities in the community are an important component of MHPSS activities. Provide information about the event (including what is known about the situation that has occurred), support available and possible MH reactions that may be experienced. Use visual leaflets/music/radio/social media. Promote culturally appropriate community burials and help with funeral rituals.

Table 5.4 - Challenges related to MHPSS responses in natural disasters

Challenges	Recommendations	Activities
Limited reliable information	<ul style="list-style-type: none"> • Confirm reliable information. • Establish good network with community leaders to mobilise population. 	<ul style="list-style-type: none"> • Community activities: regular sharing ONLY of reliable information (there are often rumours and/or incorrect information about risks, etc.). • Awareness activities to correct rumours with reliable information about the disaster/post disaster. • Regular meetings with key actors.
Providing MHPSS activities when access to basic needs is not ensured	<ul style="list-style-type: none"> • Advocacy, lobby. 	<ul style="list-style-type: none"> • Advocacy strategies. • Collect 'témoignage': ensure confidentiality and security of witness reports from MH patients. • Meetings with key actors, international organizations, etc.
Many nongovernmental organizations, confusion where to get help	<ul style="list-style-type: none"> • Regular and ongoing actor mapping. Establish a good network with other actors involved and understand their activities. • Identify MHPSS gaps and continually adapt MSF's MHPSS strategy accordingly. • Establish a referral system among different actors. 	<ul style="list-style-type: none"> • Meetings with community leaders. • Meetings with key actors.
Patients with SMDs that interrupt their treatment	<ul style="list-style-type: none"> • Ensure treatment of mental disorders is available. 	<ul style="list-style-type: none"> • Identify psychiatric facilities if any exist and assess the quality, setup an effective referral system. • If no referral system is possible, then integrate mhGAP through trained clinicians. • Ensure provision of basic psychotropic drugs.
Massive injuries, deaths	<ul style="list-style-type: none"> • Accompany grief. • Identify people with traumatic grief. 	<ul style="list-style-type: none"> • Support burials and cultural/religious ceremonies. • Psychological support to people with traumatic grief or any complicated grief and for injured people.

Challenges	Recommendations	Activities
Breakdown of community structures	<ul style="list-style-type: none">• Ensure safe spaces for children and adolescents.	<ul style="list-style-type: none">• Run child friendly spaces until other organizations arrive.

Consider that the long-term mental consequences of natural disasters may last more than a year. One study carried out 30 months after the Haiti earthquake showed high prevalence of PTSD symptoms (36.75%) and depressive symptoms (25.98%)¹⁸.

5.9 Specific considerations for children

Humanitarian disasters can have a wide range of effects on children's mental health and psychosocial wellbeing.

Children can manifest a variety of symptoms depending on their age, developmental level, culture, and temperament. The MHPSS approach is the same for all symptoms: understand the context of the child's life, explain common mental health symptoms to parents/caregivers and children and describe possible interventions that can be provided by the parent in the home setting.

Some symptoms and disorders like depression, anxiety, enuresis, hyperactivity, selective mutism and even PTSD are not exclusive to humanitarian disasters; they are common reactions in children facing situations of extreme stress¹⁹. For more information on interventions for children please refer to MHPSS for children²⁰.

However, children exposed to long or intense stress or trauma may develop more serious reactions, and the support of a specialist may be needed.

Initial intervention when natural or man-made disasters occur involves setting up activities for children to help restore some sense of normality and safety (see [Section 2.4](#), Chapter 2) for more detailed information):

- Encourage children to go back to school
- Create safe spaces for playing, sharing experiences, etc.
- Work with caregivers on reducing the child's symptoms²⁰.

5.10 Monitoring

For programmatic monitoring and indicators see [Section 2.7](#), Chapter 2.

Continuously monitor the population's needs and the presence of other actors in the region (as these will change over time). This ensures the intervention is as adapted as possible to meet the population's needs.

Routine activity monitoring is described in [Chapter 2](#). Monitoring should include some of the indicators listed in that chapter.

In addition:

- Possibly monitor data from outpatient and inpatient departments on: number of wounded, suicides, depression in adults, behavioural problems in children and medically unexplained physical symptoms.
- In MHPSS activities, monitor the percentage of patients with disaster and violence related precipitating events (including sexual violence, domestic violence and intimate partner violence that tends to increase in these situations).

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Chapter 6: Disease outbreaks

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6.1 Introduction

Acute outbreaks of diseases such as cholera, viral haemorrhagic fevers (e.g. Ebola virus disease), coronavirus (COVID-19), hepatitis E, etc. can result in mental health and psychosocial consequences for patients, their families and their communities. Outbreaks have different and varied impacts depending on the disease and its epidemiological and pathological characteristics.

- Outbreaks of highly contagious diseases with high mortality rates are particularly frightening. People cannot rely on their senses to determine physical exposure as the infectious agents (bacteria/virus) are invisible.
- When a disease with high mortality is spread from person to person via direct contact, droplet or airborne transmission, fear and helplessness are common reactions. Health providers, family members, friends and neighbours may be sources of disease. As a result, safe healthcare and social support may not be readily available when most needed.

Mental health and psychosocial support (MHPSS) is integrated into all layers of an intervention from medical care, water and sanitation activities, community-based activities (health promotion (HP), safe burials, etc.) and direct support to patient, families, survivors, communities and staff.

Assuring mental well-being counteracts threats to public health and safety caused by fear, stigmatization and misinformation. MHPSS activities must always be tailored to the social and cultural context and integrated into the public health assessment, preparation, response and recovery plans.

6.2 Risk factors for mental disorders and psychosocial problems¹

In addition to the risk factors described in the introductory chapter, during outbreaks additional specific risk factors may arise. High mortality and/or the severe stigma associated with certain outbreaks (Ebola or Marburg virus, etc.) create additional burdens for vulnerable communities. Specific risk factors for mental disorders and psychosocial problems should be considered at both community and individual level.

Risk factors at community level may include:

- Stigma: communities and healthcare workers (HCWs) often experience the burden of stigma and fear of the disease. In some cases, this may involve social exclusion or even threats of violence and death.
- Impact of quarantine: stress may be exacerbated if quarantine procedures are introduced for healthy but exposed individuals, families or entire communities in response to the outbreak².
- Social disruption: social problems may arise due to the breakdown of community support systems, social stigma and discrimination associated with the disease. Formerly functional family and community systems can be rapidly disrupted. The breakdown of these normal support structures adds a cumulative burden.
- Economic impact: the generation of income within communities is often impacted by travel and work restrictions, loss of family and community members and the collapse of businesses.
- Disruption of health systems during outbreaks may alter the pattern of health care access e.g. people experiencing the stress of having to travel long distances to obtain healthcare or people with pre-existing mental disorders not being able to get their treatments.
- Orphans, children, healthcare staff and frontline workers are particularly vulnerable.

Risk factors at individual level may include:

- **Pre-treatment**
 - Fear and confusion due to rumours and misinformation about the outbreak;
 - Grief caused by the loss of relatives, friends, colleagues, other losses (job);
 - Death or serious illness of family members;
 - Stigma, discrimination and self-blame due to the diagnosis;
 - Fear of infecting loved ones.
- **During treatment**
 - Perception of a threat to one's life, and fear of suffering/death;
 - Dealing with frightening symptoms;
 - Keeping patients in isolation, often used to manage and reduce the spread of disease in health facilities, can lead to situations where patients feel trapped, isolated and alone, even when surrounded by caring professionals;
 - Witnessing and/or caring for individuals who are severely ill and/or dying;
 - Loss of control;
 - Fear of being abandoned.
- **Post-recovery**
 - Rejection, stigma and discrimination;
 - Loss of job, family, status etc.

6.3 Clinical characteristics

As described in the introductory chapter, mental disorders increase in prevalence in populations under stress. Outbreaks can be considered potentially traumatic events (PTE) with different reactions and associated symptoms occurring at various stages of the outbreak. Fear and limited information during an outbreak can rapidly lead to stigma and marginalisation of individuals, families and communities, which in turn worsens mental disorders and psychosocial stress. While the patterns of individual and community response to outbreaks vary, the following stages are common:

Early stages

At the beginning of an outbreak, people often present with fear, anxiety and confusion. Communities begin to experience the first stages of disruption. As the outbreak continues, the consequences of the outbreak can lead to severe suffering and death, leading to experiences of personal loss, grief and mourning.

Mid stage

As outbreaks progress, people may start presenting with mental disorders – for example adjustment reaction, depression, post-traumatic stress disorder and other severe disorders. Care for people with pre-existing severe mental disorders (SMDs) may be disrupted, leading to relapse.

Late/chronic stage

Depending on the extent and level of disruption of the outbreak, families can be disrupted – as can communities. This can be associated with closure or dysfunction of schools, health facilities and other civil society structures. The breakdown of these family and community structures – that are normally protective factors for psychosocial functioning – can lead to an increased risk of individual suffering and result in a higher prevalence of mental disorders and psychosocial problems.

Customs and rituals can be disrupted at any stage of an outbreak leading to further weakening of community strengths and increasing the risk of mental disorders and psychosocial problems.

6.4 Clinical assessment

For the general approach to clinical assessment of patients see [Chapter 3](#). Given that outbreaks can be considered PTEs, additional considerations and approaches for post-event trauma should also be considered. Some specific factors for clinical assessment in outbreaks include identifying:

- Experiences of traumatic events: deaths of relatives, witnessing death of others, rejection from the family/community, complicated grief, etc.
- Potential experiences of stigmatization/discrimination.
- Individual and social resources.

When carrying out a mental health (MH) clinical assessment during an outbreak, take into consideration that the usual set-up of the consultation space may also be disrupted. The introduction of quarantine and infection control approaches for example, can result in the patient being physically separated from the clinician in order to reduce the risk of transmission of infection. This may result in reduced confidentiality. Importantly it also requires careful planning and consideration in order to maximise patient-therapist rapport.

6.5 MHPSS assessment

For the general approach to MHPSS assessment, see [Chapter 1](#). During outbreaks, there are additional considerations that should be considered. These include understanding/identifying:

- Cultural understanding of the disease, traditional practices/customs and health seeking behaviour (helps to adapt the intervention).
- Disruption of previous expressions of care, and restriction of mutual support activities (gathering as a group, touching, hugging, sharing food, mass congregations, etc.).
- Disruptions in traditional ways of coping with losses (not being able to engage in traditional burials, etc.).
- Reactions of fear, distrust and anxiety.
- Reliability of information. Lack of knowledge increases fear. Rumours, inconsistent reporting by the media and conflicting expert opinions and public health recommendations increase public anxiety.

Vulnerable subpopulations need particular attention and should be specifically considered in an assessment. Depending on the outbreak, these groups may include:

- Stigmatized survivors (or those with disabilities post-recovery) and their relatives;
- Bereaved family members and orphans;
- Older people;
- People with SMDs (potential care disruption during the emergency);
- HCWs and burial workers who have witnessed extreme morbidity and mortality.

6.6 MHPSS activity

6.6.1 General principles

Interventions begin during the early stages of the outbreak and continue after the outbreak ends to support individual and community recovery.

MHPSS in outbreaks aims to:

- Provide psychological support for patients and other people affected by the outbreak (patients' caregivers, health staff, contacts, people in quarantine, general population) presenting with mental disorders or psychosocial problems.
- Humanize patient care by considering and responding to the patient's and family's MHPSS needs and helping restore dignity through improving the environment and atmosphere of the treatment facility as well as the relationship between medical staff and patients.
- Support patients, relatives and community encouraging healthy coping skills, better acceptance of care and practices linked to measures of protection.

Clinical on-the-job training and thorough supervision and support of HCWs by MH specialists are essential components for successful integration of MHPSS into patient management (in cholera treatment centres, Ebola treatment centres, COVID-19 treatment centres, etc.). This requires training of medical staff in specific topics.

Consider:

- Key communication skills ([Appendix 14](#))
- Psychological first aid (PFA) for Ebola³
- Breaking bad news ([Appendix 13](#))
- Grief and the grieving process ([Appendix 15.1](#) and [Appendix 15.2](#))
- Identification of patients/relatives in need of care ([Appendix 16](#))

In some settings, traditional health systems play a strong role in community care. If feasible and appropriate, collaborate and share information with traditional healers and other traditional groups. Religious leaders can also be a source of help and comfort during an outbreak.

In some outbreaks, such as Ebola or Covid-19^a, teams are exposed to many stressors. Psychological support for staff (preventative and curative) by the MSF psychosocial support unit needs to be considered.

In certain outbreaks, such as during the Covid-19 pandemic, part of the MHPSS response may be provided remotely.

^a Coronavirus disease (COVID-19) pandemic.

6.6.2 Minimum package

Table 6.1 - Minimum package for outbreaks (can be implemented by medical and paramedical team members)

MHPSS minimum package (integrated)		
Expected Result	Activities	Who?
To reduce mental disorders and psychosocial problems among the population exposed to outbreaks	<ul style="list-style-type: none"> • PFA for patients with acute reactions. • Psychoeducation by health staff to inform patients and relatives about common MH reactions associated with the disease, promote positive coping and to help them come to terms with their diagnosis and the treatment. • Humanize care by ensuring it is delivered to the patient and family through improvement of the environment and atmosphere of the treatment facility. • Identify common mental disorders and psychosocial problems in health services (outpatient department, inpatient department, etc.). • Advocate for provision of basic needs within MSF and other agencies. 	Trained: general practitioners (GPs), clinical officers (COs), nurses, community HCWs, health promotion (HP) staff
	<ul style="list-style-type: none"> • Identification and management of SMDs/symptoms. 	Trained: Nurses, GPs, COs trained in mhGAP

6.6.3 Comprehensive package

In addition to the activities described in the minimum package:

Table 6.2 - Comprehensive package for outbreaks

Activities	For whom	Who
At health facility level		
Individual/family counselling/psychological care	For patients and relatives Also consider the needs of staff.	Trained counsellors, psychologists, psychiatrists
Psychosocial support groups for specific populations	<ul style="list-style-type: none"> • Orphans/children, widows, discharged patients, relatives of patients, staff involved in the outbreak, people in isolation, care-homes. 	Trained community mental health workers, social workers, counsellors, psychologists, psychiatrists

Activities	For whom	Who
Psychiatric care (including psychotropic medications)	<ul style="list-style-type: none"> Identify and treat SMDs (moderate-severe depression, psychosis, etc.)^{b,4}. 	Trained nurses, GPs, COs etc. trained in mhGAP
At community level		
Collaboration with HP and outreach teams	<ul style="list-style-type: none"> Support HP and outreach teams to ensure they can handle/mitigate strong reactions in families, neighbours and communities (training in communication skills, PFA, co-facilitation of groups when needed, etc.). Community engagement and mobilization (including representatives, leaders, etc.) when needed, in collaboration with HP (to facilitate the reintegration of survivors in their family, etc.). 	Trained HP team, support by MHPSS team if required
Individual/family counselling/psychological care	<ul style="list-style-type: none"> Psychological care from diagnosis to discharge. Follow-up of discharged patients and relatives in their communities. Follow-up of families experiencing complicated grief or multiple losses in the family. 	Trained counsellors, psychologists, psychiatrists
Group psychoeducation and other community based psychosocial activities	<ul style="list-style-type: none"> Inform the population about common mental disorders and psychosocial problems that can arise during and after the outbreak and how to cope. Promote mutual support/peer group support among affected groups (relatives, discharged patients, mourning). 	Trained community health workers, community mental health workers, social workers, counsellors, psychologists, psychiatrists
Collaboration with burial and environmental decontamination teams	<ul style="list-style-type: none"> Explain special procedures and provide support in arranging burials, ensure families are involved in the preparations. Offer supportive presence during funerals. Offer emotional support to families if needed during the mourning process (if so refer to counselling team). 	Trained community health workers, community MH workers, social workers, counsellors, psychologists, psychiatrists

^b According to WHO mhGap Intervention Guideline v.2.0.

6.7 Special considerations for children and adolescents

Children and adolescents are particularly vulnerable during outbreaks. A disease outbreak may disrupt their familiar world, affecting the people, places and routines that make them feel secure. Children may lose parents or main caregivers. They may be separated from these adults during their hospitalization or that of their caregivers. Like adults, they may be affected by stigma. Symptoms in children vary depending on their developmental age (see [Appendix 1](#)).

Information about the disease must be provided to the child/adolescent. How to communicate with the child/adolescent will depend on their developmental stage and the cultural context.

General principles when communicating with children/adolescents:

- Be honest and do not lie to children/adolescents. It is important to provide them with truthful information using age appropriate descriptions and give them the chance to express their feelings and worries.
- Put the child at ease by talking about non-threatening subjects and things they like to talk about (hobbies, what they learn at school, etc.).
- Be nurturing, supportive, and respectful. Reassure the child.
- Depending on their developmental stage, children have a different understanding of health and death:
 - Children aged 3 to 4 years: knowledge about illness is limited to where and when it hurts (symptoms). Imagination can be worse than reality (i.e. “They give me medicine to punish me”).
 - Children aged 5 to 6 years, children can link contagion (person, event or object) and illness; they cannot understand the permanence of death: they perceive it as a temporary and not definitive separation (“If I think hard enough about her, she’ll come back”); they might think they are responsible for the death of others (“My mummy died because I was naughty”).
 - Children aged 7 to 12 years: they are able to understand the disease they have and begin to understand death as part of life; can think by analogy (“The heart is a pump”/“The stomach is a cupboard with food”).
 - Adolescents aged >12 years: understand death at the same level as adults, have an opinion, may be resistant to expressing feelings and can engage in risky and impulsive activities.
- When communicating with children, use simple language, give information adapted to their understanding, and use communication tools other than language (dolls, drawing, stories, play, etc.).
- When working with children it is crucial to include parents, caregivers (if possible).
- Take children seriously and treat their thoughts, beliefs and opinions with respect.
- Allow the child to express feelings of anger. Give the child ways to communicate their feelings and concerns. Put common feelings of children into words such as anger, sadness, worry, etc.

For the non-hospitalized child:

- Educate families on the importance of maintaining a routine despite disrupted community life and possible closure of schools.
- If the caregiver is hospitalized, educate families on reactions to separation from the caregiver and how to support the child.

For the hospitalized child:

- Encourage communication and activities appropriate to the child’s developmental stage.
- In the ward, make the environment as friendly as possible ensuring compliance with infection prevention and control guidelines (easily disinfected toys, white boards for drawing, knitting needles, crayons, radios, televisions or video projectors can be considered). Special attention should be considered in contexts where due to infection control constraints, items cannot be shared and/or patients should not be encouraged to form groups.
- If the child is hospitalized without their caregiver, ensure they receive enough support from the medical staff and, or perhaps from an adult hospitalized patient capable of supporting the child. Support can include reassurance, help with daily care and stimulating activities when possible (crayons, books, small toys, music, television, etc.).
- Advise families and relevant clinical team members how to calm and distract children during medical procedures.
- Consider that hospitalized children may be frightened by staff wearing personal protective equipment (e.g. as experienced in filovirus disease outbreaks).
- Encourage communication between child/caregiver via phone, notes, drawings, etc. when separated.

When the child is discharged:

- Organize support groups for ambulatory paediatric patients. Structured activities can help them overcome their current difficulties (songs, games, fairy tales, etc.).
- After the outbreak encourage and support affected children’s reintegration back into the community and return to usual activities.
- Care for a child whose caregiver has died. Educate the new caregiver to understand the child’s reaction to loss, how to support the child in their grieving. Promote attachment between the child and new caregiver.
- In case of children/minors without any known caregivers, contact organizations that can do family tracing and/or provide shelter and/or protection. If these agencies do not exist, ensure follow up in the community. Advocate for support from other organizations.

6.8 Special considerations for older people

Older people can be particularly vulnerable to mental disorders and psychosocial problems during certain outbreaks, as seen for example in COVID-19. Those living in care homes face different challenges to older people living with their families.

An estimated 30% of residents in care homes have symptoms of depression or anxiety. If dementia is also considered, up to 80% of older people living in care homes suffer from a mental or neurological diagnosable disorder. Social activities such as walking, and gardening can improve their quality of life⁵.

MSF implemented various activities in care homes in response to COVID-19 including: training staff (PFA, communication skills, self-care), reinforcing daily family contact, ensuring social activities to prevent isolation, psychological support for those in need⁶. These principles can be applied to other contexts.

6.9 Monitoring

Routine activity monitoring is described in [Section 2.7](#), Chapter 2. Monitoring during outbreaks should include some of the indicators listed in that chapter. During outbreaks, additional monitoring could include:

- Patients' competencies and knowledge regarding their medical condition, and overall sense of control over their situation. For ways of measuring this, see MSF Guideline on Patient Support, Education and Counselling Guideline for adults living with HIV and/or TB (PSEC Guidelines⁷).
- Adherence to medical treatments and compliance and/or infection control procedures and self-care measures.
- Degree of return to daily activities and routine when possible.

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Chapter 7: Migrant, refugees and displaced populations

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7.1 Introduction

While there is no formal legal definition of a migrant, most experts agree^a that an international migrant is someone who is moving or has moved across an international border or within a State away from his/her habitual place of residence, and his/her children, regardless of: (1) a person's legal status; (2) whether the movement is voluntarily or involuntarily; (3) what the causes for the movement are; or (4) what the length of the stay is (people who change their usual residence for < 3 months for reasons of recreation, business, medical treatment or religious pilgrimage are not considered migrants)¹. Migrants can be regrouped into numerous sub-categories (see [Appendix 7](#) for specific terminology used by MSF, some of which have legal implications under international humanitarian law).

This chapter focuses on “forced migration”, migratory movement in which an element of coercion exists, including threats to life and livelihood, whether arising from natural or man-made causes (movements of refugees and internally displaced persons, people displaced by natural or environmental disasters, famine, for political reasons etc.).

For people experiencing forced migration, the accumulation of past trauma in the country of origin and along the journey together with the difficulties experienced in host countries means that mental health and psychosocial support (MHPSS) is an essential part of care.

^a Overview of international migration definitions (revised February 2020). Forced Migration Team – Analysis Department, MSF - Operational Centre Brussels.

7.2 Risk factors for mental disorders and psychosocial problems

Risk factors for mental disorders that may be experienced before migration, during the migration journey and/or after resettlement in the host country² include:

Pre-migration risk factors

In their countries of origin, migrants (especially refugees and asylum seekers) may have experienced:

- Persecution (for political, ethnic, religious or other reasons) involving torture, imprisonment, witnessing the death of family members and/or violations of human rights.
- Armed conflict, ranging from witnessing destruction and death at close quarters to multiple traumatic experiences including torture and involvement in direct combat.
- Extreme economic hardship, including lack of access to food, water, shelter, healthcare, education and other basic needs and resources.

Migration journey risk factors

The journey can take months to years, often transiting several countries. The lack of legal and safe channels to migrate or apply for asylum (closure of borders, detention, state corruption, powerful smuggling networks, etc.) often forces people to take dangerous migration routes to reach protection and a better life. They are commonly exposed to:

- Life-threatening conditions while crossing seas in unsafe boats, being locked in trains or trucks or travelling on foot across unsafe land routes.
- Violence including sexual violence, extortion, labour exploitation, human trafficking, kidnapping and torture.
- Substandard living conditions and/or detention.

Many migrants report a loss of dignity and may be separated from family members, communities and networks.

Some communities and individuals take annual or routine migrant journeys for specific cultural or occupational reasons (e.g. moving for seasonal work). They can get caught up and sometimes detained as a result of context changes such as wars, conflicts or changes in laws.

Post-migration risk factors

Once resettled in the host country, migrants may encounter other risk factors that can provoke psychological suffering and/or exacerbate pre-existing mental disorders:

- Uncertainty about the asylum application: legal admission to a host country is often a long, complex and unpredictable process, with often restricted access to legal assistance and interpreters;
- Detention associated with asylum application;
- Difficulty with social integration (exclusion, difficulty to make friends due to language barrier, etc.) and poor socioeconomic conditions (lack or limited access to basic needs, including healthcare and appropriate accommodation; social isolation and unemployment)³;
- Uncertainty about the future (fear of repatriation and persecution);
- Changes in social or family roles;
- Acculturation-related challenges.

Barriers for accessing healthcare (including MHPSS) include³:

- Lack of knowledge of legal entitlements and the healthcare system in the host country;
- Lack of trust towards services and authorities in the host country;
- Poor command of host country language;
- Cultural expectations toward healthcare professionals and beliefs about mental health (MH).

When travelling, migrants are often in “emergency mode” where all their functioning is focused on reaching the destination country. When they arrive at destination and no longer feel in danger, they commonly start to process past trauma that happened in their country of origin and/or during their journey. This can lead to the development of psychological suffering and mental disorders and ‘uncertainty regarding their future’. Recent literature suggests that specific migrant populations can present a higher risk of suicidal behavior than host populations, as well as a higher risk of death by suicide⁴.

7.3 Clinical characteristics

Migration-related mental disorders and psychosocial problems include:

- Normal reactions to traumatic events;
- Exacerbations of pre-existing mental disorders;
- Reactions and disorders triggered by conflict-related violence and displacement or related to adjustment in a host country.

Common MHPS problems among migrants and refugees include:

- Hopelessness, demoralization, anxiety/depression related disorders
- Anger and aggressive behaviour
- Boredom and lethargy
- Lack of trust
- Eating and sleeping problems
- Worries, fear for the future
- Loss and grief; sometimes complicated grief
- Alcohol and substance abuse
- Loss of dignity related to frustration of being dependent on humanitarian help

Administrative procedures encountered by migrants may contribute to high levels of mental disorders⁵. They often have comorbid somatic and psychiatric conditions in addition to post-migration living difficulties. Detention has adverse effects on MH, with higher scores of anxiety, depression, and post-traumatic stress disorder than those not detained⁶. The longer the length of time held in detention, the greater the MH deterioration⁷ is. The most common diagnoses include post-traumatic stress disorder (PTSD)^{a,8,9}, anxiety, depression and suicidal ideation. A recent meta-analysis of non-affective psychosis in refugees' populations in Canada, Denmark, Sweden and Norway suggests that there is an increased risk of non-affective psychosis compared to the host population¹⁰.

a Refugees are about 10 times more likely than the age-matched general population to suffer from PTSD.

7.4 Clinical assessment

For the general approach to clinical assessment of patients see [Chapter 3](#). In addition to this approach the following should be considered with this specific population:

Exposure to traumatic events

- Of the migrant (before and during migration)
- Attention to violence/sexual violence

Beneficiaries' perspectives on the mental health and psychosocial consequences of displacement and their coping mechanisms:

- Health seeking behaviour, health beliefs, cultural perceptions, opinions, and suggestions, etc.
- Ways of expressing emotional distress and vocabulary used
- Individual psychosocial self-help (coping) mechanisms
- Sources of relief and support in the community

Level of disruption of family and community network

- How much has migration changed familiar roles and dynamics?

Screening tools that can be used to assess individuals ([Appendix 3](#)) including Refugee health screening (RHS) 15. When introducing a screening tool, always check it is culturally acceptable and validated by the migrant population before use. If it has not been validated in the population the results should be interpreted with considerable caution.

7.5 MHPSS assessment

For the general approach to MHPSS assessment, see [Chapter 1](#). There are some specificities regarding the assessment of resources and services for migrants:

General context:

- Assess the stage of migration the patient is in, including what their migration route has been, how long have they been here, if they plan to stay and their legal status.
- Attempt to understand the socio-political context of the patient's home country.
- Determine their economic situation/living conditions (accommodation, access to food, protection, etc.). As migrants, do they access services and which ones (healthcare, social assistance, provision of legal aid, access to work/education...), including whether they feel comfortable and safe to access these services. It is also helpful to understand what medical and/or MH conditions (and how many cases) are seen in primary health services accessed by migrants.
- Amongst the migrants for whom you are providing services, it is helpful to understand which the main nationalities present and which languages are spoken by them.

Vulnerable subgroups

- Identify whether or not there are particularly vulnerable sub-populations that need to be considered when assessing the context, for example; unaccompanied minors, people with medical or MH conditions, pregnant women, victims of torture/ill treatment or sexual violence, lone mothers, etc.

Setting and other actors

If the MHPSS activity is to be implemented in a camp setting (internally displaced peoples or refugee camp) and MSF is the only actor providing MHPSS care, a comprehensive package should be implemented. Depending on the population of the camp, a psychiatrist may be required as part of the MHPSS team.

7.6 MHPSS activity planning

Migrants' needs are diverse and complex. Often basic needs (including protection, legal rights, access to healthcare, etc.) are not met. A holistic/multi-disciplinary approach (including medical, MHPSS, social, legal support) is required. The intervention is highly dependent on the context.

Medical-legal support and considerations (medical certificates of violence, sexual violence, MH, etc.)^a are essential as certain clinical documents may impact present/future asylum procedures, favour access to social assistance, recognition as vulnerable by UNHCR^b, etc.

The terminology and definitions used for both the context and setting of migration activity need to be specific. The terminology used must be validated by the coordination team. See [Appendix 7](#) for the definition of terms – including in migrant contexts 'Transit' 'Destination' and 'Return', and concerning migration activity settings 'Formal', 'Closed', 'Urban/Informal' and 'Integrated'.

7.6.1 Short transit (hours to a few days)

Migrants in short transit settings are usually in “emergency mode”. Their entire functioning aims to continue the journey. The context and their emotional state do not allow the processing of experiences, losses and changes.

Objectives of MHPSS activities in this setting are to:

- Restore dignity;
- Support/increase coping skills;
- Provide psychological support;
- Detect and treat people with severe mental disorders.



To “open” traumas via a psychotherapeutic approach can be harmful at this stage of migration. It may exacerbate underlying psychological suffering or increase symptoms that cannot be treated in such a short time.

Do not carry out surveys, questionnaires and screening tools linked with past traumatic events at this stage.

Minimum Package:

- Psychological first aid (PFA), including provision of practical information and referral to socio-legal assistance;
- Psycho education (effects of stress/trauma and recommended coping mechanisms, information on care available in the destination country, advice on how to alleviate children's stress, etc.);
- Care of people with acute and severe mental disorders;
- Referral to specialised medical or MH care if necessary and available.
- Advocacy.

^a The delivery of MH certificates (systematic versus on request/for some specific subgroups) will vary depending on the project. MSF's legal department can help analyze the legal framework and provide guidance on the purpose and content of certificates.

^b UNHCR: United Nations High Commissioner for Refugees

Comprehensive package:

- Single shot MH consultations (specific clinical intervention when there are limitations linked to organizational, contextual or individual factors making it impossible or improbable to establish a multi-session strategy).
- Continuation of treatment of previously diagnosed chronic conditions such as epilepsy, serious mental disorders, or any other chronic diseases such as diabetes or hypertension.
- Long term psychotropic medication should be initiated with caution. Ensure the person can adhere to the treatment during their journey and ensure at least three months' supply.
- Additional activities include detection and management of people at risk of severe mental disorders because of a serious traumatic event (e.g. sexual violence, torture/ill-treatment, see [Chapter 9](#) and [Chapter 10](#)).
- Issue MH certificates if needed and if approved by the operational hierarchy and legal department.
- Referral to specialised medical or MH care if necessary and available.

7.6.2 Long transit (weeks up to months/years) and destination countries

Short/long term counselling or psychotherapy is implemented for migrants presenting signs of psychosocial problems or mental disorders. Challenges for a migrant in this situation may include:

- Finding information on care available.
- Seeking and accessing care for the experience of grief and losses.
- Processing stressful/traumatic situations (multiple, chronic, intense, significant stress, absence of locus of control).
- Acculturative stress (linked to adjusting to new culture).
- Building a new identity (“sense of self”).

Interventions are adjusted to the specific population, vulnerable groups, length of stay, identified needs, etc. A social worker should work together with the MHPSS team in order to assess and provide social care and support, including making links and referrals to other organisations.

Minimum package for long transit migrants

Activities include:

- PFA
- Psychoeducation
- Provision of information about services and available support, socio-legal assistance.
- Psychosocial support activities: initiating cultural and recreational activities as wellbeing catalysts to help reinstate social bonds and promote integration in the host society.
- Detection and treatment of people with acute and severe mental disorders.
- Referral to other appropriate actors (for housing, provision of basic needs, administrative and legal support, access to care, access to family tracing, referral to protection actors for unaccompanied minors, etc.).

Comprehensive package for long transit migrants

Activities include standard minimum package interventions such as PFA and psychoeducation as well as:

- Detection and treatment of severe mental disorders, mapping of the possibility of hospitalization in psychiatric facilities (preferably a psychiatric unit in a general hospital).

- Short/long term counselling or psychotherapy in individual, family and group settings as needed focusing on:
 - Creating basic trust and feelings of safety;
 - Restoring coherence in life history;
 - Regain self-control (over body, emotions, thoughts, environment, etc.);
 - Developing coping mechanisms;
 - Supporting the elaboration of trauma(s), grieving processes and the difficulties of acculturation;
 - Working on the family structure (family sessions, parenting skills, etc.).
- Psychosocial activities including interventions which strengthen family support and parenting skills interventions.
- Provision of MH certificates as needed, help with legal procedures, depending on their stage in the asylum process/ legal status (See [Section 2.10](#), Chapter 2).

The involvement of the host community, civil society and diaspora may be key to the effectiveness of the community-based interventions implemented. Ensure multi-disciplinary meetings.

7.7 Specificities/challenges and corresponding recommendations in detention settings

Rates of mental disorders amongst populations held in detention are substantially higher than those in community settings and often linked with the detention itself. The provision of psychiatric care or a referral system to existing psychiatric professionals/psychiatric facilities is often required.

Challenges for patients may include confinement, isolation, lack of freedom, unmet basic needs, perceptions of being arbitrarily punished, uncertainty about the future, fear of being deported, loss of hope, etc. Suicide and self-harm may also be higher. Children in particular show evidence of severe impairment when in detention.

Restoring people's ability to make their own choices seems difficult, if not impossible, in a detention setting where people are deprived of their freedom. The role of the psychologist or counsellor to help them adjust and tolerate detention conditions is paradoxical. Staff may experience the ethical dilemma related to the possibility of MSF (or themselves individually) being perceived as being complicit with or 'supporting the system'¹¹. Advocacy, either public or through diplomatic means, can sometimes be considered, however this is the responsibility of the field coordination team (project coordinator, head of mission) after discussion with MSF headquarters. It is the responsibility of the mental health activities manager (or medical manager if there is no mental health activities manager) to document and communicate the situation to the project coordinator and coordination team. If appropriate MSF may consider alerting and/or referring cases to other organizations such as ICRC^a, IOM^b or other relevant actors.

It may be difficult to set up a counselling room for private sessions and to request staff have free access to detainees. Specific agreements on access and security issues with authorities, with clear definitions of terms of collaboration (working spaces for consultation, etc.) and some degree of independent functioning in the detention facility may be a "pre requirement".

When migrants report incidents of verbal and/or physical violence by authorities (or representatives of authorities), protection and safety is not ensured. The role of MSF concerning the report of these violations is not easy. Consider alerting and/or referring cases to other organizations such as UNHCR.

MH clinical files or MH certificates usually contain sensitive information: handle their content, transport and storage with great caution. For more information see [Section 2.10](#), Chapter 2. In these contexts, ensure that the project has a clear procedure for file management that is validated by the coordination team, the MH advisor and the legal department.

See [Chapter 10](#) for more information on working with victims of torture.

a ICRC: International Committee of the Red Cross

b IOM: International Organization for Migration

7.8 Specificities/challenges and corresponding recommendations for working with victims of human trafficking

All activities dealing with victims of human trafficking require supervision by a therapeutically experienced clinical psychologist or equivalent professional. Since this is a highly sensitive issue, protection measures should always be taken by informing the project coordinator about the situation and agree on what protection measures should be taken.

7.8.1 Therapeutic objectives for working with trafficking survivors

This includes:

- Restore the individual's perception of safety.
- Restore interpersonal relationships and connection to others.
- Refer for appropriate medical care.
- Refer to a specialized organization working in protection.

7.8.2 Therapeutic objectives for working with people in continued trafficking situations

When working with victims of human trafficking who are still in a situation of trafficking, the extent of individual work that can be accomplished with the victim will depend on the starting point related to the consciousness of their situation, their expectations, the limits they have established and will not cross (if any) and their general MH state.

There are several limitations faced when working with patients in these conditions, impacting the therapeutic outcome. If these patients are encountered during MSF activities, the response can include:

- Ensure confidentiality.
- Strengthen coping mechanisms.
- Refer for appropriate medical care.
- Refer to a specialized organization working in protection.

7.9 Special considerations for children and adolescents

Caring for migrant children and adolescents requires:

- An understanding of the complex ways in which their past/current experience(s) has harmed them.
- Tailoring services to meet the needs of each age group and in ways appropriate to their age and characteristics.
- Implementing strategies aimed at mitigating the effects of past trauma/current difficulties and fostering healthier patterns of development.

Frequent relocations between asylum seeker centres are associated with mental disorders in children¹². Mothers often report:

- Changes in their child's behaviour.
- Their child has difficulty controlling his/her reactions.
- Inability to show affection¹³.

Many will spend their entire childhoods away from home, sometimes separated from their families. Before and during migration, children/adolescents face greater risks to their psychological development: they commonly experience fear or anxiety, they may have witnessed or experienced violent acts and can be at risk of abuse, neglect, violence, exploitation, trafficking. They are affected not only by what happens to them, but by what they are deprived of, for example missing out on developmental essentials such as play and school. Migrant children may also be indirectly affected through the impact of their parent/caregiver's mental disorders and psychosocial problems on their care and the development of parent/caregiver-child relationships. Children and adolescents are also at risk of developing mental disorders associated with the re-settlement period (with the most common symptoms including post-traumatic symptoms, depression, anxiety and externalizing behaviours)¹⁴.

Possible MHPSS activities that can benefit children/adolescent migrants by helping the family include:

- Family tracing through referral organizations if close relatives are missing: an absent parent means less protection and care, less income generated, etc. Anxiety or grief over the absent relative adds to the overall stress on the family.
- Psychosocial support activities: activities that promote family support such as parenting skills interventions, with the priority of helping parents and other childcare-givers meet the emotional and developmental needs of their children. Activities should recognize the parents' own needs and pay particular attention to single parents.
- Identify and manage the MHPSS needs of parents, in particular parents with a severe mental disorder (psychosis, severe PTSD, severe depression etc.).
- Parental support network (groups of mothers, etc.) can be organized to assist each other in child-care, and these networks can be used to teach parental skills.

Specificities for unaccompanied minors (UAMs)

The migration experience means loss of the familiar (the person's usual daily life activities, home, language, social network, etc.) without the support of a family/community. UAMs are at high risk of exposure to traumatic events, physical and sexual abuse or any other type of abuse/exploitation. They experience issues associated with separation, neglect, and the impact on attachment, particularly at younger ages. Research shows greater psychiatric morbidity

compared to the general population¹⁵. Difficulties often persist over time if there is a lack of adequate support. UAMs are likely to have a more complex presentation of post traumatic symptoms that can include difficulty regulating emotions and behaviours, substance abuse, self-injury, etc. UAMs are very often adolescent – adding another specific consideration to ensure that any needs assessment carried out considers their perspective and developmental stage and social background.

Needs and resources assessment should be carried out and will vary depending on context, ethnic groups, stage of migration (see [Chapter 1](#)). It is crucial to simultaneously consider including assessment of access to safe shelter and medical care since these are significant and urgent protection needs.

Activities to be implemented include:

- The care package required for UAMs is similar to that described in [Section 2.4](#), Chapter 2, however, specific adaptations may be required e.g. friendly adolescent activities, dedicated facilities for UAM MHPSS activities.
- Professionals must be trained to recognise and provide for their specific needs.
- Peer support can have significant impact, particularly if the peers identified are appropriate for the developmental stages of the UAMs being cared for.
- Protection and legal aspects (often complex legal situation, e.g. regarding determination of age).
- Assess psychiatric care needs: often high prevalence of mental disorders.

7.10 Monitoring

Routine activity monitoring is described in [Section 2.7](#), Chapter 2. Monitoring should include the indicators listed in that chapter.

It is challenging to measure the impact of an intervention in a transit situation (temporary intervention). A measure of the patient's experience through a satisfaction survey can be set up (questionnaire, focus group discussions, etc.) to understand how services are perceived by migrants.

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Chapter 8: Sexual and reproductive health

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8.1 Introduction

There are specific mental disorders and psychosocial problems associated with sexual and reproductive health (SRH) conditions like unwanted pregnancies, stillbirths, infant deaths, any pregnancy related complication (including obstetric fistula), adolescent pregnancies, etc. Furthermore, there are specific mental disorders that are related to pregnancy and delivery, such as perinatal depression and post-partum psychosis. These disorders and problems impact the well-being of the woman, as well as the health and development of her infant, her family and the community.

About 20% of mothers in low- and middle-income countries and around 10% in high income countries suffer from a mental disorder after childbirth.¹

8.2 Risk factors for mental disorders and psychosocial problems

As well as the risk factors listed in [Section 5.2](#), Chapter 5 the presence of additional SRH conditions increases a woman's vulnerability to developing a disorder.

These include:

- Unwanted pregnancy
- Abortion (unsafe abortion and miscarriage) and abortion related complications
- Sexually transmitted infections (including HIV^a)
- Infertility and pregnancy complications
- Stillbirth and neonatal death^b
- Fistula, vaginal/perineal/anal injury, and incontinence
- Constraints in taking reproductive health related decisions.
- Preterm birth and adolescent pregnancy are conditions associated with increased risk of postpartum depression^{2,3}.
- Exposure to violence including physical violence, sexual violence, intimate partner violence and psychological violence puts women at greater risk of mental disorders and psychosocial problems. Past childhood abuse (adverse childhood experiences) increases risk of postpartum psychiatric illness with an observed dose-response effect⁴.

Social and economic risk factors include all those mentioned in the introductory chapter, but additional specific factors include:

- Unsupportive partner
- Sole responsibility for childcare or care of dependent family/household
- Unmarried, divorced, widowed
- Life circumstances and cultural stressors such as power inequalities, or work overload (outside and inside the house).

a HIV: human immunodeficiency virus

b Neonates who die in the first four weeks of life, usually during the first week (early neonatal deaths).

8.3 Clinical characteristics

A review of studies in high income countries shows prevalence rates of depression (major and minor) to be 11% during pregnancy and 18% during the first 3 months after delivery. Common perinatal mental disorders (including depression) are more prevalent in low- and lower-middle-income countries, particularly among poorer women with gender-based risks or a psychiatric history⁵. In some cases, they may present with severe symptoms including suicidal ideation, aggressive behaviour or behaviour that is harmful to the infant. As a result, the child's growth and development may be compromised.

During pregnancy

Individual and pregnancy related factors contribute to perceived stress in pregnant women. Anxiety and depression during pregnancy can be harmful to the foetus, resulting in preterm births or low birthweight neonates, as well as increased risk of child emotional problems and increased risk of clinical depression in the child's adolescent years⁶.

During the post-partum period

Becoming a mother places great demands on individual psychological resources and existing relationships. Early diagnosis and treatment interventions are imperative for the health and well-being of the mother and child.

- **Post-partum 'blues'**: common symptoms are labile mood, heightened sensitivity, tearfulness, anxiety and irritability. The blues occur between three- and five-days post-partum and usually resolves within a couple of weeks.
- **Post-partum depression**: more intense than post-partum blues, symptoms are generally the same as those associated with major depression, including depressed mood, anhedonia and low energy with additional anxiety symptoms being frequent. Thoughts of harming herself or the neonate/infant are common. The mother often expresses persistent doubts and excessive worries about her ability to care for her new neonate/infant and/or trouble bonding with the infant. Postpartum depression usually begins within 1 to 12 months after delivery. This condition, while frequent, is under diagnosed. Hence, training medical staff on early identification is essential. Screening tools to identify perinatal depression, such as the Edinburgh Postnatal Depression Screen (EPDS) can be used in some contexts (see [Appendix 3](#)). Be cautious when using non-English versions of EPDS. It seems the translation, cultural adaptation and validation processes of non-English versions of the EPDS used in low-and middle-income countries are often not very reliable⁷.

In some women, symptoms that appear to be post-partum 'blues' can continue and become more severe. In others, a period of wellbeing after delivery is followed by a gradual onset of depression. Untreated post-partum depression can have adverse long-term effects. For the mother, the episode can be the precursor of chronic or recurrent depression. For her children, a mother's on-going depression can contribute to emotional, behavioural, cognitive and interpersonal problems in the child's later life with increased risk of malnutrition and other medical problems.

- **Post-partum psychosis**: this is a medical emergency and the most severe of perinatal mental health disorders (rates of 1-2/1000 deliveries)⁸. Symptoms range in intensity and typically include depressed or elated mood (which can fluctuate rapidly), disorganized behaviour,

delusions and hallucinations. There is significantly increased risk of suicide and infanticide. Onset is rapid, with symptoms presenting as early as 48 to 72 hours post-partum. Most episodes develop within the first 2 weeks after delivery.

Perinatal mortality and subsequent depression

After the death of a baby, acknowledge the family's need to grieve for their infant. In these situations, parents have an increased incidence of depressive symptoms, guilt, prolonged grieving and feelings of loss of control. Women who experience a stillbirth or a neonatal death are 7-9 times more likely⁹ to suffer from depression than a woman with a live infant. Social consequences include isolation from friends, family and social networks, leaving them more emotionally vulnerable.

8.4 MHPSS^a assessment

Consider what SRH activities are already implemented.

Collect and analyse information on the current context and its links with mental disorders and psychosocial problems experienced in the target population (see [Chapter 1](#)). Collect information about cultural practices and beliefs, including rituals, marriage, pregnancy, birth, death, mourning, education, parenthood, family structure, emotional expression, verbal and non-verbal communication, etc.

In collaboration with the medical staff, define the implementation of an MHPSS activity component in an SRH program according to needs and including referral criteria between departments. Gather information:

- Participate in multidisciplinary meetings.
- Identify current patient flows.
- Observe maternity rounds.
- Identify counselling knowledge levels and experiences of midwives and nurses.

^a MHPSS : mental health and psychosocial support

8.5 MHPSS activity planning

MHPSS activities for women, mothers, neonates, fathers, families and/or support systems should be integrated in SRH programs.

Specific activities focus on:

- Mental health (MH) of the mother: treatment for depression, treatment of post-partum psychosis and treatment of other mental disorders/psychosocial problems.
- Mother-infant interaction: interventions to promote positive mother-infant interaction.
- Father and other family members: psychoeducation on how to support the mother and provision of infant care, counselling for any concerns or distress with special attention to the father.

The effectiveness of the activity improves when involving, as much as possible, the social environment (father, extended family, cooperation of traditional birth attendants and community leaders, etc.). All interventions must consider the context and culture of beneficiaries. Main points to consider:

- All health professionals in perinatal, maternal and infant services should be able to recognize the symptoms of mental disorders (with special focus on postpartum depression and postpartum psychosis) and to provide psychological first aid (PFA).
- Ensure patient's basic needs and quality support systems.
- Good collaboration in a multidisciplinary team (medical and MHPSS) is essential.

Particularly vulnerable women who should always receive an MH assessment, including those who:

- Exhibit mental distress or mental disorder.
- Gave birth to a preterm infant who is sick or requires palliative care.
- Experience the death of a foetus or neonate.
- Victims of violence (harassment, abuse, rape, human trafficking etc.).

8.5.1 MHPSS activities during pre and post-natal care

Psychosocial stimulation

Neonates need and benefit from positive interactions with a loving caregiver (usually the mother) who looks at, talks to, touches and holds her infant beginning at birth.

MHPSS teams, midwives and nurses need to be aware that when interactions are absent an intervention promoting positive interactions between mother (and father) and infant is necessary.

Keep in mind:

- Sick or preterm neonates tolerate a lower level of interaction, but still require and benefit from an appropriate level of stimulation.
- Mothers are often frightened of holding a small preterm neonate. They may require guidance to feel comfortable interacting with their infant.
- Fathers frequently feel they are not needed or necessary. They may require support and encouragement to interact with their infant when culturally appropriate.

- Neonates give signals of responding to a mother's attention with eye contact, calming and adapting to her body when held. Point this out to a mother as an affirmation of her care.
- Neonates give signals when stimulation has reached a maximum threshold with crying, gaze aversion, hiccups and, for preterm infants, signs of respiratory distress. Educate mothers in these signs and in the infant's needs.
- Establishing breastfeeding (crucial for adequate growth in preterm, sick and healthy neonates) depends greatly on a positive mother-infant interaction.

Parent-newborn counselling

Counselling for a depressed mother/parent/caregiver helps them understand potential difficulties and find solutions. The parent and infant are consulted together. Counsellors point out the newborn's signals for interaction and guide the parent on how to respond to their infant.

- Observe the attachment behaviour in the mother/neonate interaction. Facilitate interaction between them, ensuring their basic needs are fulfilled (food, breastfeeding, safety, warmth, affection and stimulation).
- Encourage parents to identify and respond to their infant's needs. This is a time of bonding, developing trust and getting to know one another.
- Identify mothers' difficulties in providing effective care and sensitively respond to their infants. Facilitate socioemotional connectedness with appropriate stimulation and care practices adapted to the cultural context (skin-to-skin contact, gentle massage moves, eye contact, verbal/non-verbal communication, etc.).
- Encourage interaction between women in the wards (if in-patient intervention).
- Refer to family and support networks, as needed.

Post-partum blues

Educate the mother and family of this common reaction in women's experience while adjusting to having given birth and now caring for an infant. Fluctuating hormonal levels contribute to blues. Family support is helpful and curative. Offer counselling if the condition persists or intensifies.

Post-partum depression

- Counselling and other psychosocial interventions¹⁰.
- Ensure care and protection of the neonate. Mothers should continue to breastfeed and participate in the infant's care unless assessed to be dangerous to the infant.
- In case of severe depression, refer to a psychiatrist or trained professional for pharmacological treatment. Breastfeeding is NOT contraindicated if the mother is treated with a selective serotonin reuptake inhibitor anti-depressant.

Post-partum psychosis

- First line treatment is antipsychotic medication. Breastfeeding is NOT contraindicated if antipsychotic medication is prescribed in appropriate dosages.
- Provide psychoeducation for the father and family about the disorder and how to best support the mother while hospitalized and at home.
- Ensure care and protection of the neonate. Supervise the mother while breastfeeding and caring for her infant. During the first days never leave the mother alone with her infant.
- Provide counselling for the mother when she can engage in the counselling process.
- After remission of the episode, provide psychoeducation to the mother about the risk of recurrence in future pregnancies. This risk is higher when there has been a previous puerperal psychosis and also if there is previous personal or family history of bipolar disorder¹¹.

8.5.2 Safe abortion care (SAC)

When a woman is determined to end her pregnancy, she will seek out an abortion regardless of the safety and legality of the procedure. When safe abortion is not available, she will risk her life to terminate the pregnancy. Unsafe abortion is one of the major causes of preventable maternal death.

Access to SAC remains a priority within contexts in which MSF works to reduce maternal mortality and prevent the consequences of unsafe abortion.

Safe abortion does not cause MH problems

Women/girls choosing a safe abortion method have normal reactions such as stress, sadness, grief, feeling guilty, shame, fear of being negatively judged and the wish to keep it secret. They also have feelings such as relief and are grateful for the safe abortion¹². They may experience a sense of empowerment because they feel in control of themselves, their bodies and their lives.

A comprehensive review of scientific literature conducted in 2008 found that “the highest-quality research available does not support the hypothesis that abortion leads to long-term MH problems. Lingering post-abortion feelings of sadness, guilt, regret, and depression appear to occur in only a minority of women” and evidence also suggests that teenagers who have abortions are no more likely to become depressed or have low self-esteem than their peers whose pregnancies do not end in abortion^{13,14}.

Patient abortion counselling

Patient abortion counselling provides the woman with information about the procedure and its risks/complications, to ensure she is taking a decision in full possession of all relevant information without pressure or coercion (ensure it is her own choice). This type of counselling is done by the healthcare provider providing the SAC, usually a midwife/nurse who is usually under the direction of a supervising midwife or equivalent position in the medical team. A routine consultation with an MH counsellor is not required.

If specific situations require an MHPSS activity that is not available (for example due to lack of a trained MH professional), ensure referral (see [Appendix 16](#)).

MHPSS teams can provide psychological support for patients and give technical support to medical staff for difficult or specific cases/situations ensuring a non-judgmental attitude amongst all staff. They can give input on stress management, managing emotions, identifying psychological signs and symptoms, etc. Training is recommended for SRH and MHPSS teams on how to recognize mental disorders and psychosocial problems.

When a woman/girl is in a distressed emotional state it is better to try to ensure provision of support to reduce distress before taking important decisions.

8.5.3 MHPSS activities for fistula repair interventions

A fistula is an abnormal communication between the birth canal and adjacent anatomical structures (bladder, urethra, rectum or combinations of these). A large majority of obstetric fistulas are the result of prolonged and/or obstructed labour. Fistulas can also be caused by caesarean section, hysterectomy, forceps delivery, traditional/ritual treatments, rape or torture.

Physical complications of fistula include incontinence, chronic urinary tract infections, vaginal scarring, secondary infertility and nerve and musculoskeletal injury.

Psychological consequences are related to suffering as a result of symptoms related to the fistula (leaking, smell, skin eruptions) or complications created by isolation or stigmatization from the family and community. Fistulas also are usually linked with a traumatic experience (such as difficult birth, still birth, uterine rupture, sexual violence, etc.), which have their own psychological consequences. These consequences may include:

- Depression (mild to severe) and grief due to multiple losses (fertility, marital status, child, job, friends, etc.);
- Anxiety (acute or chronic) due to fears of rejection, stigmatization, loss of control of her body;
- Feelings of shame;
- Social isolation (self-initiated or due to community rejection);
- Loss of self-esteem due to stigmatization and loss of role in society.

MHPSS in individual sessions

- Ensure a confidential quiet room where the patient feels at ease;
- Be warm and welcoming at admission;
- Ensure a complete and empathic explanation of the treatment steps (admission, during hospitalization, at discharge, follow-up);
- Motivate her to adhere to treatment;
- Respect her emotions and feelings related to the treatment. Follow up on her concerns;
- Recognize alarm signs of psychological distress and respond appropriately.

MHPSS in group sessions

- Facilitated by the psychologist/counsellor;
- A specific place can be provided as a gathering place for the women (for example, a “mother’s village”);
- A fistula ambassador (a woman who has had a successful fistula operation) can be identified among the group to testify and support the women in the community;
- Organize support for women who do not fulfil the criteria for surgery or those who have had unsuccessful surgery with no option for further repair.

All medical staff should be able to provide basic counselling. Successful fistula repair is an important step in women regaining dignity and confidence in their bodies.

8.6 Special considerations for pregnancy in adolescence

Adolescents (age 10-19 years old) are at the beginning of their sexual and reproductive lives. They are particularly vulnerable because of the lack of accessible adolescent-friendly health services and restrictions on the provision of contraception in many contexts. They are therefore exposed to risks such as early and unwanted pregnancy, death during childbirth, pregnancy-related complications, sexually transmitted infections and unsafe abortions. They are vulnerable to the use of tobacco, alcohol and other drugs and more vulnerable to exposure to violence.

Studies show that early childbearing is associated with an elevated risk of substance abuse after delivery¹⁵ and that teen mothers are also at risk of developing symptoms of posttraumatic stress disorder, mainly because of their high risk of exposure to community and interpersonal violence^{16,17}.

Adolescent pregnancy is often not the result of a deliberate choice and can be frequently linked to sexual violence. Early pregnancies also have negative social and economic effects on girls, their families and communities. Unmarried pregnant adolescents may face stigma or rejection by parents and peers and threats of violence and are more likely to have poorer connections with their families. Adolescent girls with unwanted pregnancies are at elevated risk of suicide.

MHPSS activities need an integrative and preventive approach to detect early mental disorders, reduce stigma, isolation and discrimination and facilitate adolescent's access to SRH healthcare. Activities are implemented for patients, families and communities. When developing and implementing a program for this population, consider the following:

- Identify specific difficulties for adolescents (access to health services, etc.);
- Organize peer supportive groups and other social activities adapted to adolescents considering their physical, cognitive, emotional, behavioural and social development and cultural practices;
- Provide support by developing links to social services or organizations that offer income generating activities;
- Support adolescent mothers in caring for their neonates (psychoeducation, etc.);
- Focus on early detection of MH symptoms and caring for victims of sexual violence.

“Adolescent friendly health services” bring together quality essential comprehensive packages of services that are accessible, acceptable and appropriate for young people. Pay specific attention to welcoming the patient. Preventive, supportive and curative interventions should be implemented in a supportive environment. Activities may include training and raising awareness campaigns, group sessions for pregnant teenagers and teenage mothers, etc. Awareness and support groups can be organized in schools, within health facilities, etc.

Medical and MHPSS teams should be trained on the specific needs and approaches to working with adolescents and in detection of mental disorders, psychosocial problems and sexual violence.

8.7 Monitoring

Routine activity monitoring should include the relevant indicators listed in [Section 2.7, Chapter 2](#)). Collaborate regularly with medical professionals ensuring interventions are adapted to the patients' needs.

In addition to ensuring the inclusion of program monitoring items listed in [Section 2.7, Chapter 2](#), consider one or more of the following:

- Monitor number of sessions and category of symptoms in pre and post-natal care;
- Monitor number of sessions and category of symptoms presented by adolescents;
- Monitor number of sessions for women who experience neonatal death/stillbirth/abortion;
- Monitor the percentage of patients with violence related precipitating events such as sexual violence and intimate partner violence;
- Monitor improvement mother-infant interaction;
- Monitor relevant diagnoses such as post-partum depression and post-partum psychosis.

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Chapter 9: Survivors/victims of sexual violence

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9.1 Introduction

Sexual violence (SV) is an underestimated problem occurring in all countries and societies cutting across all social classes. The lifetime risk of attempted or completed rape is up to 19% for women and nearly 1.7% for men¹. Around the world, 1 in 14 (7.2%) women have experienced SV by a non-partner, and almost 1 in 3 (30%) women have experienced physical and/or SV by an intimate partner².

Situations of conflict, post-conflict and displacement exacerbate existing violence, including SV. In emergencies, conflict, disaster and displacement, the risk and vulnerability to SV and intimate partner violence (IPV) is increased due to the breakdown of families, communities, law and order, increased impunity and decreased access to economic resources. SV has been used to terrorize and humiliate civilians in conflicts. Around the world, 1 in 5 (21.4%) refugee or displaced women have experienced SV in humanitarian emergencies resulting from conflict³. Even though anyone can suffer SV, some groups are at higher risk such as unaccompanied minors, child soldiers, people with disabilities and lesbian, gay, transgender, bisexual, intersex and queer (LGTBIQ) persons.

SV has physical, psychological and social consequences for victims/survivors^a. It also has an impact on their children and their families. Hence, in MSF the package of care includes medical care, together with mental health (MH) care, social care and the provision of a medico-legal certificate.

An effective mental health and psychosocial support (MHPSS) response to SV is needed due to the higher prevalence of several mental disorders (mainly post-traumatic stress disorder (PTSD), depression and substance use disorders) among SV survivors. Rape is a trauma associated with one of the highest risks of developing PTSD. The lifetime prevalence of PTSD for women who have been sexually assaulted is 50%⁴. Childhood sexual abuse has been associated with long-term outcomes of higher rates of PTSD and substance misuse⁵.

Studies report war rape survivors suffer greater severity of certain PTSD symptoms (avoidance and hyperarousal symptoms) compared to survivors of other war-related traumas. Male rape survivors have higher rates of PTSD compared to female rape survivors. Survivors of conflict-related sexual violence experience less social acknowledgement than survivors of non-sexual war trauma. As well as PTSD symptoms most SV survivors experience some degree of posttraumatic growth⁶.

a The term “survivor” refers to a person who has experienced SV. It is as it focuses on agency, strength, resilience, empowerment, efforts, ability and capacity of an individual to cope, heal and recover. The term “victim” is used in legal sectors, but it has been avoided as it is seen as stigmatizing; victims can be perceived as powerless or passive. However, the term “victim” recognizes the harm and violation of human rights and the usefulness of the term in the legal sector is acknowledged. The term “patient” focuses on the provision of medical care and MHPSS after SV.

All language should be person-centered, show respect and be based on the perspective of the patient. Their preferred term may depend on their phase of recovery. Recognise the harm they have experienced, and move together toward recognizing their strength, capacity to cope and recovery.

This guide uses the terms patient, victim and survivor interchangeably, but the term survivor is used more frequently and preferred.

This guide also uses the terms they/them to reflect that survivors of SV may be women, men, girls, boys or LGBTIQ persons.

9.1.1 Defining terms

Sexual violence^{b,7}

SV is any sexual act, attempt to obtain an act, unwanted sexual comments or advances, or acts to traffic, directed against a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship, in any setting, including, home and work.

This can include: rape within marriage or dating relationships, rape by strangers, rape during armed conflict, sexual slavery, unwanted sexual advances or sexual harassment, including demanding sex in return for favours, sexual abuse of people with disabilities, sexual abuse of children, forced marriage, marriage of children, denial of the right to use contraception or measures to protect against sexually transmitted infections (STIs), forced pregnancy, forced abortion, enforced sterilization, violent acts against the sexual integrity of women, including female genital mutilation, and obligatory inspections for virginity, forced prostitution and trafficking of people for the purpose of sexual exploitation.

Rape is forced, coerced or non-consensual penetration – however slight – of the vagina, anus or mouth with a penis or other body part or penetration of the vagina or anus with any object³.

Intimate partner violence is behaviour by a current or former intimate partner (such as husband, boyfriend, wife or girlfriend) which causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviour.

For more information see MSF Sexual Violence guideline (OCA, 2019)⁸ and Medical Protocol of Sexual Violence Care (MSF, 2019)⁹.

b Many other humanitarian organizations use the term gender-based violence (GBV) to describe SV. GBV is an umbrella term for any harmful act that is perpetrated against a person's will that is based on socially ascribed (gender) differences between males and females. Common forms of GBV include SV and IPV (also called domestic violence).

9.2 Risk factors for mental disorders and psychosocial problems

The main risk factor is SV itself. The cumulative factors of the person's context and life experiences are also major contributors, for example if the person lives in a conflict setting. Refer to the [General introduction](#) for general contributing risk factors.

9.3 Clinical characteristics

SV survivors go through a series of psychological reactions in the days, weeks and even years following the aggression. Mainly survivors remain silent, and fear disclosing the assault due to stigma, judgement, feelings of guilt and shame as well as to protect themselves from repercussions if they live in situations of continued assault risk or believe they will face stigma if they speak up. Survivors tend to isolate themselves and only seek medical care after the event if they have physical symptoms or injuries. This avoidance behaviour is also a characteristic feature of people who have faced severe trauma, and often results in a delay seeking help. In addition, SV survivors face many barriers to disclosing violence and seeking help. They may lack knowledge of the health consequences, the benefits and importance of care, and face practical barriers to accessing this care.

As well as psychological reactions, SV survivors may present to primary health care with general non-specific physical symptoms such as abdominal pain, general body pain, fatigue, insomnia or more specific symptoms like vaginal discharge, genital injuries, etc.

Short term reactions and consequences:

- *Shame* is an intense emotional wound for survivors. Survivors feel invaded, defiled, and humiliated, while simultaneously experiencing the indignity of being helpless and at the mercy of another person.
- *Guilty feelings* are the result of self-blame, due to what they may have had to do in order to survive the assault, including saving themselves from serious physical harm or death.
- *Feeling of powerlessness*.
- *Sadness, fear and anger*.
- *Feelings of hopelessness and helplessness*, having no control over what happens, including sometimes a tendency to simply give up and accept their fate.
- *Low self-esteem* – violence can sometimes result in survivors feeling a lack of value or worth of their own body or integrity.
- *Denial and minimization*, refusing to believe the event was abusive.
- *Fear of, or having to face, any of the following consequences*: repercussions, retaliation, stigmatization of not being believed, being blamed, judged responsible, rejected, mistreated and/or socially ostracized, illtreated or killed, forced to marry their perpetrator. SV survivors may present other physical, emotional, cognitive and behavioural symptoms as explained in [Section 5.3](#), Chapter 5 concerning people exposed to a potentially traumatic event. One of these symptoms can be fragmented memories, when SV survivors are unable to remember all or part of important elements of the traumatic event. This inability to recall elements of the event can also be considered a protective factor.

Some survivors may have traumatic amnesia – an inability to remember all or part of the event(s). When traumatic amnesia fades away, survivors can have invasive, uncontrolled and fragmented traumatic memories, flashbacks, nightmares and re-experience vivid sensations and distress.

Long term reactions and consequences for the survivor's well-being can stem from a combination of psychological, emotional and physical injury (internal injuries, fistula, etc.), STI and unwanted pregnancy. Mental disorders such as depression, post-traumatic stress disorder or other conditions may emerge weeks, months or years after the event.

Survivors may have some degree of post-traumatic growth. It has been defined as a beneficial change in cognitive and emotional capacities beyond previous levels of adaptation, psychological functioning, or life awareness after trauma. It refers to a permanent change. Growth gains are possible while still experiencing substantial distress.

9.4 Clinical assessment

Due to the complex consequences of SV, the assessment should be as comprehensive as possible focusing on medical, psychological and social aspects.

Do not expect the entire history of the traumatic event or all the symptoms to be elicited in one interview. Memories may be fragmented, and it may be impossible for the victim to recollect important details of the event (comparable to the dissociative amnesia and cognitive alteration typical in post-traumatic stress disorder). Never force someone to talk.

In the situation where you can collect a history, this should follow the general principles of patient assessment as described in [Chapter 3](#). If you can safely collect specific additional information on the person's SV experience, focus on:

- The patients' situation pre and post assault
- History of the event(s)

It is not necessary to know the history of the event(s) to provide MHPSS. Reassure the survivor that they can explain what they want about the event. This history may previously have been collected and recorded. The patient should not have to face multiple re-telling of their experience.



Remember: when obtaining a history of trauma from the patient, you risk worsening their symptomatology and causing psychological harm. When caring for patients who are SV survivors, it is important to first work on the stabilization of their symptoms before entering into the memory of the trauma.

If MH staff do not identify a survivor of SV there is a missed opportunity for care and support. They have a tremendous opportunity to help survivors break the silence, end their feeling of isolation, helplessness and suffering and support them to seek medical care and psychosocial support.

There must be a private, confidential and safe place to ask patients about SV. Staff must be trained on how to provide a supportive, compassionate and non-judgmental response, and must be able to provide or refer to care.

Safe identification of SV survivors:

- Be alert to signs of physical violence such as abrasions or other wounds that do not “fit” with the explanation given by the patient:
 - Be alert to symptoms that may be the result of a rape (STI, adolescent pregnancy, fistula, incomplete abortion, etc.).
 - Be alert to vague complaints or chronic symptoms with no apparent physical origin.
 - Be alert to psychological warning signs (lack of appetite, inability to sleep) and acute signs of post-traumatic stress disorder.
 - Listen carefully to a person who claims they are possessed by evil spirits or who has been accused (or accuse themselves) of breaking a taboo. Cultural elements resulting from customs, religious or moral values can be used as vectors for the expression of mental suffering¹⁰.

Consider the following process for interview and assessment:

- Always reassure the survivor that they are in a safe place and they can decide when to stop the session (try to give them back the control they have lost).
- Consider this may be the only time the survivor will present for care.
- Actively and carefully listen. Do not be judgmental. Be empathic and patient while treating the survivor with dignity. Provide a person-centred care approach that responds to survivor's concerns.
- Do not force the survivor to speak. Ask non-intrusive questions and reassure them that they can explain what they want about the event(s) or even not talk about it.
- Identify the stress and emotional reactions of the survivor. Allow them to express emotions and feelings (crying, anger, shame). Validate their emotions.
- Explain the reasons behind the survivor's reaction and tell them directly it was not their fault and they are not to blame. Some survivors blame themselves for their reaction during the potentially traumatic event, especially if they experienced a freeze response.
- Give appropriate information.
- Ensure availability of a person to accompany the survivor, if they wish.
- Respect the wishes, rights, needs and capacities of the survivor. Do not tell them what to do or what choices to make.
- Assess the level of risk and safety of the survivor (is the victim in current danger) taking protection measures, if necessary.
- Provide clothes and propose a shower after medical examination and hygiene kit (according to needs and context).
- Evaluate social needs of vulnerable survivors and refer accordingly.
- Ensure referral and accompaniment to identified partners/actors.
- Evaluate the need for protection.
- Identify with the survivor a resource person (someone trusted, friend, family, community member, etc.) to give support to the victim. Map other existing actors for potential referral for psychosocial activities to help the patient reconnect socially.

9.5 MHPSS assessment

A needs and resources assessment should be carried out as described in Chapter 1. In addition, if working with the medical team to set up an SV project or activity, seek information on prevalence of SV in the community. Attempt to understand SV in the community, including perception of SV survivors in the community, the social consequences for them (forced marriage, higher risk of future SV) and taboos.

It is important to understand barriers to health care and identify any other actors that may be providing MHPSS to SV survivors. This includes an assessment of the capacity of the SV medical staff (midwives, nurses, general practitioner...) to provide at least the minimum MHPSS package.

Design and implement MHPSS for SV survivors taking into consideration all genders and age ranges. Always coordinate with the rest of the medical team on how to best integrate MHPSS into the activity so it exists as part of the activity and not something in parallel. Integration of MHPSS is most easily done from inception of the SV activity.

The particular circumstances of SV against men should be considered during each assessment of needs and resources. Understanding this will help decide what specific clinical approaches and MHPSS activities may be necessary or beneficial in welcoming and providing care to men who are SV survivors.

9.6 MHPSS activity planning

All survivors should receive medical care, including MH care, as required. SV care is multidisciplinary and includes social and legal support. When there is a health promotion (HP) team, there needs to be collaboration between them and the MH and medical teams, to ensure the development of appropriate messages to the community.

Early medical care is essential to treat injuries and to prevent the transmission of STIs (including HIV^a and hepatitis B), tetanus and unwanted pregnancy. This medical care must be provided as soon as possible. For more information see Medical Protocol for Sexual Violence Care⁹.

Always assess safety and protection of the survivor. Train the team on how to do a risk assessment and safety planning.

Early psychological support contributes to re-establishing the survivor's basic trust and supports their coping mechanisms. MHPSS should be integrated in a multi-disciplinary approach (with medical, MHPSS, social and legal aspects). It begins with recognizing/identifying survivors.

Usually MSF offers a medico-legal certificate to SV survivors. This should be discussed with the operational centre's legal department and SV advisor.

Consider how to provide legal support. This is usually carried out by another actor and hence it is important to understand the legal pathway available.

9.6.1 Minimum package

This is a package delivered when there are no MH professionals in the project. The medical team must ensure a warm welcome and in addition to medical care, assure the provision of:

- **Psychological First Aid (PFA)** for survivors in crisis. Assess risk and develop a safety plan if needed.
- **Psychosocial support to all survivors.** Psychosocial support usually refers to communication skills including careful listening, asking about needs, with non-judgmental attitude, validating and re-assuring, strengthening coping skills and exploring social support.
- **Identification and management of survivors with acute severe mental disorders** If the team is likely to provide care to many SV survivors, teams should consider having a short visit by an MH professional to provide: training on PFA, education on specific MH aspects of SV presentations (to improve safe identification of cases) and identification/referral of survivors with severe MH symptoms.

Patient reception

The patient reception area must be designed and organised together with the medical team. Aspects of patient welcoming include:

- Focus on “welcoming” in all areas, including the reception area. If a person is well received, they will feel reassured and confident in the ensuing care. If not, they may regard the examinations and treatment as another assault on their person.

a HIV: human immunodeficiency virus

- Ensure confidentiality during all steps and in all spaces by all staff (triage, entry door, reception, medical space facilities) and inform survivors of the limits of confidentiality (for example, when there is mandatory reporting). Conduct the consultation in a private and safe place.
- Ask for consent and respect survivor's right to choose. Make sure they feel safe.

Essential messages to SV survivor¹¹

Demonstrate through body language that you are listening to the patient and respond with validating messages that allow the patient to feel heard and believed. **These sentences must be adapted to the language and age of the SV victim.** Examples of validating messages can include:

- I'm very sorry that happened to you.
- I'm really glad you have the courage to tell me.
- You are here in a safe place.
- I want you to know it wasn't your fault.
- Thank you for your trust.
- I will do everything I can to help you.

Always try to enable a safe discharge: assess the risk for the survivor or repeated survivor at discharge. If they are at high imminent risk of SV develop a safety plan with the survivor and if available with a non-offending support person.

9.6.2 Comprehensive package

A **comprehensive package** of MHPSS for survivors of SV includes:

- Psychoeducation about the mental health and psychosocial consequences of SV, coping mechanisms and when to ask for support.
- Psychosocial interventions which encourage family and community support.
- Individual, family and group counselling/psychotherapy
- Identification and management of patients with mental disorders

Counselling or psychological support should be provided to all SV survivors who request and accept it. This can be provided through individual, family or group settings.

When SV survivors receive MH care first, they should always be referred for medical care too. Exceptions may occur in some programs when the SV occurred more than 6 months ago. Exceptions, including this one, must always be validated by the SV Advisor.

Sometimes the first consultation can be shared with the medical clinician (midwife, doctor...). In these cases, with the patient's consent, the MH clinician will start the consultation as an MH consultation and afterwards the medical staff continues, with MH staff remaining present. This way the survivor will not be required to repeat their presenting history. Shared consultations can also lead to the patient feeling more comprehensively supported.

Another option is the MH staff summarizes the narrative to the medical clinician in presence of the patient and then leaves. Afterwards the medical clinician can focus on what is medically still required to know from the patient, specifically for the medical examination and care.

The survivor must always give their verbal consent for any of these consultations and for information to be shared among the medical and MH staff.

Comprehensive care for survivors requires participation and support of trusted family, friends and community members.

SV and MH certificates

MH certificates^b can be important for SV survivors for legal procedures. See [Section 2.10](#), Chapter 2 for more details.

Support groups for SV survivors

SV can make a survivor feel as if they have lost complete power and control of their own life. Support groups can be a life changing experience for SV survivors. The process is based on group cohesion and reciprocity in support, giving survivors the opportunity to speak out about their experiences. These groups can have talking as their main activity, or other ways of expression (dancing, singing, etc.). After silence and shame, survivors can connect with others who have experienced similar forms of violence. Participation in these groups may reduce feelings of shame, guilt and increase the sense of self and enhance self-esteem.

^b The standardized MH certificate can be adapted to context, in agreement with the legal department, as well as the way to provide it, according to needs and capacity (for example, in a systematic way or not).

9.7 Special considerations for men

SV against men is a significant problem, even if under-reported.

Rape and other forms of sexual coercion directed against men and boys take place in a variety of settings including homes, schools, military settings, detention centres, prisons and police custody. Such violence may take different forms, such as being forced to have sex with others or as “punishment” with rape and other SV forms (genital torture, forced sterilization, sexual slavery, etc.).

Men may be even less likely than women survivors to report an assault to the authorities or seek care. This silence may be due to shame, guilt and/or fear to be seen as weak or being labelled homosexual or bisexual. They may fear being devalued, banished, denounced and even attacked by their community. They may feel that their masculine identity, their personal and social identity have been destroyed. They develop a feeling of guilt for not defending themselves as they believe they should have done. Men may feel confused and ashamed by involuntary physical arousal during an assault, inform men and boys about the normal involuntarily physiological response of erection or ejaculation.

Some specific psychological reactions are observed such as violent and irritable behaviour and social withdrawal. Entire families can be impacted if the survivor is not receiving adequate MHPSS. In addition, when the survivor is a man there is a higher risk of the onset of IPV and/or poverty due to loss of livelihood.

Provide validating messages that separate their personal identity from aggression, invulnerability, and emotional silencing, and provide hopeful images of survivors who based their sense of masculinity on being a loving husband, family member, friend and constructive member of the community.

9.8 Special considerations for children and adolescents

Sexual abuse against children, boys or girls, remains a taboo and difficult to disclose in many settings. Very few children who experience sexual abuse seek or receive any type of services: they may experience fear of disclosing their experience of abuse to an adult caregiver (especially if the perpetrator is a family member or known to the family), owing to the stigma and feelings of shame. Other barriers to seeking help could be: the children know their perpetrator (usually child sexual violence is intrafamilial), they have loyalty to the known perpetrator, and they may not know what is right or wrong, may be afraid of further violence or have been threatened by the perpetrator or others.

Boys and girls can react differently to sexual abuse. Age and developmental stage and cultural context also influence reactions. Some children may show no obvious signs that the traumatic event has occurred, while others show multiple signs. Often children do not have any physical signs of SV, due to the absence of physical force, the use of coercion, threats and manipulation, the lack of physical resistance of the child and the abuse being progressive and ongoing. Hence, most signs and symptoms are behavioural and emotional in nature. However, physical examination or observation can indicate abuse as well.

High-risk subgroups

Some children and adolescents are more vulnerable than others, including children and adolescents living with disabilities, children and adolescents affected by armed conflict, street children, unaccompanied minors and LGBTI adolescents.

Pay specific attention to:

- The physical condition of the child and always prioritize physical emergencies (e.g. severe injury).
- The age, gender, culture, education including cognitive, social, emotional, language, physical development and adaptive behaviours.
- Prioritize, assess and ensure the safety/security of the victim and take child protection measures including timely referrals, if necessary.
- Seeking consent from the child – or assent if they are too young to consent.

Consent^a is an active, affirmative, clear, conscious, direct, unimpaired, and voluntary agreement to receive a specific medical procedure. Obtaining consent is a process that includes a non-coercive interaction between medical staff and patients (or their legal representatives when applicable, such as family members). When correctly implemented, a valid consent balances the asymmetric relationship between MSF medical staff (possessing the medical technical knowledge) and the patient (who is frequently in a vulnerable situation). For this to be true, the patient must be informed on what the medical procedure consists as well as on the risks and consequences related thereto before consenting to it. For consent to be valid, it must be voluntary, informed, specific and the person consenting must have the capacity to make the decision.

Assente^a – it is the agreement of a person not capable of consenting. It is the expressed willingness to participate in services. For younger children who are legally too young to give informed consent, but who are old enough to understand and agree to participate in services, the child's "informed assent" is sought. Informed assent is the expressed willingness of the child to participate in services.

^a Definitions from MSF International Legal Department.

- Usually children between 6 and 14 years should provide informed assent to participate in services. Children should not be forced to undergo physical examination.
- Adolescents aged 15 and older are generally considered sufficiently mature to make decisions (to provide informed consent).
These age ranges are not fixed, they are given as general markers to help the mental health activities manager.

In the initial interview

- It is key to facilitate safe disclosure and be careful when history taking.
- Do not judge or question the authenticity of the child's words.
- Reassure and praise the child about revealing the abuse and perpetrator.
- Reassure the child that they are not to blame. It is important to let the child know that children/adolescents should not be sexually abused and that what has happened is wrong.
- Minimize the need for the child or adolescent to repeatedly tell their history of sexual abuse, as it can be re-traumatizing.
- For reasons of confidentiality and safety, the child or adolescent should be seen on their own (i.e. separately from their caregivers), while offering to have another adult present (staff member) as support. Always ask the child/adolescent if they agree to be separated from their caregivers for the consultation.
Sometimes young children feel distress when they are separated from their caregivers; if so keep a caregiver present during the consultation (when appropriate). If after a while the child feels comfortable enough, try and remain alone with the child for a while.
- Always consider the first consultation may be the only consultation.
- Provide:
 - Information to parents about SV and how to care for a child/adolescent survivor (what words to say, how to approach, etc.).
 - Psychoeducation.
 - Psychological/psychosocial support (individual or in support groups).
 - Information and referrals for protection, legal support, social services and others.

Parents or adults who accompany or care for a child or adolescent SV survivor should be supported through all the process. The disclosure of a sexual assault is an event that affects the whole family and can lead to serious psychological distress. Be alert to signs of stress or distress in parents. Parents may need guidance on how to support their child or adolescent. It is important to assess the interaction between parents and the child/adolescent including their communication. Address the identified needs by providing supportive interventions such as parenting skills approaches that aim to promote the well-being of children and adolescents through improving parents' stress management skills, positive parenting practices, and strategies for supporting children and adolescents.

Home visits and other family support activities bringing resources to families in their homes can be considered according to the cultural and security context. In such situations, sometimes mediation with the family will find an alternative safe situation for the child. For example, if the perpetrator is the uncle discuss with the parents of the child how to keep the uncle away from their house and their children.



Be attentive and always consider that the perpetrator could be a caregiver, a parent, a family member. In such cases, **the priority is to evaluate the current danger and the specific protection of the child/adolescent.** Explain to the caregivers the risk of repetition and the need to protect their child/adolescent. Referral to protection and legal services in some cases may be the best practice.

When the perpetrator is a member of the family or someone close to the family always check the other children. Explain the need of protection for all of them and invite them for a consultation. It is very common that several children suffer SV by the same perpetrator, possibly over different periods.

Always assess the risk of the child/adolescent before ending the consultation. Also, take the proper measures to protect them.

Warning signs of possible child sexual abuse

- **Physical warning signs in children and adolescents of possible child sexual abuse^b**
 - Injury and/or complaints of pain
 - Genital or urinary tract irritation, persistent or recurring pain during urination and/or bowel movements, STIs
 - Frequent, unexplained sore throats or other physical symptoms (including somatic complaints like headache, general body pain, stomach aches, etc.)
 - Wetting and soiling accidents unrelated to bathroom training
 - Weight loss or gain
 - Lack of personal care
- **Warning signs or symptoms in infants: 1 month to 12 months^c**
 - Crying/whimpering/screaming more than usual
 - Intense fear reactions to an individual or to people in general
 - Avoidance conduct and/or frozen vigilance
 - Clinging, unusual attachment to caregivers
 - Sadness, swaying, lack of interest in toys or no answer to stimulation
 - Extreme upset at diapering or bathing
 - Infants hyperkinetic, agitated
 - Eating and sleeping disturbances
- **Warning signs or symptoms in children 1 to 10 years old** (all the previous symptoms plus)
 - Any sudden change in child's affect, behaviour or interest
 - Inhibition, very passive or agitation, restlessness, biting or other aggressive behaviour towards other children or against themselves (self-mutilation), prone to accidents
 - Unusual difficulties at school (lack of concentration, sudden refusal to go to school)
 - Sadness and/or isolation
 - Fears, defence gestures at each attempt of approach, feeling of insecurity
 - Refuse to wash, lack of personal hygiene, self-neglect
 - Enuresis, encopresis and other regressive behaviours
- **Warning signs or symptoms in adolescents over 10 years old** (all the previous symptoms plus the following)
 - Poor self-esteem
 - Risk-taking/self-destructive behaviour, self-harm, suicidal thoughts/attempt
 - Substance use
 - Delinquent behaviour and/or running away
 - Prostitution, early pregnancy
- **Warning signs or symptoms in children and adolescents in their sexual behaviour**
 - Sexualized behaviour inappropriate for their age
 - Age inappropriate interest/curiosity in sex, premature sexuality, seductive behaviour
 - Display knowledge of sexual acts or sexual activities inappropriate for the age

^b Deaths from child abuse are underreported as they are incorrectly documented as due to other causes.

^c These frequently go unnoticed.

- Repeated attempt to involve others in sexual activity, inappropriate sexual play
- Sexual harassment of other children
- Sexual drawings
- Persistent or unusual concern about sexual orientation

Common reasons children do not disclose sexual abuse

- *Fear of consequences*: fear of telling an adult because they feel physically threatened or believe they will be taken away from their families or blamed for shaming the family or involving outside authorities. The fear of the consequences may be greater than fear of the abuse itself.
- *Fear of dismissal*: fear that adults will not believe them and refuse to help. The perpetrator may compound this fear by convincing the child that no one will believe them, they will get into trouble if they speak out, etc.
- *Manipulation*: the perpetrator may trick or bribe the child (for example, give the child a gift in exchange for non-disclosure). The perpetrator may make the child feel embarrassed, guilty or that the child is to blame and “invited” the abuse.
- *Self-blame*: belief it is their fault, or the abuse is deserved (for example, the child may think it was their fault for inviting the perpetrator to their place or for being in the wrong place at the wrong time). A child may feel they allowed the abuse and should have stopped it.
- *Protection*: of the perpetrator and/or family in some way, especially if the perpetrator is close to the child and their family.
- *Age*: very young children may be unaware they have experienced sexual abuse. They may think the abuse is normal particularly if the abuser is someone the child knows and trusts. They may also have linguistic or developmental limitations that prevent disclosure.
- *Physical or mental disability*: if they are unable to speak to or otherwise reach out to a service provider.

9.9 Monitoring

Routine activity monitoring is described in [Section 2.6](#), Chapter 2. Monitoring should include some of the indicators listed in that chapter.

Possible additional indicators in a 'comprehensive' or vertical project can include one or more of the following:

- Compare number of SV survivors who receive medical care and number who have received MHPSS
- % of survivors that received both medical and MH care
- Monitor number of male survivors
- Monitor the percentage of patients with symptoms of self-harm, suicide attempt, symptoms of depression and medically unexplained physical symptoms
- Monitor number of group sessions done for SV survivors
- Monitor number of follow-up sessions for SV survivors

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10.1 Introduction

In 2014, torture was practiced in 141 countries in every region of the world¹. An estimated 5-35% of the refugee population has experienced forms of torture². In humanitarian settings torture is likely to be more prevalent due to armed conflict, other forms of violence, the presence of different armed groups.

According to international law, torture is described as the infliction of severe pain (whether physical or psychological) by a perpetrator who acts purposefully and on behalf of the state^{a,3}.

- “Torture consists of severe pain or suffering, whether physical or mental, inflicted for such purposes as obtaining information or a confession, exerting pressure, intimidation or humiliation”.
- Cruel or inhuman (synonymous terms) treatment consists of acts which cause serious pain or suffering, whether physical or mental, or which constitute a serious outrage upon individual dignity. Unlike torture, these acts do not need to be committed for a specific purpose.
- Humiliating or degrading (synonymous terms) treatment consists of acts which cause real and serious humiliation or a serious outrage upon human dignity, and whose intensity is such that any reasonable person would feel outraged.”⁴

Torture methods are designed to prolong the victims’ pain and fear for as long as possible (sometimes without leaving visible evidence).

Torture has an extremely high impact on the mental health (MH) and well-being of those exposed to it. Torture survivors are more likely than individuals exposed to other forms of violence to report symptoms of post-traumatic stress disorder (PTSD), major depression, anxiety, substance abuse and sometimes long-term personality change⁵. Any program providing care to victims/survivors of torture must include a mental health and psychosocial support (MHPSS) component.

Table 10.1 - Forms of torture/ill treatment (often combined)

PHYSICAL	Blunt trauma, penetrating/crush injuries, burns, electric shocks, asphyxiation, prolonged suspension/restraint, forced body positions, traumatic removal of tissue and appendages, chemical exposure, etc.
PSYCHOLOGICAL	Threats, mock executions, sensory deprivation/overstimulation (sleep, light, food/water, prolonged isolation), forced to witness torture, forced to engage in practises against one’s religion, etc.
SEXUAL	Sexual humiliation, rape, trauma to the genitalia, etc.

a “[...] any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him, or a third person, information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to, lawful sanctions.”³

10.2 Risk factors for mental disorders and psychosocial problems

The personal experience of torture is, per se, a risk factor for development of a mental disorder. The consequences of torture are also mediators of mental disorders and hence require consideration. The primary aim of many forms of torture is to deliberately destroy the physical, psychological and social integrity and the functioning of the victim of torture (VoT^a)/survivor of torture (SoT), breaking their identity and personality⁶. It fosters a humiliating dependency on the torturer.

The consequences of torture/ill treatment are diverse. The types of sequelae depend on:

- Individual patient characteristics (age, coping capabilities, previous traumas, additional losses, pre-existing disorders, physical health, etc.).
- Personal experience of the torture (conditions of torture, belief system preparedness, meaning attributed to the cause of torture etc.).
- Social, political and cultural factors (social context before, during and after torture, support system, political activism, etc.).

The psychological consequences of torture occur in the context of personal attribution of meaning, personality development and social, political and cultural factors. For this reason, it cannot be assumed that all forms of torture have the same outcome. It is important to recognize that not everyone who has been tortured develops a diagnosable mental illness.

Torture has consequences at:

Individual level:

- Profound, immediate and long-term particularly complex physical, psychological and social sequelae.

Family level:

- Different forms of family dysfunction.
- Disruptions of quality of life.
- Secondary traumatization.

Societal level:

- Creation of an atmosphere of pervasive threat, chronic fear, terror, hopelessness, etc.
- Repressive ecology (a state of generalized insecurity, rupture of social group identity, inward looking attitudes, loss of social cohesion, etc.).
- Breaks or damages social coherence (pre-existing solidarity inherent to the group) and/or identity of entire communities.

a There is no consensus yet in MSF projects on the use of the terminologies “victims” (VoT) versus “survivors”(SoT): both have advantages and disadvantages.

“Victim” is used in legal and medical sectors. « Survivor” is a person who has experienced torture etc. The term survivor is used in MHPSS sector because it focuses on strength, resilience, empowerment, efforts, ability and capacity of an individual to cope, heal and recover. The term victim has been avoided because it is seen as stigmatising; victims can be perceived as powerless or passive. However, the term victim recognises that a violation against one’s human rights and the usefulness of the term victim in the legal sector is acknowledged. From the patient’s perspective – which should be taken into account – use of the term depends on their preference – and often on the phase of recovery they have reached. As a therapist, it is important to recognise their status as victim and the harm they experienced, moving together toward the survivor perspective. In this guideline the terms patient, victim and survivor are used interchangeably.

10.3 Clinical characteristics

Every aspect of a SoT's life is dramatically altered/affected by the experience. They are often stripped of dignity, humanity and control and feel "dehumanized".

Survivors may:

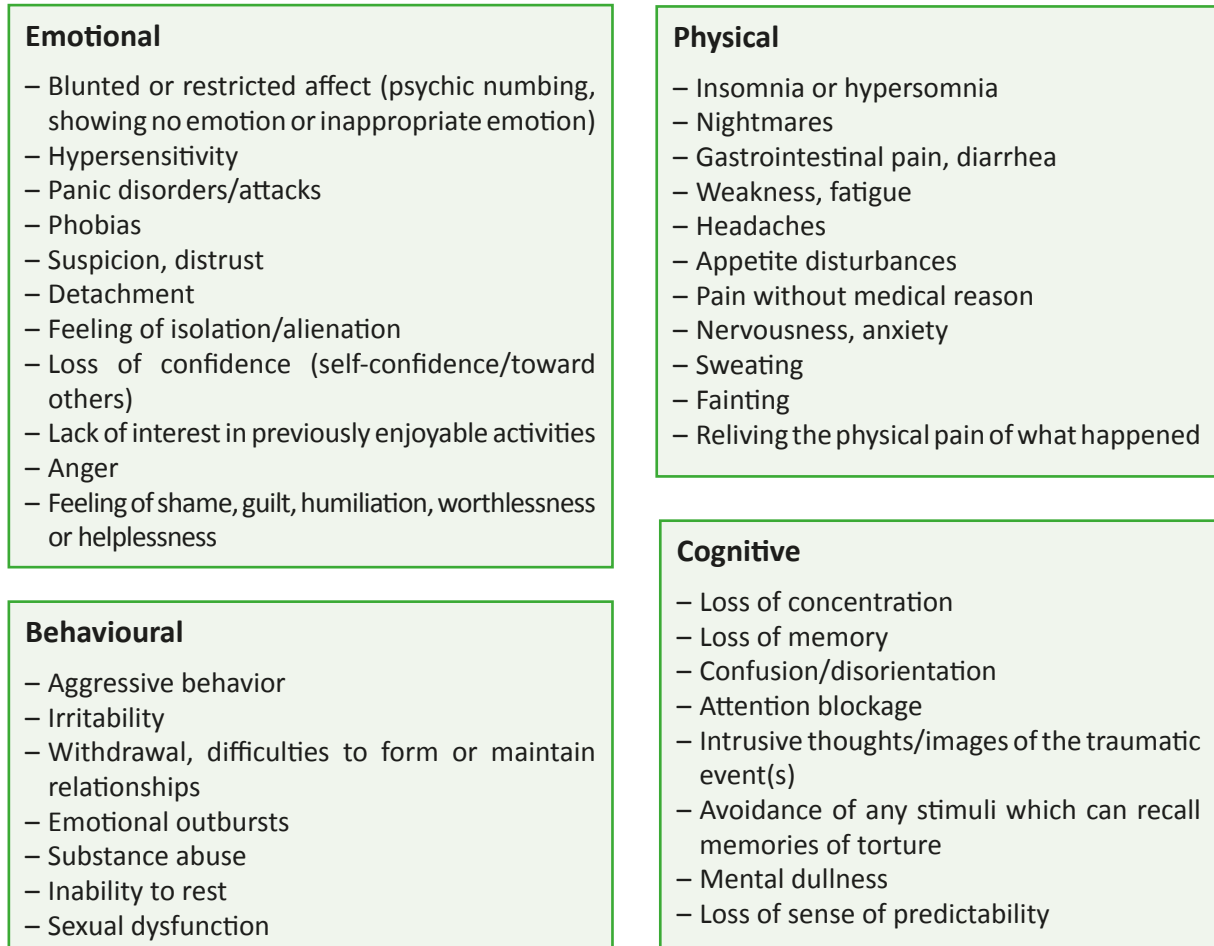
- Blame themselves for their experience and the consequences the experience has on others;
- Feel humiliated for letting the torture happen;
- Have a shattered sense of connection with individuals and the community;
- Have their fundamental assumptions about safety, values, beliefs and systems of meaning about themselves and the world impacted⁷.

Torture has "fragmenting" effects on the individual's perception of themselves and of the world.

10.3.1 Commonly observed symptoms

SoT commonly experience intense fear of harm or death, helplessness, loss of control, humiliation and degradation. The range of symptoms is wide and includes features of many of common psychiatric conditions. It may be hard to interpret as a single disorder.

Figure 10.1 - Commonly observed symptoms for SoT



10.3.2 Mental disorders associated with torture

The prevalence of depression, anxiety and/or PTSD ranges from 15%-85% amongst SoT⁸. The most common psychiatric diagnosis are:

- Depressive disorders
- PTSD/complex trauma
- Generalized anxiety
- Panic disorders
- Enduring personality change^a
- Somatoform disorders
- Psychosis (acute or prolonged)
- Substance abuse
- Dissociative disorders

Comorbidities are frequent and clinical presentation may be complex. Avoid making a diagnosis too rapidly.

a A significant and persistent change in the individual's pattern of perceiving, relating to thinking about the environment and him/herself, associated with inflexible and maladaptive behaviours not present before the traumatic experience. This is characterized by a hostile and distrustful attitude toward the world, social withdraw, feeling of emptiness or hopelessness, a chronic feeling of "being on edge" as if constantly threatened and estrangement (ICD 10)

10.4 Clinical assessment

Due to the complex consequences of torture, the assessment should be as comprehensive as possible focusing on medical, psychological and social aspects.

The entire history of the traumatic event and the complete range of symptoms are rarely elicited in one interview. Memories may be fragmented, and it may be impossible for the survivor to recollect important details of the event (comparable to the dissociative amnesia and cognitive alteration typical in post-traumatic stress disorders).

If history taking is possible, this should follow the general principles of patient assessment as described in [Section 3.3](#), Chapter 3. If it is possible to safely collect specific additional information on the person's history of torture, focus on their:

- History of torture
- Situation pre and post torture

Keep in mind that this history may previously have been collected and recorded. The patient should not have to face multiple re-telling of their experience.



Remember: when obtaining a history of trauma or torture from the patient, there is a risk of worsening their symptomatology and causing psychological harm. When caring for patients who have been victims of torture, it is important to first work on the stabilization of their symptoms before entering the memory of the trauma.

Consider the following process for interview and assessment:

- Set up an appropriate interview space (ensuring confidentiality and ensuring adequate space and comfort).
- Reassure them, explain that it is a safe space for them.
- Explain the structure of the interview (who/what/why/how) and help the patient prepare for it.
- Provide patient-tailored information, explanation and choice.
- Never pressure the patient to talk about traumatic events. Let them talk about what they want/can, when they want, at their own pace.
- Respect defence mechanisms and silence.
- Avoid authoritative instructions/leading questions. Invite the patient to share, do not interrogate, etc.
- Be sensitive in tone, phrasing and sequencing of questions. Use the patient's words. Acknowledge, validate and normalize reactions: "Many people feel..."/de-stigmatize.
- Accept the expression of emotion. If overwhelming, propose short breaks or switch to neutral topics.
- Be sensitive to emotional state/reactions, acknowledge them and respect needs and limits. Watch for signs of distress.

- Avoid national or religious emblems in the clinical or surrounding spaces^a.
- Provide closure: discuss the experience of the interview at the end and plan the next step if possible.
- Knowledge of the patient's context (political and historical elements, etc.) and general cultural dimensions are key to complete a proper assessment and improve understanding of the patient.
- Psychological and medical assessments (and legal, when needed) are analysed together for an overview of the person's general functioning.
- Ask to assess the SoT's relatives. They may be affected by what happened to the patient but prefer to keep silent and not seek help to avoid increasing the suffering of their relative.
- Map other existing actors for potential referral for psychosocial activities to help the patient reconnect socially, or for specialized care (neurologists, etc.), etc. as needs may be multiple.

a VoT are often tortured because of belonging to an ethnic group or religion. Any triggers/stimuli can cause reactions of past tortures. The perception by the patient that the professional is someone who is neutral and not associated with the perpetrating authority will improve trust and thus the therapeutic relationship.


10.5 MHPSS assessment

For the general approach to MHPSS assessment, see [Chapter 1](#). There are some specificities regarding the assessment of resources and services for SoT:

- Community perception of SoT;
- Highly vulnerable population (refugees, asylum seekers) and common methods of torture locally used;
- Legal implications for SoT and MSF (when dealing with SoT);
- Other actors providing legal support for SoT;
- Security risks for SoT and MSF (when dealing with SoT).

10.6 MHPSS activity planning

Activities for SoT depend on the context - from psychological first aid (PFA) and psychoeducation (migrants in transit, etc.) to rehabilitation including mid/long term therapy/counselling.

 Note: MSF may encounter survivors of torture in programs not developed for this specific patient group. The principles of assessment and management of these patients should follow the processes described in this chapter. **Given the specificities and expertise required however, each case by necessity should be discussed with the mental health activities manager or if not available the MH advisor.**

10.6.1 Objectives of MHPSS activities

Provide a dialogue to talk about what happened, in order to:

- Restore trust, dignity and hope;
- Grieve losses (physical, psychological and community);
- Accept and adapt to disabilities;
- Restore coping skills and increase functionality and self-esteem.

10.6.2 Clinical care framework

Regarding principles of clinical care for SoT see the end of [Section 5.6.4](#), Chapter 5 focusing on the care of patients who have experienced potentially traumatic events.

In addition, consider the following:

- Torture aims to destroy the feeling of belonging to the human race and will commonly impact the victim's social links and their ability to interact with others. SoT often find it difficult to trust anyone. Therefore, it is essential to explicitly raise confidentiality during/after treatment, for any elements that they mention. Treat the patient with respect and humanity (avoid victimization, pity, banalization, etc.). Be non-judgmental.
- Ensure the patient feels they are in control (e.g. choose sitting arrangements/distance with the clinician, the patient themselves defines the objectives to reach in care, avoid authoritative instructions). It is also important that they are directly involved in their care, decisions taken, provision of information, etc.
- Often patients are terrified that they have to describe elements of their story linked to torture. It is essential to explain that they do not have to express elements that are too painful; let them talk about what they want/can, when they want, at their own pace.
- Avoid reacting with disbelief or confrontational/argumentative attitudes. SoT tend to easily re-experience the relationship of abuse that they had with the perpetrator.
- Ensure safety and provide a stable setting/environment for SoT's care (for example, avoid noisy/crowded waiting areas, ensure regular scheduled appointments, ensure there is no danger in the room for suicidal patients, when feasible keep the same cultural mediator for every session, etc.).
- Be attentive to dissociation. Often when SoT are able to narrate their experience of torture, they may seem too calm because they may be detached from their emotions.

10.6.3 Importance of the physical setting

The physical setting should ensure appropriate physical healthcare conditions (light, ventilation, size, temperature, etc.) with specific attention to:

- Ensuring privacy (sound and visual) and avoidance of interruptions/people entering;
- Avoiding potential “reminders” present (medical material may be a trigger, etc.);
- Maintaining proper distance (individual/culturally dependent) as sitting too close or far may evoke stress;
- Not artificially creating a hierarchical position (professional sits higher than patient, professional has a nicer chair, etc.).

Immediately address common scenarios in health facilities and consultation rooms that may evoke stress (waiting for an appointment in the waiting room, hearing children cry, loud noises, medical exams, some medical materials, religious or national emblems that may represent a trigger of torture etc.).

10.6.4 Packages of care

Implementing a holistic multidisciplinary culturally sensitive approach is important not only for dealing with the consequences of torture but also represents the attempt to implement a de-fragmenting re-composition process. The intervention should include the provision or at least the consideration of the following elements of care:

- Medical care (pain management, physiotherapy if available, etc.);
- Psychological and psychiatric care;
- Medical and MH certificates and legal assistance when needed/possible;
- Social assistance (with referral system to ensure basic needs);
- Protection when needed/feasible.

Minimum package

The minimum elements of care delivered in projects with a low number of SoT should be considered on a case by case basis, depending on the capacity available in the team and the possibility of referral. Due to case complexity, clinical meetings of clinicians and other team members involved in the patient’s care are recommended on a regular basis if possible (multidisciplinary team meetings).

MSF should provide trauma-informed healthcare.

The principles of trauma-informed healthcare are consistent with patient-centred care approaches. Trauma informed healthcare has been defined as “a strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment”⁹.

This is key in most settings where MSF works because most of the population has been exposed to trauma. These patients can have some trauma related symptoms “triggered” by sights, smells, sounds, and situations that occur in the healthcare setting. Excessive waiting times, invasive physical procedures, the need to undress, the inherent imbalance in power between the patient and the providers, the use of physical restraints, and more may result in re-traumatization. Therefore, patients may become anxious, belligerent, aggressive and perceived as problematic, or overly submissive. As a result, they may avoid going to healthcare

settings or drop out of treatment. Often, neither patients nor health staff are aware of these issues unless the healthcare setting becomes “trauma informed.”

Comprehensive package

In a comprehensive package of care, assessment and treatment of patients should be provided through a multidisciplinary team approach. This should include the following specific activities:

- Medical care and follow-up (pain management, physiotherapy, etc.)
- Psychological support and care (counselling, psychotherapy depending on possibility of follow up, relaxation techniques, tools to relieve anxiety, etc.)
- Identification and care of severe mental disorders and provision of psychiatric care
- Identification and care of sexual violence cases (often part of torture) and referral to appropriate medical care
- Group support for stabilized patients who can integrate in a group setting, group of experts-by-experience
- Psychoeducation on symptoms for patients and relatives
- Support of relatives
- MH certificates^a (can be important for SoT for legal procedures, especially for migrants as past exposure to torture can facilitate access to asylum procedures/specific support). See [Section 2.10](#), Chapter 2 for more details
- Training of other professionals on the psychological specificities of SoT
- Patient referral for specialized care, referral for legal support



Ensure adequate and sufficient staff support, as risk of vicarious trauma is high in work with SoT. Pay special attention to the emotional state of a translator, if present. If the consultation was emotionally heavy, debrief with someone. When possible, organize group and individual supervisions by an external psychologist.

a The standardized MH certificate can be adapted to context, in agreement with the legal department, as well as the way to provide it, according to needs and capacity (for example, systematically or not).

10.7 Special considerations for children and adolescents

Children can themselves be direct victims of torture and can also have been witness to torture inflicted on relatives, which could provoke similar reactions.

The response to torture/ill treatment will be affected by the child's:

- Chronological age and developmental stage;
- Whether they were a victim or witness;
- Perception of the danger;
- Past experience with trauma;
- Relationship to the perpetrator;
- Presence/availability of adults to help.

See [Section 2.4](#), Chapter 2 for further recommendations.

10.8 Monitoring

Routine activity monitoring is described in [Section 2.7](#), Chapter 2. Monitoring should include certain indicators listed in the chapter.

Due to severity of the MH condition experienced by the SoT, long term follow up may be needed. The objective of care should be defined at the beginning of the project according to the setting and context (e.g. rehabilitation versus stabilisation) therefore indicators should consider these objectives in terms of outcomes achieved.

Screening tools to identify symptoms or resilience factors can be used during the assessment, and then repeated on a regular basis during the course of the treatment. Due to the severity of the psychological and psychiatric impact of torture on the victim, even with long term psychological support, symptoms may remain. The measure of outcomes will therefore be focused more upon degree of severity and/or on general functioning.

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Chapter 11: Substance use

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11.1 Introduction

The misuse of psychoactive substances, prescription medications and alcohol is a worldwide problem. An increase in the use of alcohol and other substances such as nicotine, cocaine, cannabis, heroine, opioids^a are among the many health and social issues associated with conflict and displacement¹.

People who use substances are encountered in all programs, particularly in projects that address human immunodeficiency virus (HIV), hepatitis C virus (HCV) and tuberculosis (TB) where substance users represent a vulnerable and frequently neglected sub-group of patients.

Health problems associated with alcohol and other substance use include those caused by acute intoxication, withdrawal symptoms and life-threatening overdoses. In some conflict-affected settings, a clear association between suicide and alcohol use has been documented¹.

Substance use disorders (including abuse and dependence disorders) are mental disorders themselves^b. The World Health Organization (WHO) in the International Classification of Diseases 11 (ICD-11) describes various substance related disorders including: harmful pattern of use, dependence, intoxication, withdrawal state, substance-induced delirium, substance-induced psychotic disorder, other substance-induced disorders, other specified/unspecified mental and behavioral disorders due to use of substances. In this chapter, only harmful use of substances will be discussed. This is defined as a pattern of use that causes damage to physical or mental health (MH) and can lead to psychological, familial and socio-economic consequences.

a In WHO ICD-11, the main substances identified are: alcohol, cannabis, synthetic cannabinoids, opioids, sedatives (hypnotics or anxiolytics), cocaine, stimulants (including amphetamines, methamphetamine or methcathinone), synthetic cathinones, caffeine, hallucinogens, nicotine, volatile inhalants, MDMA (Ecstasy) or related drugs (including MDA), dissociative drugs (including ketamine and phencyclidine [PCP]), other specified psychoactive substances (including medications), unknown or unspecified psychoactive substances, non-psychoactive substances.

b According to ICD-11, Disorders due to substance use and addictive behaviours are mental and behavioural disorders that develop as a result of the use of predominantly psychoactive substances, including medications, or specific repetitive rewarding and reinforcing behaviours.

11.2 Risk factors for mental disorders and psychosocial problems

The reasons people start to use substances varies. Most people use substances to experience joy, pleasure and/or relaxation. This use does not cause significant risk for social, physical or MH (recreational use is pleasure/reward driven). Substances can also be used as self-medication to cope with distressful feelings or psychological disorders. Regular use can lead to harmful and impulsive use (habit driven) which might lead to dependence (compulsive use).

The complex interaction between the individual characteristics, the specific context and the substance itself influence the effects and outcomes of substance use on a person². In addition, substance use disorders are frequently co-morbid with other mental disorders – particularly depression, post-traumatic stress disorder, psychosis – and causality between substance use disorders and other mental disorders can be inter-related.

Risk factors for harmful use of substances include and are associated with:

- **Context:** sub-standard or difficult living conditions (poverty, family violence, neglect or abuse during childhood, substance use in family members, etc.), conflict, displacement, social environment (peer pressure, availability and accessibility of drugs, etc.).
- **Personal factors:** low self-esteem, high reactivity to stress, high trait impulsivity, depression and trauma, social isolation, chronic illness, biology, age (adolescence is a time of increased risk), genetics, etc.
- **Drug involved:** type of drug, amount and route of use, poly-substance use, etc.

11.3 Clinical characteristics

Psychoactive drugs are chemical substances that change brain functioning and result in alterations in perception, mood, consciousness/thoughts and behaviour.

There are numerous and diverse types of substances with different effects (sedative, stimulant, hallucinogenic, etc.) which also vary from person to person depending on amount taken and routes of administration (ingestion, injection, smoking, snorting).

Many substance users take more than one type of drug. The diagnosis of the disorder is classified, whenever possible, according to the most important single substance (or class of substances) used. See [Appendix 10](#) for categories of psychoactive drugs and their clinical characteristics.

Key terminologies in clinical substance use disorder presentations include the following, as mentioned or described in MSF's validated treatment algorithm for substance use disorder management – WHO's mhGAP-IG 2.0³.

- **Intoxication:** a transient condition following intake of a psychoactive substance resulting in disturbances of consciousness, cognition, perception, affect, or behaviour.
- **Overdose (OD):** the use of any drug in such an amount that acute adverse physical or mental effects are produced.
- **Harmful use:** a pattern of psychoactive substance use that damages either physical health (liver disease, etc.) or MH (episodes of depressive disorder, etc.). It is often associated with social and occupational consequences (family or work problems, etc.).
- **Dependence:** a cluster of physiological, behavioural, and cognitive phenomena in which the use of a psychoactive substance takes on a much higher priority for a given individual than other behaviours that once had greater value. It is characterized by a strong craving to use the substance and a loss of control over its use. It is often associated with high levels of substance use and the presence of a withdrawal state upon cessation.
- **Withdrawal:** the experience of a set of unpleasant symptoms following the abrupt cessation or reduction in dose of a psychoactive substance that has been consumed in high enough doses and for a long enough duration for the person to be physically or mentally dependent on it. Withdrawal symptoms are, essentially, opposite to those that are produced by the psychoactive substance itself. Withdrawal from some substances – particularly alcohol and benzodiazepines, can be life threatening.
- **Delirium associated with substance use:** confusion, hallucination, racing thoughts, anxiety, agitation, disorientation, typically in association with either stimulant intoxication or alcohol (or other sedative) withdrawal.
- **Craving:** a strong feeling or sense of compulsion to use substances. Classical triggers that induce craving and relapse into substance use are re-exposure to drugs, stress and environmental triggers³.

11.4 Clinical assessment

Remember that taking a substance use history is part of a routine MH assessment. Pay special attention when a patient presents with any of the signs and symptoms of substance use conditions listed in the section above.

Patients with harmful use of substances or substance dependence disorders included in a medical program should benefit from individual specific assessment and follow up. The overall goal, irrespective of the program's structure, is to provide medical care to this vulnerable group that otherwise may not have access to it, due to stigma, discrimination, etc. Use of illegal drugs is socially and morally disapproved. Without confidence and trust, people who use substances do not easily open up or listen to psychoeducation messages.



Emergency presentations of disorders due to substance use

Acute substance disorder presentations, in particular withdrawal and delirium states, can be medical emergencies. The MSF validated guideline for management of substance disorder emergencies is the Substance Disorders algorithm of the mhGAP Intervention Guide³.

After ruling out or managing medical emergencies, the assessment should take the following steps:

First steps:

- Establish a trustful, non-judgmental and confidential relationship. Attitude is key in accessing this hidden group.
- Understand the patterns of use and patient's personal situation.

Recommendations:

After ensuring the patient is not critically ill (requiring immediate medical attention):

- Clarify types (recreational, harmful, dependence) and patterns of substance use (when, how, with whom, where, etc.).
- Understand the patient's psychosocial situation and reasons for using (self-medication, etc.).
- Determine the stage of change which will direct the nature of intervention. See [Appendix 11](#) for Prochaska and DiClemente's stages of change model. Understanding which stage of change the person is at is one of the first steps of the Motivational Interviewing intervention described below in [Section 11.6.2](#).

Use available tools, brief or more comprehensive, to screen for alcohol and other substance use ([Appendix 3](#)):

- Audit screening tool: alcohol;
- CAGE-AID: alcohol and other substance use;
- ASSIST: a comprehensive screening tool for substance use.

Use of a screening tool is always accompanied with explanation on its use and benefits for the patient.

The objective is to act **with** the patient and not to act **for** the patient. The challenge is how to engage people in our care. It is important to understand the stage of use and patient's personal situation in order to propose a realistic step by step support process. Reducing or stopping substance use is a difficult, often slow, process. The patient must know that they will not be rejected if they relapse.

11.5 MHPSS assessment

Context analysis

In order to provide an adequate mental health and psychosocial support (MHPSS) response, it is important to first analyse substance use and its particular public health impact, taking into consideration the regional and national contexts (health system and legal context), epidemiology and socio-cultural aspects.

At local level, more detailed information is needed:

- Local actors (non-governmental organizations, community-based organizations, etc.): attitude of organization/actor, availability and quality of harm reduction and treatment services (methadone, new psychoactive substances, etc.), accessibility (free of charge? who has access (women, all ethnic groups, etc.)? etc.);
- Medical actors (Ministry of Health and private facilities): quality of basic health services and specialized services (HIV, HCV, etc.), medical/social actors' perception about people who use substances, etc.;
- Size and dynamics of the population;
- Vulnerable (hidden and neglected) groups;
- Particular risk behaviours.

Assessment of the way of living of people who use alcohol and other substances

Individual interviews, focus group discussions (FGDs) and direct observation are tools used to assess the medical needs of people who use alcohol and other substances. When facing this hidden and hard to reach group, working with peer workers can be effective⁴.

Peer workers:

- Have had similar experiences of addiction and living conditions as the patient and therefore understand the patient's situation as they have lived through it and are now stabilized.
- Know where (geographically) the target population lives/meet together.
- Can bridge the mistrust and fear of people who use substances towards health services, helping to overcome it.
- When trained/supervised, should be included in the first steps of outreach activities.

Information is gathered during the assessment from people who use alcohol and other substances regarding:

- What they define as their "problems";
- The dynamics of the population (role of leaders/dealers, hotspots, etc.);
- Their perceptions of risk and access to harm reduction measures;
- Which substances are used; how they are used; where the substance or substances are obtained;
- How they perceive social/health organizations/ police or other relevant organisations.

11.6 MHPSS activity planning

Medical, mental health and psychosocial supports require multidisciplinary teams. The operational set up of substance use programs varies depending on context, medical objectives, feasibility, etc. Individual needs can be:

- Integrated as part of the medical care provided (e.g. HIV, HBV^a and HCV, TB);
- A specific focus (target group) due to vulnerability: those neglected and frequently excluded from the healthcare system (e.g. homeless populations, sex workers).

Because adherence to medical treatment is often the main challenge with people who use alcohol and other substances, specific activities (peer workers, a workforce such as community health workers who provide outreach/defaulting tracing, etc.) are developed in some programs. Mobile clinics increase accessibility to medical care.

When considering and developing interventions for people who use substances, different services such as housing, legal support, occupational therapy and social work should be considered and can be provided either directly or indirectly (through referrals, partnerships, etc.). These approaches should be considered in addition to medical programs. Medical programs can include provision of primary healthcare with testing and treatment, links to secondary and tertiary healthcare, provision of care for chronic communicable diseases such as HIV/HCV/HBV/TB, etc. Care and/or referral for management of sexual violence and sexual and reproductive health is important to consider, particularly in vulnerable populations.

Program complexity can vary according to each specific context and the available resources.

There are different settings for providing prevention and treatment interventions, namely: community-based outreach settings, non-specialised for the treatment of people with substance use disorders, specialised outpatient treatment, specialised inpatient treatment (short-term or long-term)⁵.

11.6.1 General principles

In addition to the minimum requirements (staff, medications, and general resources, etc.) for any medical programs, ensure:

- Appropriate attitudes from all staff members (guards, triage nurses, care providers, etc.) when engaging and providing services. This is key to cultivating relationships of trust. Trainings will help to achieve this.
- Shifting from a standard medical approach (e.g. appointment times and fixed clinics) to a broader more inclusive and assertive care approach. The aim is to understand and respond to the needs of the population and genuinely engage with them (e.g. mobile clinics, flexible clinic opening and appointment times, active patient tracing to improve engagement and follow-up etc.).
- Implementing a multidisciplinary patient-centred approach (doctors, nurses, psychologists, social workers, community health workers, peer workers, etc.).

a HBV : hepatitis B virus

11.6.2 Minimum package

In programs addressing HIV, TB and HCV, the following (minimum) activities should be set up to tackle the substance use problem, enhance adherence to treatment, gain a better understanding of the magnitude of the problem and help in deciding if scaling up activities is pertinent (comprehensive package). The minimum package can also be delivered within general health care activities (primary health, out-patient department or emergency room) or implemented as part of MHPSS programs, when the MHPSS program doesn't have substance use disorders as part of it.

The minimum package includes:

- Basic training for teams on detection of substance users within the project's cohort (see mhGAP-IG algorithm substance use disorders³);
- Psychological First Aid adapted to substance use;
- Psychoeducation activities;
- Identification and treatment of comorbid severe mental disorders;
- Referral to specialized care if available;
- Advocacy for scaling up of services (within MSF and/or to the Ministry of Health);
- Motivational interviewing approach (basic motivational skills training for teams treating patients with substance use disorders), see below.

Screening, Brief Interventions and Referral to Treatment (SBIRT) is the main approach used in health settings that are not specialized in the treatment of substance use disorders.

Health, prevention and harm reduction program services can be included, depending on the program.

Points to consider include:

- Sexual and reproductive health (including treatment of sexually transmitted infections);
- HIV testing and antiretroviral therapy;
- Diagnosis and treatment of HBV, HCV, TB;
- Overdose management;
- Needle and syringe exchange program;
- Condom distribution;
- Focused information, education and communication sessions for substance users and their partners.

Motivational interviewing (MI): MI is a person-centred approach to patient care that helps people resolve ambivalent feelings and find the internal motivation they need to change their problematic behaviour⁶. It is a practical, empathetic and short-term process that takes into consideration how difficult it is to make lifestyle changes. To adopt an MI approach the clinician needs to understand the 'Stages of Change' ([Appendix 11](#)). In MI, the clinician understands that it is the person's own reasons for change, and not the reasons identified by the clinician, that will lead to a change in the person's behaviour: the person who has the problem is the person who has the answer to solving it.

MI specifically avoids: arguing with the person, offering direct advice, giving the person solutions, dominating the session with an 'authoritarian/expert' stance, imposing diagnoses or labels, behaving coercively.

Reducing substance or alcohol use is an effective strategy for change and harm reduction. The goal does not have to be abstinence to be beneficial.

Patients need to:

- Recognize the disadvantages of the status quo;
- Recognize the advantages of change;
- Be optimistic about change;
- Have an intention to change;
- Make a commitment to change.

Table 11.1 - Change statements

Sentiment	Explanation	Examples
Desire	Statement patients make about preference for change	<ul style="list-style-type: none"> • I would like to.... • I wish... • I really want to quit...
Ability	Statement patients make about self-capability	<ul style="list-style-type: none"> • I think I could use less
Reasons	Statement patients make that are specific arguments for change	<ul style="list-style-type: none"> • I know I would feel better if I quit • I would have more money if I was spending less on substances
Need	Statement patients make about feeling an obligation to change	<ul style="list-style-type: none"> • I should do this for my family
Commitment	Statements patients make about the action(s) they will take to change	<ul style="list-style-type: none"> • I hope to... • I plan to... • I am going to make a list of pros and cons for quitting

The clinician practices MI with five general principles in mind:

- Express empathy through reflective listening: be respectful and accepting of where the patient is in the “change” process. Remember that ambivalence towards change is normal. Recognising ‘change statements’ (Table 11.1) expressed by the patient can help identify any goals the patient may have.
- Develop discrepancy between patients’ goals or values and their current behaviour: emphasize awareness of the consequences of problematic behaviours. Avoid taking sides.
- Avoid argument and direct confrontation: adjust to patient resistance rather than opposing it directly. Invite and do not impose new perceptions. Engage patients in solving problems. Avoid labelling.
- Support self-efficacy and optimism: foster patients’ belief in the possibility of change.
- Emphasize that patients are responsible for making changes: guide patients to explore a range of alternative approaches to change.

11.6.3 Comprehensive package

Comprehensive packages should include all the activities and interventions listed in the Minimum package (note in particular the importance of training teams in MI so this can be integrated into each clinician’s approach), as well as a combination of some of the following:

- Mental health care (counselling/psychological and pharmacological interventions)
- Harm reduction interventions for example:
 - Opioid substitution therapy (or other evidence-based treatment for drug dependence)
 - Needle exchange programs
 - Tobacco cessation program (including basic counselling and nicotine replacement therapy)

- Detoxification programs (including rehabilitation interventions)
- Social assistance: socio-economic reintegration, social and legal support
- Other psychosocial activities
- Safe places: drop-in centres, shelters
- Advocacy strategy: including scaling up of services, protection and legal advocacy, etc.

Some community-based interventions (outreach activities through community health workers and peer workers, etc.) can also be implemented in order to:

- Reach less visible populations and trace patients who have defaulted;
- Promote proximity and accessibility to medical services and harm reduction services;
- Work closely with existing structures (drop-in centres, shelters, etc.).

For the implementation of a comprehensive package, a mental health activity manager (MHAM) and MHPSS team is required.

Psychosocial and psychological interventions

- **Brief interventions:** are part of SBIRT and use the collaborative conversation style of MI to address problematic or risky substance use but delivered over a shorter timeframe ranging from 5–30 minutes. Personalised feedback is provided on a person’s substance use. Questions are asked about the benefits and harms of substance use in an attempt to elicit a motivation to change. In concluding the brief session, a plan for change and a follow-up is negotiated. Brief interventions consist of five phases, called the 5As’ — ask, advise, assess, assist and arrange⁷.
- **Relapse prevention** the emphasis is on training people with substance use problems and disorders to develop skills to identify situations or states (triggers for craving) where they are most vulnerable to substance use, to avoid high-risk situations and to use cognitive and behavioural strategies to cope effectively with these situations and achieve a life-style balance.
- **Contingency management:** contingency management involves giving patients concrete rewards to reinforce positive behaviours, such as abstinence, treatment attendance, compliance with medication or a patient’s own particular treatment goals.
- **Self-help groups (“mutual-help groups”)** e.g. alcoholics anonymous, narcotics anonymous, etc.: voluntary groups where people meet to discuss and address shared problems such as alcohol, drug or other addictions. Participants provide support for each other, with senior members often mentoring or ‘sponsoring’ new ones. As well as helping substance users, some self-help groups exist to support the family members of people with alcohol and other substance-related problems. The groups aim to create a drug-free supportive network around the individual during the recovery process and provide opportunities to share experiences and feelings.
- **There are other psychological interventions that may be implemented such as: cognitive-behavioural therapy, motivational enhancement therapy, family therapy and others.**

11.7 Special considerations for children and adolescents

Clarify the confidential nature of the healthcare discussion, including in what circumstances the child or adolescent's parents or caregivers will be given any information. Ask what else is going on in the adolescent's life and identify their most important underlying issues. Explore the following areas:

- Home, education and employment
- Activities
- Drugs and alcohol
- Peer pressure
- Sexuality
- Safety
- Suicide/depression
- Other MH conditions

Children and adolescents also experience difficulties with substances when their parents use substances. The safety and wellbeing of these children should be considered to ensure their protection. A protection framework, setting out the processes for consideration and management of child safety issues, needs to be planned for each activity. Depending on the context this can mean assessing and engaging with other protection actors. The MSF legal department can be consulted regarding aspects of a protection framework particularly if it involves consideration of referral or reporting of cases to government authorities.

11.8 Special considerations for pregnant and breastfeeding women

Pregnancy

Pregnant women who use substances need specific follow-up as medical problems for mother, foetus and neonate can be serious, particularly for methamphetamine and crack (cocaine) users, as they impact foetal development. Substance use in pregnancy can lead to foetal malformations including developmental disorders, miscarriage, premature birth, and general health consequences for the woman. The neonates of opioid (heroin, opium and other opiates) users can also experience significant physical withdrawal symptoms at birth requiring identification, close monitoring and treatment.

If the woman is dependent on opioids and not able to stop using drugs, the safest solution is to propose/refer her to a methadone maintenance treatment (MMT) clinic for stabilization, if available.

Other examples of health-related issues linked to a pregnant substance users' lifestyle are inadequate rest/nutrition/hydration, cigarette smoking, use of other substances and being a victim of violence.

It is not uncommon for women to be reluctant to disclose substance use, as they often fear criticism or dread having the child removed from their care. Pregnancy can be a strong motivator for change in some women. Health workers can skilfully employ motivational approaches during this time. A pregnant woman needs to have regular supportive antenatal care which improves outcomes for both the mother and the neonate.

Delivery and breastfeeding

The best option (if available) is that delivery occurs in a maternity with specialized services, where the neonate's withdrawal symptoms can be appropriately managed. However, women may fear intervention of social services (in some countries these neonates are frequently taken away from their mothers).

- **MMT:** breastfeeding is not contra-indicated for women under MMT, but close monitoring of the neonate/infant is necessary.
- **Methamphetamine:** its use reduces the quantity of breast milk. Methamphetamine can be released into breast milk (and has been found in the urine of substance users' neonates). Infants breastfed by methamphetamine-using mothers may experience a range of drug-induced behavioural problems such as irritability, poor sleeping patterns, agitation and crying.

11.9 Monitoring

As a starting point, some of the general MH indicators listed in [Section 2.7](#), Chapter 2 will enable monitoring of activities that involve care of patients with substance use difficulties. Comparison of these indicator outcomes between substance using and non-substance using populations can be valuable.

Specific indicators assessing effectiveness of screening and interventions for people with substance use disorders (some of the following adapted from UK NICE Guidelines⁸) may include:

- a) **Screening:** in projects treating patients with TB, HIV, HCV or non-communicable diseases, consider: proportion of patients screened using appropriate tools (i.e. AUDIT, CAGE-AID, ASSIST - see [Appendix 18](#)).
- b) **Provision of MHPSS interventions:** proportion of people in treatment with substance use disorders who receive appropriate psychosocial interventions (e.g. an MI approach in medical or nursing consultations, or psychotherapy/counselling from a trained MH clinician).
- c) **Provision of treatment for co-morbid mental disorders:** proportion of people in treatment with substance use disorders who have comorbid depression, anxiety or psychotic disorders who receive treatments for those disorders.
- d) **Virus screening:** proportion of people in treatment with substance use disorders, with unknown hepatitis B, hepatitis C, HIV status who receive testing for each virus.
- e) **Access to services:** proportion of people in treatment with substance use disorders who receive support to access services that promote recovery and reintegration (this can be divided into healthcare, referral or support for housing/shelter).
- f) **Observation of staff attitudes** towards people who use alcohol and other substances⁹. Proportion of staff with positive attitudes to people in treatment with substance use disorders (questionnaire monitoring this can be adapted from the reference above).

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12.1 Introduction

Although malnutrition can affect adults and older people, it is usually children under five years of age who disproportionately suffer from both chronic and acute malnutrition. The focus of this chapter is the mental health and psychosocial support (MHPSS) component of malnutrition treatment in children under 5 years old.

Therapeutic feeding programmes (TFP) in MSF should address the nutritional, medical and psychosocial aspects of moderate acute malnutrition (MAM) and/or severe acute malnutrition (SAM) in children under 5 years old.

Depending on the severity of their nutritional status, patients are treated in either:

- Inpatient settings: in-patient therapeutic feeding centres (ITFC)^a or
- Out-patient settings: ambulatory therapeutic feeding centres (ATFC)^b

Treatments consist of nutritional, medical and psychosocial interventions. Providing psychosocial stimulation has an added positive impact on the child's development and recovery¹. Depending on operational strategy, preventive nutrition activities can also be implemented (e.g. infant and young child feeding in emergencies) and these activities should include an MHPSS component.

a Other organizations may refer to ITFCs as stabilisation centres (SC).

b Other organizations may refer to ATFCs as outpatient therapeutic programmes (OTP) or supplementary feeding programmes (SFP) which are usually for MAM.

12.2 Risk factors for mental disorders and psychosocial problems

In most chapters, this section only refers to risk factors resulting in the development of mental disorders and psychosocial problems. In this chapter, this section focuses on the psychosocial and cultural risk factors that may contribute to the development of malnutrition. Factors such as severe and seasonal food shortages, impact of conflict and displacement are some of the main causes of malnutrition in the contexts where MSF works. Health factors e.g. diarrhoea, malaria, HIV and TB can also result in malnutrition.

It is crucial managers and team members understand the full range of psychosocial and cultural determinants of malnutrition in the contexts where they work. For a more detailed description of these risk factors see the MSF guide «Psycho-social aspects of child malnutrition»¹.

Cultural factors

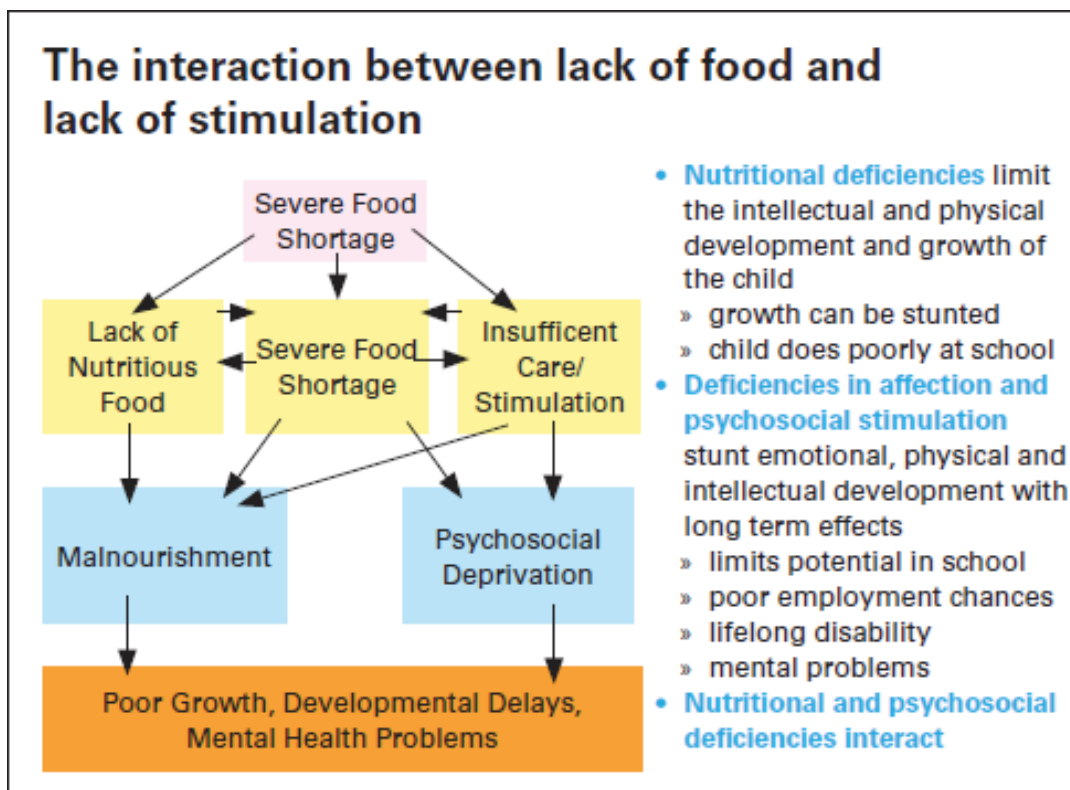
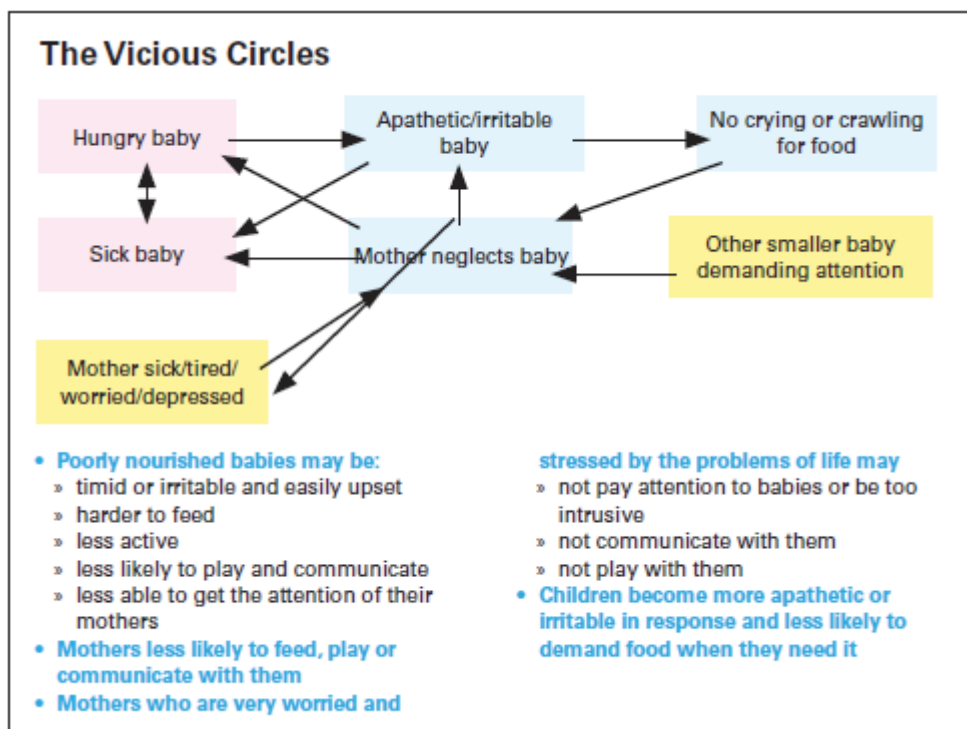
These factors include:

- Breastfeeding practices, start of complementary feeding, early weaning due to the birth of the next child, family eating practices, beliefs about illness and malnutrition, impact of birth order, impact of gender, impact of wife order (in polygamous cultures), use of ineffective or harmful alternative medicines, isolation, lack of support networks, etc.

Psychological factors

Psychological factors are also considered to play an important role in the development of child malnutrition. Caregivers under great pressure (war, displacement, economic difficulty or facing food shortages) can feel distressed and find it difficult to provide their children with the usual care and stimulation. Malnourished children may also be difficult to care for, as they are often irritable and reject the food and milk they are offered. Caregivers can feel hopeless and defeated in their role².

High rates of depression are found in caregivers of malnourished children, impacting caregiver-child interaction^{3,4}. As the primary caregiver becomes less engaged with their child, the child withdraws with decreasing attention-seeking behaviour. In turn, the caregiver further withdraws. A vicious circle ensues with the increasing withdrawal of both caregiver and child. Both poor nutrition and lack of stimulation in the caregiver-child relationship are major causes of developmental delays⁵ (see [Figure 12.1](#) and [Figure 12.2](#)). Caregiver depression may affect a child's physical health and development. The child's deterioration then negatively affects the caregiver's health-promoting behaviour and child-care practices⁶.

Figure 12.1 - Interaction between lack of food and lack of stimulation⁷.Figure 12.2 - How mother and infant problems in stressful environments may interact⁷.

12.3 Clinical characteristics

Behavioural changes are common in moderately and severely malnourished children and can lead to disruption of a positive and mutual caregiver-child relationship.

Malnourished children:

- Are less active and curious about their environment;
- Often do not engage with caregivers or respond to playful stimulation or comfort from the caregiver;
- May show a variety of behavioural changes such as: apathy, irritability, clinging to the caregiver, regression to a previous developmental stage, avoid eye contact, anorexia; in more severe cases: become disconnected from their environment;
- May suffer delays in mental and behavioural development.

Caregivers may present with excessive feelings of guilt, worry, stress and fear or other mental health problems and disorders (e.g. depression).

12.4 Clinical assessment

An important first step is to talk to ITFC staff and other staff (ATFC staff, midwives, community health workers, traditional birth attendants) to understand the socio- cultural practices of the specific context.

The team should assess the ITFC in order to observe:

- Children’s appearance (hygiene, dress, affect).
- Impairment in caregiver-child interaction (no eye contact, lack of physical contact, absence of mutual play, etc.).
- Irritable children (with caregiver not responding to the child or the child not responding to the caregiver’s efforts to comfort them).
- Impaired feeding practices (no social interaction, no face to face contact, forced feeding, etc.).
- Caregiver appears exhausted, sad, withdrawn, apathetic, etc.; child appears sad, apathetic, etc.



Remember, when carrying out individual assessments of children and caregivers, always rule out potential medical conditions.

Assessment of a caregiver-child pair^a

Further information can be found in [Section 3.3](#), Chapter 3.

- Assess the child’s development as well as their behavioural and emotional status (affect and social interaction): a table with the major developmental milestones (neonate to 5 years old) can be used as a guide to determine the child’s developmental capacities (see [Appendix 1](#)).
- Assess the caregiver including their physical health, mental health (MH), social support system and caregiving ability. Clinically interview the caregiver, including a mental status exam, personal history and social history. Tools can be used to assess depression or psychological distress (see [Appendix 3](#)).
- Assess caregiver-child interaction and relationship: observe and assess during feeding, caregiving and daily routines such as bathing the child (see [Table 12.1](#) following page).

^a Previously known as the caregiver-child dyad.

Table 12.1 - Chart for observations of mother-child interactions, ACF⁸

Mother-child interactions			
Date:	Child's name:	Mother/caregiver's name:	
CODE	◇ = Always or constant	● = Occasional or absent	✕ = Not observed
Child		Mother	
EMOTIONAL INTERACTIONS			
Smiles at mother		Responds to baby smiles	
Responds to mother's smiles		Smiles at her baby	
Shows affection to its mother		Shows affection to her child	
Seeks affection from its mother		Seeks affection from her child	
PHYSICAL INTERACTIONS			
Can be separated from its mother		Takes the child in her arms	
Seeks physical contact		Encourages the child not to be clingy	
Uses touch to explore		Stimulates the child's sense of touch	
Is active and moves		Encourages the child to be active	
Gives objects to its mother		Takes objects given by the child	
Takes objects given by its mother		Gives objects to the child	
Imitates his/her mother's gestures		Encourages the child to imitate her gestures	
VERBAL INTERACTIONS			
Uses his/her voice to communicate		Uses her voice to communicate	
Understands instructions and warnings		Gives explanations	
Laughs		Reacts to her child's cries	
Imitates, responds by echoing		Encourages the child to imitate her words and sounds	
VISUAL INTERACTIONS			
Looks for its mother and watches her		Seeks out visual contact with the child	
Responds to its mother's looks		Looks at her child	
Calls its mother's attention to objects		Calls the child's attention to objects	
Observes its environment		Encourages the child to observe his/her environment	
TOTAL			
		CHILD	MOTHER
EMOTIONAL INTERACTIONS	◇		
	●		
	✕		
PHYSICAL INTERACTIONS	◇		
	●		
	✕		
VERBAL INTERACTIONS	◇		
	●		
	✕		
VISUAL INTERACTIONS	◇		
	●		
	✕		
TOTAL	◇		
	●		
	✕		
Notes and action plan:			

This chart is to be used in the first assessment. It can also be used to monitor the evolution of the interaction on a weekly basis.

Caregiver-child play interaction assessment

Do not forget that in many contexts, caregivers may not be the person who spends most of the time with the child or plays with them at home (it may be other siblings, other family members etc.). Factor this in when assessing the interaction.

- Ask the caregiver how the child plays at home and with whom.
- Sit on the floor together with the caregiver and child with a ball or a simple toy (such as a plastic bottle⁹) or whatever may be culturally appropriate and encourage a play session between the caregiver and the child. You can also ask the caregiver to engage in a stimulating interaction that they might do at home (such as singing, talking, dancing, etc.).
- Introduce a game between you, the caregiver and the child (singing, clapping etc.) and assess responsiveness.

12.5 MHPSS assessment

A needs and resources assessment should be carried out as described in [Chapter 1](#). In addition, when working with the medical team to set up the MHPSS component:

- Seek information on prevalence of malnutrition in the community;
- Attempt to understand malnutrition in the community including perception of children with malnutrition, of mothers of malnourished children and the social consequences (stigma, blaming of mothers, social isolation);
- Assess the knowledge and attitude among health staff of these perceptions.

Identify what type of TFP MSF is running (ITFC, ATFC, other) and how many children there are in the program. In a nutritional crisis a comprehensive MHPSS package is mandatory.

Always ask information about ATFC defaulter rates, if there are self-discharges from the ITFC and why. Ask about the patient flow, the schedule of routine healthcare activities in the TFP (medical round, milk preparation, feeding time, etc.) and the health facility (to identify a place for children corner). Identify, in coordination with the supervisor/manager of the TFP, potential human resources that can implement the MHPSS activity. It can be someone from the MHPSS team (counselor or community mental health worker) but also a nutrition assistant or a community health worker.

Always coordinate with the rest of the medical team on how to best integrate MHPSS care into the TFP so it exists as part of the activity and not something in parallel. Integration of MHPSS is most easily done from inception of the TFP.

12.6 MHPSS activity planning

Interventions focus on restoring and/or promoting a mutual positive caregiver-child relationship and providing developmentally appropriate stimulation.

A multidisciplinary approach with a combination of appropriate feeding practices, medical care and psychosocial stimulation is necessary in the rehabilitation of the malnourished child. Psychosocial stimulation includes emotional, psychomotor and sensory stimulation with the objective of promoting a positive interaction between caregiver and child. Psychomotor stimulation activities involve movement, talk, play, etc. and are essential in TFPs¹⁰.

It is important to create a pleasant and reassuring environment in the ITFC/ATFC and to provide activities aimed at restoring and/or promoting a mutually positive caregiver-child relationship and providing developmentally appropriate stimulation, creating social interactions and improving therapy in a pleasant and joyful environment and space.

Play allows children to use their creativity while developing their imagination, dexterity, and physical, cognitive, and emotional strength. Play is important to healthy brain development. It is through play that children at a very early age engage and interact in the world around them. Toys and play sessions should be included and play areas should be provided as these are a good way of making children more active and restoring their appetite. Homemade toys as part of creative projects or from simple everyday objects can be much appreciated and beneficial for children and their caregivers.

The human resources needed to implement psychosocial activities vary depending on the set-up of the feeding program, the centre's team and the workload. A mental health activity manager (MHAM) is recommended to set up integrated MHPSS activities.

12.6.1 Minimum package

All TFP activities are carried out by nutrition staff. An MHAM is recommended for about three months at the initial set-up of a project, to provide training and supervision of staff and assist in the implementation of activities. A permanent supervisor then provides on-going training and supervision.

Table 12.2 - Minimum package for malnutrition

For all Settings	ITFC	ATFC
<ul style="list-style-type: none"> • Ensure the basic space required is set up (child friendly areas for stimulating activities, rest areas for caregivers, etc.). • Raise staff awareness and provide them training on MHPSS principles and activities in relation to nutrition. • Train staff to provide adequate communication between health staff and patients/children and caregivers (emphasize that staff should not blame caregivers). • Provide psychological first aid (PFA) training for staff. • Provide psycho-education messages for caregivers on the principles of the treatment and, in a culturally sensitive way, how to improve caregiver-child interaction and the negative consequences of lack of stimulation. • Identify children and/or caregivers who require referral for specialized care [Recognition of the most frequent presentations of MH conditions]. 	<ul style="list-style-type: none"> • Provision of PFA when needed. • Daily psychosocial stimulation activities that promote caregiver-child interaction (caregiver-child play with homemade toys, singing, dancing, massage¹¹). • Observe and record in the counselling file notes on interactions between the child and caregiver (holding, caring practice, verbal and non-verbal exchanges) to detect vulnerable pairs and provide support during psychosocial activities (to promote caregiver-child interaction). • Identify caregivers suffering from severe mental disorders (moderate-severe depression, psychosis) and refer to the medical team or person appointed to offer support. 	<ul style="list-style-type: none"> • Daily group psychosocial stimulation activities that promote caregiver-child interaction (psychomotor stimulation, sensory stimulation, caregiver-child play with homemade toys). • Observe and record in the file notes on interactions between the child and caregiver (holding, caring practice, verbal and non-verbal exchanges) to detect vulnerable pairs and provide support during psychosocial activities (to promote caregiver-child interaction). • Identification and management (PFA and referrals for further MH care) for caregivers who present mental disorders or psychosocial problems (social isolation, adolescent caregivers, no family support). • Mobilization of community resources (extended family, neighbours, leaders) to support the family if needed. • Referral to other specialized services if needed.

12.6.2 Comprehensive package

In addition to the activities described in the minimum package:

Table 12.3 - Comprehensive package for malnutrition

For all Settings	ITFC	ATFC
<p>Implement:</p> <ul style="list-style-type: none"> • Regular multi-disciplinary meetings. • Psycho-education of caregiver on developmental stages of the child and importance of interaction and the relation with malnutrition. • Daily psychosocial stimulation activities that promote caregiver-child interaction. • Support groups for caregivers (tea groups, breastfeeding groups, etc.): ideal places to discuss difficulties in mothering, parenting skills, coping strategies and provide mutual support. • Individual and group counselling (and follow up) for caregivers suffering from common mental disorders. • Identify caregivers suffering from severe mental disorders (severe depression, psychosis) and refer to the psychiatrist/clinician trained in mhGAP-IG for pharmacological adjuvant treatment. 	<ul style="list-style-type: none"> • Observation of caregiver-child interactions with detailed assessment when noting difficult or disrupted relationships. • Psychosocial-stimulation sessions to promote the caregiver-child interaction: during phase 1 emphasize talking to and touching the child; in phase 2: short sessions should be facilitated (20-40 minutes) for small groups of caregivers to play with their child; consult with ITFC manager for best time to schedule these sessions. • During the preparation for discharge, individual counselling and group discussion informing and educating the caregivers on good practices to avoid relapses (topics to discuss include causes and consequences of malnutrition, psychosocial stimulation, appropriate feeding practices and health seeking behaviour). 	<ul style="list-style-type: none"> • Observation of caregiver-child interaction and advice concerning stimulation and interaction. • Monitor psychological well-being of caregiver. • Screening for depression among caregivers (PHQ-9). • Identification of children in need of MH care and referral to MHPSS team. • MH care when MH needs are identified in the child or caregiver. • Referrals when needed. • Daily group psychosocial stimulation activities that promote caregiver-child interaction (psychomotor stimulation, sensory stimulation, caregiver-child play with homemade toys). • Individual caregiver-child psychosocial stimulation sessions.

12.7 Monitoring

Routine activity monitoring is described in [Section 2.7](#), Chapter 2. Monitoring should include some of the indicators listed in that chapter.

In addition, items for consideration may include:

Improvement of the caregiver's mental health

Tools: MH data tool, counselling file, complaint and functionality scores, administration of monitoring tools such as the clinical global impression scales.

- Improved mental status
- Improved ability for caregiving including observation of spontaneous and independent caregiving practices

Improvement of the child MH

Tools: through observation and recording in the counselling file.

- Playfulness
- Affect
- Developmental abilities
- Social interaction especially with caregiver

Improvement caregiver-child- interaction

Tools: observation grids can be adapted from the ACF guideline⁸.

- Improved attachment (checklist before and after the psychosocial intervention)
- Interaction during play session
- Interaction during general care
- Improvement in hygiene and appearance of the child

Programmatic monitoring

This can be done in various ways, for example:

- Number of psycho-stimulation sessions per month (1/day)
- Percentage of caregivers diagnosed with depression who received appropriate treatment

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13.1 Introduction

The interaction between physical and mental health (MH) is well established. Poor MH exacerbates physical health problems and physical health problems can precipitate mental disorders. Mental disorders, such as depression, represent an important risk factor for premature mortality not only in industrialised countries but also in low-income and middle-income countries.

Importantly, MH issues are linked to an increased risk of mortality due to associated physical health issues, such as cardiovascular disease and cancer¹. People with severe mental disorders (SMDs) are two to three times more likely to experience cardiovascular morbidity, diabetes and other physical conditions than the general population².

People with non-communicable diseases (NCDs)^a are two to three times more likely to experience mental disorders and psychosocial problems than the general population³. In addition, chronic communicable diseases such as HIV^b and TBc also have strong associations with mental health disorders and psychosocial problems (MHPSS). Depression is the most common MH disorder among people living with HIV (PLHIV). Prevalence of major depression among patients with HIV has been estimated to be between 15 and 40 percent⁴. There is growing evidence associating psychiatric disorders such as depression, anxiety and psychosis with drug resistant tuberculosis (DR-TB) and with HIV/DR-TB coinfection⁵.

Mental disorder and medical comorbidity may lead to poor adherence to treatment and medical advice and reduced ability to manage physical symptoms effectively. These factors can then result in poorer outcomes, including worse clinical state, poorer quality of life and increased risk behaviours.

Supporting the MH needs of people with chronic disease, particularly through inclusion in self-management support programs (living well groups, peer support programs, etc.) and provision of assessment and treatment of MH disorders and psychosocial problems, leads to improvements in both mental and physical health.

MSF has developed guidelines on NCDs and Patient Support, Education and Counselling (PSEC) for people living with HIV and/or Tuberculosis (TB) where more information can be found.

a In this chapter, when we refer to “chronic diseases” it mainly refers to NCDs and HIV/TB.

According to OCA NCDs guideline: “NCDs refers to those chronic conditions that represent the highest burden of disease: hypertension and cardiovascular disease, chronic respiratory disease (asthma and COPD), diabetes and hypothyroidism, epilepsy and cancer”.

b HIV: Human immunodeficiency virus.

13.2 Risk factors for mental disorders and psychosocial problems

Risk factors for developing mental disorders and psychosocial problems can be considered as a result of multiple inter-related.

When considering risk factors for mental disorders and psychosocial problems amongst people with chronic diseases, it is important to take into account the following risk factors in particular:

- Lifestyle factors: as well as being a risk factor for NCDs, note that sedentary behaviour, unhealthy diet, and harmful use of alcohol and other substances are also risk factors for mental disorders and psychosocial problems.
- Chronic disease comorbidity: rates of depression are higher in people with more than one chronic disease than in people with one chronic disease alone (e.g. a person with diabetes who also has hypertension is at greater risk of developing depression than someone with diabetes alone⁶). Presence of chronic disease comorbidity has been found to be a strong predictor of anxiety and stress amongst patients with diabetes⁷.
- Chronic disease medications: some drugs used to treat chronic diseases may cause psychiatric side effects or exacerbate previous psychiatric disorders e.g. levetiracetam, digoxin, beclomethasone, atorvastatin, methyldopa, or some treatments for chronic infections such as cycloserine for TB and efavirenz for HIV.
- Noncompliance with treatment may be a cause or a result of mental disorder.
- Patient's perception of severity e.g. there is a higher prevalence of depression in people with diabetes if they believe they have a severe and difficult to treat disease^{5,8}.
- Stigmatization related to certain chronic disorders increases the risk of stress, anxiety and depression, e.g. epilepsy, HIV and TB.
- The pathological processes of some chronic disorders can be linked to mental disorders and psychosocial problems. Thyroid disorder is a classic example that needs to be considered as a potential direct cause of MH symptoms (e.g. depressive symptoms as a result of hypothyroidism and manic symptoms as a result of hyperthyroidism). Other important examples of this include HIV, TB meningitis and neuro-syphilis associated with neuropsychiatric disorders.

13.3 Clinical characteristics

At any point during the steps of a patient's medical assessment and care, from screening to retention and adherence to treatment, mental disorders and psychosocial problems may develop or be detected. These should therefore be systematically considered at all stages of chronic disease management.

Diagnosis

Diagnosis is the beginning of a long and challenging journey involving regular visits to hospitals, adherence to complex medical regimens and life-style changes. Immediate and on-going medical investigations may be invasive, uncomfortable or painful, with treatment regimens requiring medication, injections, blood tests, etc. The potential long-term impact of the disease on the patient's situation and future plans may be difficult to come to terms with.

Adapting to a life with a chronic disorder may involve the patient experiencing grief reactions. For more information related to grief, see [Appendix 15.1](#) and [Appendix 15.2](#).

Disclosure

The term disclosure can be used for 2 different situations: disclosure of the patient's diagnosis to others and disclosure of the diagnosis by the doctor/health practitioner to the patient. Particularly for communicable diseases, disclosure can be a very stressful moment due to its potential consequences on relationships (family rejection, divorce, marriage plans cancelled, etc.), financial situation (unemployment, etc.), stigma and marginalization in the community. Despite evidence of disclosure improving prognosis^{9,10} many patients with chronic diseases choose not to disclose their condition. As with all interventions, children and adolescents require specific consideration (see [Section 2.4](#), Chapter 2 and [Section 13.7](#)).

Starting medications and adherence

Ongoing monitoring and management include adhering to sometimes life-long treatments. Taking daily medications that may provoke unpleasant side-effects can be stressful, hampering adherence to treatment. Clinicians should also keep in mind, as noted in [Section 13.2](#), that some medications used to treat chronic diseases can also result in MH symptoms.

Disease progression

Chronic diseases may be accompanied by increasing medical complications (organ failure in diabetes, difficulty breathing in chronic obstructive pulmonary disease, opportunistic infections in HIV/AIDS, etc.). These complications impact a person's quality of life. They precipitate feelings of hopelessness that treatment is not effective, fear/anxiety for the future, depression and, sometimes, suicidal ideation.



Keep in mind that some chronic diseases may lead to, or be associated with, neuropsychiatric symptoms. This is particularly the case with chronic infectious diseases that directly result in pathological processes in the brain. Consider for example the following:

- HIV – can be associated with psychosis, manic features, cognitive impairment and dementia.
- Neurosyphilis – associated with psychosis, agitation and dementia.
- TB – can cause meningitis which may present with agitation or other psychiatric symptoms.

End of life decisions

Recognizing that the condition has progressed and that the terminal phase of the disease is approaching is a distressing moment for the patient, their family and for the staff providing care. In some cases, the patient may be reluctant to discuss the need to change treatment goals or the possibility of death. In others, it is the doctor's avoidance that limits the chance for the patient to raise these issues (see palliative care and end of life issues in [Section 13.8](#)).

13.4 Clinical assessment

The MH assessment of the patient should follow the general principles of assessment explained in [Chapter 3](#).

Prior to beginning a long (potentially life-long) course of treatment and/or at different moments in the patient's treatment history, ensure a routine MH assessment for all patients. This MH assessment can be done by the clinician responsible for the patient's care or by a MH professional (if available). Priority and specific focus should be given to those who are more at risk of developing MH problems/disorders, particularly patients:

- Diagnosed with DR-TB prior to initiation of treatment.
- With persistent adherence problems e.g. those with HIV/AIDS presenting with a high viral load requiring enhanced adherence counselling^a.
- Identified by healthcare workers as struggling with their medical condition and/or life circumstances.
- In vulnerable/high risk groups e.g. drug users, sex workers, children, etc.
- With a chronic disease who have a previously diagnosed psychiatric disorder.

Specificities of MH assessment in patients with chronic diseases should include:

- Identification of possible barriers to treatment adherence including lack of social support system, loss of job, lack of knowledge, substance abuse, psychiatric disorder, unsupportive relationship with the medical team, etc.
- Use of screening tools^b (see [Appendix 3](#)) can be helpful, including:
 - Patient health questionnaire (PHQ 9): detection of symptoms of depression;
 - PGeneralized anxiety disorder (GAD): detection of symptoms of anxiety;
 - PCAGE-Adapted to include drugs (CAGE-AID): detection of alcohol/substance use;
 - PALcohol use disorders identification test (AUDIT): detection of alcohol use.

a See MSF Patient support, education and counselling: guideline for adults living with HIV and/or TB (PSEC guide).
<https://msfintl.sharepoint.com/sites/msfintlcommunities/IGP/International%20internal%20guidelines/Forms/AllItems.aspx>

b The choice of which screening tool to use should be discussed with the MH advisor.

13.5 MHPSS assessment

Collect and analyse information on the current context and its links with MH suffering of the target population (see [Chapter 1](#)). It is important to collect information about cultural practices and beliefs – including cultural understanding of the disease within its local context, beliefs, myths, stereotypes, irrational fears and health seeking behaviours. Understand issues surrounding stigma and discrimination identifying vulnerable groups of people who may be affected. For example: for diabetes that requires insulin treatment, assess the perception of injections; for hepatitis C virus and HIV/AIDS, assess sexual and reproductive health behaviours, local customs, gender roles and community dynamics; for epilepsy, understand local beliefs (sometimes explained as being possessed by an evil spirit, etc.).

13.6 MHPSS activity planning

13.6.1. General principles

MHPSS is an integrated component in the management of chronic diseases and needs to be considered in conjunction with PSEC^a when providing care in projects managing chronic diseases. PSEC entails educational and emotional support activities offered to the patient to support their adjustment to chronic disease. Hence, PSEC and MHPSS activities are complementary when caring for a patient with a chronic disease.

General principles of this integrated care include:

- A multidisciplinary approach, necessary for early detection and treatment that addresses the needs of patients and their families, following a person-centred approach.
- Use of the principles of Motivational Interviewing Techniques^b in medical, PSEC and MHPSS consultations.
- PSEC activities aiming at empowering the patient, their family and environment in the face of their disease and treatment, beyond the purely medical aspects of care with the following goals:
 - Understanding and acceptance of the person’s health status, illness and treatment.
 - Recognition of the consequences of their status and illness in their daily life (family aspects, emotional and sexual, friendships, occupational, etc.).
 - Adaptation of the person’s behavior and acceptance of the reality of their situation.
 - Active involvement and responsibility in the treatment.
- MHPSS care (including psychiatric treatment) including:
 - Addressing pre-existing mental disorders and psychosocial problems that impact the patient’s ability to adjust to and manage their disease.
 - Identification and management of new mental disorders (special caution when ruling out medical conditions as potential causes of mental symptoms/disorder).
- Identification and support of specific vulnerable and/or marginalized groups (i.e. homeless, sex workers, ethnic minorities, LGBTQI, etc.).
- Ensuring follow-up care is provided.

To provide these services, different staff members can participate in performing different patient support tasks. All staff involved in the medical care of patients with a chronic disease must be trained in the basics of patient education and counselling and take a clinical approach which is patient-centred and considers the patient’s own goals. According to the staff set-up and package of care, the MH activity manager (MHAM) and the PSEC manager (where there is one), with the project medical referent are responsible for ensuring team members from each area of expertise works together (multi-disciplinary team meetings, internal referral pathways, case discussions, etc.) and cover the different aspects of a patient’s complex needs in order to provide individualized patient-centred quality of care. Clearly defined roles and responsibilities of each profession, a common patient file, regular daily contact between medical, MHPSS and PSEC staff, and planned team meetings are essential.

a PSEC is the term used in MSF for these activities. WHO and other international actors use different terms such as prevention and adherence counselling for HIV, nutrition, diabetes etc.

b Motivational interviewing is a directive, patient-centered counseling style for eliciting behavior change by helping patients to explore and resolve ambivalence.

Basic MHPSS activities can be added to existing PSEC activities or can be more developed as stand-alone activities to provide support for patients with moderate and severe MH conditions. Activities can be structured as either a minimum or more comprehensive package as follows:

- Minimum package: PSEC and basic MHPSS in palliative care^{c,11}.
- Comprehensive package: PSEC, MH care and more comprehensive palliative care.

13.6.2 Minimum package

An MHAM or PSEC manager should be present to support and provide training to the entire clinical team, including PSEC counsellors-educators, and to help identify mental disorders. The MHAM should furthermore provide MH clinical supervision for at least the first three months of the intervention to ensure PSEC is well implemented and that prescribing clinicians can also treat moderate to SMDs^d.

PSEC focuses on supporting patient self-management, including acceptance of their diagnosis, adherence to treatment (self-care skills) and ability to live with the disease (coping skills). Good self-management requires that patients:

- Have a good understanding of their condition and know how to manage it.
- Are empowered to discuss and agree upon treatment plans and goals with healthcare workers and others coordinating their care.
- Adhere to the agreed upon treatment/care plan.
- Monitor and manage signs/symptoms of their condition. Know when and how to access specialised services.
- Maintain everyday living activities by managing the condition's impact on their physical and emotional wellbeing.
- Change negative lifestyle behaviours, improving general health and preventing further progression of their condition.
- Have access to support services and the confidence/ability to use them.

Table 13.1 - Minimum package for chronic diseases

Patient education	Help patients understand their disease and treatment. Help patients acquire and maintain abilities that allow them to optimally manage their lives with their disease.
PSEC Counselling^e	Aims to help patients find solutions to daily problems that have a negative impact on their adherence to treatment, and to provide emotional support in difficult situations.

c WHO defines palliative care as the prevention and relief of suffering of adult and paediatric patients and their families facing the problems associated with life-threatening illness. These problems include physical, psychological, social and spiritual suffering of patients, and psychological, social and spiritual suffering of family members. Palliative care entails early identification and impeccable assessment and treatment of these problems. It enhances quality of life, promotes dignity and comfort, and may also positively influence the course of illness. It is applicable early in the course of illness in conjunction with other therapies that are intended to prolong life and provides accompaniment for the patient and family throughout the course of illness. After the patient's death, it also accompanies bereaved family members.

d Additional supervision and support of these activities is provided by another medical team member when the MHAM is not present.

e Compared with nondirective counselling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counsellor is intentionally directive in pursuing this goal.

Adherence counselling	<p>“Adherence is the degree or extent of conformity to the recommendations about day-to-day treatment by the provider with respect to the timing, dosage, and frequency”^f. Many patients have trouble following treatment recommendations. Adherence counselling aims to help patients find solutions to daily problems that have a negative impact on their adherence to treatment and to provide emotional support in difficult situations.</p> <p>Counselling is also used for testing/screening, linkage to care and retention in care.</p>
Support groups	<p>Allow patients to share their experiences, helping them understand they are not alone on their journey, create awareness on their shared challenges and coping mechanisms, reducing their sense of isolation and building a sense of community.</p> <ul style="list-style-type: none"> • Weekly 1.5/2-hours sessions facilitated by counsellors. • Safe space where people can get support from peers and counsellors. • No fixed format.
Identification and management of moderate-severe disorders	<p>All team members should be trained to identify moderate to SMDs. Medical doctors or prescribing clinicians should be trained in the identification and treatment of SMDs according to WHO mhGAP Intervention Guideline v.2.¹²</p>
MHPSS in palliative care	<p>The aim of palliative care is to control a person’s physical symptoms, ease their suffering and address any social, psychological and spiritual needs. Basic intervention involves early identification of palliative care needs by medical staff. The crucial MHPSS element for palliative care is patient and family-centered communication to establish goals of care, as well as psychological first aid.</p>

13.6.3 Comprehensive package

In addition to the activities described in the minimum package, MHPSS team members (in collaboration with the PSEC team members, if present) provide the following core activities. If the additional support is not available, they may also be designated to carry out adherence counselling.

^f See MSF Patient support, education and counselling: guideline for adults living with HIV and/or TB (PSEC guide).
<https://msfintl.sharepoint.com/sites/msfintlcommunities/IGP/International%20internal%20guidelines/Forms/AllItems.aspx>

Table 13.2 - Comprehensive package for chronic diseases

MH counselling sessions	<p>Individual and/or family MH counselling is helpful for dealing with MHPSS issues, especially for sensitive and/or private issues that the patient does not want to discuss in a group.</p> <ul style="list-style-type: none"> • Depending on the MH needs, a short intervention of 1-5 sessions or medium-term intervention 6-12 sessions. • The first session is usually 60 minutes. Each follow-up session is 30-60 minutes. • Sessions are every week or other week with follow-up after 3 months. Coordinate with medical appointments (particularly if distance makes frequent attendance difficult for certain patients). Use screening tools. • They must be done by MH counsellors or psychologists.
“Living well” group (see Appendix 12)	<p>Sessions for newly diagnosed and/or patients struggling to manage their diseases: adjustment (psychological and lifestyle related), behaviour change/motivation, adherence to treatment, disclosure (if applicable), communication (with health promotor) and living well (being a responsible patient).</p> <ul style="list-style-type: none"> • Weekly 2 hour closed (additional participants are not included after the first session) group with structured content continuing for 6 sessions. • Sessions moderated by the counsellor with support from the health promotion and medical teams as needed.
Psycho-education group	<p>Brief information sessions aimed to raise awareness of the psychological impact people may experience and services offered.</p> <p>Moderated by the counsellor or health promotor and conducted in waiting areas.</p>
Identification and management of moderate-SMDs	<p>Ensure access to assessment, diagnosis and psychotropic medication, according to clinical needs. This can be done in the NCD clinic by mhGAP³-trained doctors or via referral to an external psychiatrist.</p>
Palliative care with MH specialised component	<p>Assessing and managing psychological needs when they arise</p> <p>Accompany the grief of the patient (self-image loss and own death) and their relatives’ grief.</p> <p>Help the patient live as actively as possible.</p> <p>Help patient and relatives discuss practical steps (living with assistance, funeral, etc.) if appropriate.</p> <p>Integrate the spiritual /religious component (assess needs and manage them).</p>

13.7 Special considerations for children and adolescents

Children's understanding of a chronic disease depends on their cognitive developmental stage. For children and/or young people, grasping the immediate and long-term implications of a diagnosis is a complex process. The immediate demands of treatment may be confusing and frustrating. The disease or treatment can hinder their development and maintenance of friendships. This can result in them being increasingly dependent on their parents and siblings.

Disclosure to children/adolescents can be done at once or progressively. Disclosure is essential as it will improve their involvement in the treatment and the prognosis. The explanation of the disease, treatment and consequences must always be adapted to their cognitive developmental stage and emotional status.

Progressive disclosure for children – for example with HIV

When working with children under 12, progressive disclosure is recommended¹³. Progressive disclosure is the process of gradually informing children about what is happening in their body, ending with naming the disease. A first step is partial disclosure--providing information about what is happening in the body without naming the disease. Partial disclosure begins when the child understands concepts of illness (often around the age of 5–6 or earlier depending on the child's cognitive development). Full disclosure is usually done around 9–10 years old or when the child is asking questions about the name of the infection/treatment, suggesting the child is ready. Full disclosure should be done at the latest before the age of 12, when the child reaches adolescence and keeping the secret has negative consequences on the adolescent's treatment, emotional wellbeing and family relationships. Full disclosure means naming the virus and providing information on transmission modes, prevention, sexual and reproductive health⁵.

Problems with adherence in adolescence

Particularly if asymptomatic^a, adolescents may lack the motivation to continue treatment and can question the diagnosis and or react against the need for treatment^b. Adolescents are concerned about their ability to have romantic and sexual relationships, if they can get married and have children, etc. Adolescents in disagreement/conflict with their families or healthcare providers, may risk stopping treatment. There are examples of programs with adolescents that have had high rates of retention in care when they have defined a specific strategy that is developmentally and socially appropriate¹⁴.

Support from caregivers

Identify a caregiver who is committed to accompanying and supporting the child/adolescent and closely following their disease management (at the clinic and at home). The caregiver offers the child encouragement and emotional support. The caregiver is experienced in

a But also potentially when experiencing symptoms.

b Despite this, adolescents who have achieved normal developmental milestones are capable of abstract thinking, building hypotheses and experimenting with them. For example, they can make hypotheses about the causes of illness and link symptoms to organ function. They also understand the chronicity of an illness and the concept of a life-long illness and treatment.

providing care and comfort for the patient and is, ideally, a family member or someone legally responsible for the child. However, it is relatively common that adolescents reject their key caregivers as they seek more autonomy.

A caregiver presenting with mental disorder (depression, substance use, etc.) may need extra support in caring for the child. If possible, caregivers presenting with mental disorders or psychosocial problems should be referred to a separate counsellor to address issues beyond the care of the child. Sessions may also be held with the child and caregiver together, with the child and caregiver separately or with a group of children and caregivers.

Psychosocial stimulation

Caregivers frequently view children with chronic diseases as being “sick” and not able to participate in education, play and other developmentally appropriate activities. Children with certain chronic diseases and their families may be marginalized and stigmatized. These children may be “hidden” in their homes and denied the stimulation necessary for progressing developmentally. Seek to ensure children with chronic diseases attend school, play with other children and participate in normal childhood activities, according to their capacities.

13.8 Special considerations for palliative and end of life care

Palliative care is an approach that provides quality of life for patients and their families facing a life-threatening disease that cannot be cured¹⁵. This is done through a holistic, patient-centred approach to the prevention and relief of suffering.

Main care components include:

- Assessing and managing physical symptoms and psychological needs.
- Assessing social, religious and spiritual needs.
- Addressing the needs of family and other caregivers.
- Assessing prognosis: recognizing when a patient is in the terminal phase, to ensure adequate support and symptom control is provided as needed.

The goal of end of life care is to ensure comfort and dignity during the dying process. Along with management of pain and other symptoms, support for the patient and family's psychological, social and spiritual wellbeing should also be a priority for team members.

MHPSS aims to:

- Train and support medical staff on practicing good communication skills with the patients and their relatives, involving them in the decision making¹⁶.
- Attend to and support the patient or partner/family through acknowledging grief and providing counselling when required (see [Appendix 15.1](#) and [Appendix 15.2](#)).
- Relieve distressing symptoms (anxiety/mood related symptoms, fear, uncertainty about future, agitation, etc.).
- Support the patient and family by integrating religious and spiritual aspects of care.
- Support patients to find ways to live as actively as possible until death.
- Consider interventions that support families to cope with their relative's disease, facing end of life issues, and then attending to bereavement.
- Help patients and relatives discuss practical steps where appropriate (i.e. provision of support and care at home, funeral), particularly in situations where normal processes are disrupted (e.g. in outbreaks, during migrant journeys etc.).

13.9 Monitoring

Routine activity monitoring is described in [Section 2.7](#), Chapter 2. Monitoring should include some of the indicators listed in that chapter.

Collaborate regularly with other medical professionals to ensure interventions are adapted to the patients' needs.

Monitor the percentage of patients receiving PSEC according to protocol.

Further indicators could include:

- Percentage of patients with the chronic disease who have received screening for early detection of MH symptoms (see [Appendix 3](#) for possible tools).
- Integration of routine multi-disciplinary team meetings where the patients' psychological status is considered.

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14.1 Introduction

Emergency care programs, in particular trauma centres and burn units, are dedicated to seriously injured patients who may be victims of:

- War and violence (blasts, gunshot wounds, etc.)
- Natural disasters (earthquakes, typhoons, etc.)
- Non-violence related accidents (road traffic accidents, gas or fuel tank explosion, domestic accidents, etc.)

Many patients are not only physically but also psychologically affected by the event itself and any life changing injuries (amputation, blindness, etc.). They can often require repeated surgical interventions along with psychosocial support. Early detection and interventions addressing psychological distress are essential in promoting physical and mental recovery.

Mental health support is not only the task of psychologists or psychiatrists. All staff providing care should be trained in psychological first aid (PFA), psychological reactions to trauma, listening skills and breaking bad news (see [Appendix 13](#)) in order to provide compassionate care and reassurance to patients dealing with the repercussions of life changing injuries.

14.2 Risk factors for mental disorders and psychosocial problems

The psychosocial impact of burn and/or trauma injuries is determined by various factors:

Patient

Family/personal history and personality determine a patient's reactions and coping capacities. A patient's interpretation of the event and the meaning given to the event plays a role in the adjustment process to the injury. While most patients benefit from supportive counselling focusing on adjustment to the hospital's constraints and new physical condition, those who show symptoms of mental disorders and psychosocial problems require further assessment and specialized interventions (see [Chapter 2](#)).

Context

The event leading to the patient's injury has a psychosocial impact itself:

- Whether the event was directed at the victim personally or the result of an accident.
- The impact on family, friends or others affected by the same event.
- Material destruction (house, properties, etc.).
- Loss of loved ones.

Functional consequences of physical trauma (depending on the site of the injury)

- Loss of specific skills and/or autonomy (limb amputation, blindness, etc.).
- Sexual dysfunction.
- Loss of economic capability (ability to work).
- Loss of self-esteem (feeling powerless, helplessness, feeling guilty, etc.).
- Loss of developmental achievements of childhood (regression or delay in development, feeding, etc.).

Social consequences

- Change in body image.
- Rejection and potential social isolation.
- Limited marriage opportunities.
- Stigmatization.

Family and relative's reaction

- Anxiety and distress of family members can impact the patient.
- Traumatized family members may be unable to provide support to the patient.
- Parental guilt because of what happened to their child/children (domestic accident, etc.).
- Financial and social burden on families of disabled patients.
- Changes in perception of their family member (as well as of the community) after the incident.

14.3 Clinical characteristics

14.3.1 Stages of care


The stressors and psychological reactions may vary according to the different phases of treatment.

Critical stage

A general sense of feeling powerless (loss of control) is frequently experienced during this stage. Drowsiness, confusion, disorientation and other clinical signs of delirium are common. Delirium is defined as a disturbed level of consciousness (i.e. a reduced clarity of awareness of the environment), with a reduced ability to focus, sustain, or shift attention and either a change in cognition (e.g. memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance (e.g. hallucinations, delusions). Delirium can be hyperactive (agitated) or hypoactive (lethargic). The underlying organic cause should be identified and managed appropriately. Brief psychotic reactions can also occur.

Acute stage

Stressors are related to the intensive care environment and uncertainty about outcomes. The acute phase of recovery focuses on restorative care while patients continue to undergo painful treatments (e.g. dressing changes, surgery, IV cannulation, and venepuncture). Patients may need various levels of intimate nursing care – including assistance with toileting, personal hygiene, eating and drinking and mobilising. Patients are more aware of the physical and psychological impact of their injuries. Symptoms of depression, anxiety, sleep disturbance and grief can appear.

 Inadequate management of anxiety and pain during the acute stage has a negative impact on the patient's psychological well-being in the short and long term, with the risk of developing post-traumatic stress reactions.

Middle/long term rehabilitation stage

The middle to long-term stage of recovery typically begins after discharge from hospital, when patients begin to reintegrate into society. For patients who have suffered from severe burns/trauma, this stage may involve continued outpatient physical rehabilitation, sometimes with continuation of procedures such as dressing changes, physiotherapy and surgery. This is a period when patients slowly regain a sense of competence while simultaneously adjusting to the practical limitations of their injury.

In addition to the high demands of rehabilitation, patients must deal with social stressors including family strains, return to work, sexual dysfunction, changes in body image and disruption in daily life. Many people continue to have vivid memories of the incident, causing distress. Patients may also develop symptoms of depression and post-traumatic stress disorder (PTSD). Depression is prevalent in 13-23% of burn patients and PTSD in 13-45%.¹

The first year after initial hospitalisation is a psychologically unique period of high distress. Patients are:

- Dealing with grief and mourning their previous life.
- Accepting their new life and the redefinition of what a “normal” life is.
- Living with the sequelae of the medical intervention, including amputation, scar tissue and disability. Pain resulting from the injury and treatment, including chronic pain, is important to consider.

14.3.2 Types and characteristics of pain

Pain plays an important role throughout treatment and it is important to know the different types and characteristics:

- **Acute pain (lasting less than three months):** is of sudden onset, felt immediately following injury, usually moderate to severe in intensity initially and gradually decreasing in intensity. It is usually nociceptive in nature, due to tissue injury, and decreases with the healing of wounds.
- **Chronic pain (lasting more than three months):** is persistent pain that continues beyond the expected normal time of healing. It is due to chronic sensitisation of the central nervous system due to repeated and high intensity noxious stimuli. It may persist in the absence of identifiable pathophysiology or medical illness. Chronic pain is often associated with a negative impact on daily life. It causes disability and psychological symptoms.
- **Procedural pain:** due to a diagnostic or therapeutic procedure (e.g. dressing, physiotherapy).
- **Incident pain:** is a pain induced by simple movement (e.g. cough).
- **Background pain:** low-grade but persistent discomfort with no clear end.
- **Breakthrough pain:** is characterized as a temporary increase in pain severity over and above a pre-existing baseline pain level. It is usually severe, of sudden onset and short duration. Several episodes of breakthrough pain can occur daily. It can occur unexpectedly and independently of any stimulus (without a preceding incident or an obvious precipitating factor).
- **Phantom limb:** a type of neuropathic sensation felt in an absent limb or portion of limb. Most amputees experience phantom sensations at some point in their lives. It is important to distinguish between phantom limb sensations that are non-painful and almost always present after amputation and phantom limb pain which is pathological and requires intervention.

It is important to conduct a thorough pain assessment in order to determine which type of pain is the greatest problem – and thus provide the most appropriate management.

14.4 Clinical assessment

Consideration of the patient's full medical, social and emotional needs is the basis of best practice care in these settings. Effective assessment of the patient's pain is more likely to lead to an appropriate pain management strategy – and thus to improved mental health (MH) outcomes. See MSF intersectional pain assessment procedures².

Patient assessment

Mental disorders and psychosocial problems are associated with several factors, such as the individual characteristics of each patient, the traumatic experience and the severity of the physical disability. When assessing a patient consider all the aspects described in [Section 14.2](#) especially in the following high risk groups:

- Patients with symptoms of psychological distress or behavioural disorders (pre-existing disorder or as consequence of an event, injuries and hospitalization).
- Patients with severe disability (amputation, disfiguration, etc.).
- Isolated patients (no caregivers, no visitors).
- Patients who have lost relatives in the same incident.
- Patients who have experienced horrific events.

Screening tools like the SRQ 20, PHQ 9 and GAD 7 can be used at admission for early detection of psychological distress, to identify and support those most in need, and to avoid missing vulnerable patients ([Appendix 3](#)). Patients suffering from severe mental disorders should receive treatment or be referred for specialized care. An assessment of referral possibilities should be carried out before starting activities.

Pain assessment

Pain assessment is critical to optimal pain management. See the pain assessment procedure in the [Manual of Nursing Procedures](#)².

Although pain assessment falls under the clinical responsibility of doctors and nurses, it is important that the mental health activity managers (MHAM) and mental health and psychosocial support (MHPSS) team are aware of how to perform a pain assessment in case they are asked to participate in one.

The intensity of the pain felt by the patient and the way they will express it is linked to several factors:

- Biomedical factors: type of injury and patient's physical condition.
- Psychological factors: state of anxiety and fear and patient's overall psychological condition
- Social factors: cultural representation of pain and ways to express it.
- Individual factors: patient's representation of pain, coping mechanism and understanding of the present situation.
- Other factors conditioning the pain: anticipatory fear and avoidance strategies due to generalized hyperesthesia (abnormal increase in sensitivity).

14.5 MHPSS assessment

For the general approach to MHPSS assessment, see [Chapter 1](#).

14.6 MHPSS activity planning

Programs implemented in trauma centres and burn units aim to help patients cope better with reactions associated with the physical trauma and the medical procedures during the critical phase, acute phase and throughout the recovery process. Psychological and psychosocial support is critical for distressed patients at all stages of the treatment.

14.6.1 General principles

Due to the complex nature of burn and/or trauma injuries a single specialist cannot be expected to possess the range of skills, knowledge and energy required for the comprehensive care of these patients. These settings benefit most from truly multi-disciplinary care³.

An integrated multidisciplinary approach recognizes the importance of each individual expertise in the treatment and care of each individual patient. In this multidisciplinary approach, MHPSS involves ensuring that:

- The patient’s psychological state is recognized as an essential component in their overall improvement.
- Psychological assessment and treatment are parts of the care provided to all patients – in both inpatient and community settings.
- The psychologist/counsellor is fully part of the medical team (participates in medical meetings, shared confidentiality^a, contributes to discussions on problematic cases, etc.).

Due to their physical condition, wounded patients are also more dependent on their relatives (temporarily or definitively). For this reason, it is also essential, in any activity, to build a trusting relationship with, and provide support to, families in order to ensure proper follow up and adherence to medical treatment.



There is very often a lack of confidentiality during consultations in inpatient settings due to lack of privacy (shared rooms for immobilized patients). This is an issue the clinical team should be sensitive to. Where possible consider finding another room if practical or use dividers between beds and speak softly.

Physiological recovery can be divided into three main stages (see [Section 14.3.1](#)) with specifically associated psychosocial needs.

Critical stage

- Supportive psychological interventions focus on immediate concerns such as sleep, pain control, and protecting patients’ coping strategies.
- Non-pharmacological approaches to pain control such as relaxation, can be effective. Managing mild delirium can also involve non-pharmacological approaches, such as creating a quiet and calming environment, regularly and calmly orienting the patient in time, place and person.
- Family members may be anxious and distressed while observing the patient undergo treatment, which fosters the same response in the patient. Help family members understand this effect and help them to convey a sense of hope and calmness to the patient.

^a Shared confidentiality refers to the possibility of sharing patient information with other staff involved in their care, always with the patient’s consent.

Acute stage

- Wards can be noisy with little privacy or time alone for the patient. This makes it difficult to relax, to express their grief, anger, frustrations and fears. These factors often lead to difficulty sleeping. Relaxation and other calming approaches such as meditation are helpful. Pragmatic solutions such as ear plugs can be useful. Very short-term use of medications to assist with sleep can also be considered.
- Occasionally patients will benefit from being able to talk through the events of the incident, but they should not be pushed to do so.
- Refer to a psychologist and psychiatrist when suicidal ideation is detected.
- Brief psychological counselling for depression, anxiety and trauma symptoms as well as assisting with pain management.
- Support during medical procedures such as dressing changes.

Middle/long term rehabilitation stage

- Planning for follow up visits in an outpatient clinic to screen for symptoms of distress and to provide on-going counselling support in a very delicate phase.
- Ancillary resources such as peer counselling and peer support groups can also be important services to burn and trauma survivors as well as referrals to organizations that provide skills training, social support, etc.
- Brief and medium-term psychological counselling for support in managing symptoms of depression, anxiety, trauma and assisting with pain management.

While planning the intervention, ensure:

- A multidisciplinary approach is implemented. MH professionals are part of the medical team or patient care team (surgeons, anaesthesiologists, nurses, physiotherapists, social workers, occupational therapists) and participate in clinical rounds, general meetings and specific case management meetings.
- Patients with psychological distress can be referred for assessment and follow up by all team members. Since everyone contributes to patients' improvement, patient information should be shared within the multidisciplinary team in the best interests of the patient.

14.6.2 Minimum package

The following activities are part of the minimum package and are carried out by medical staff who are able to deliver the following:

- PFA;
- Psychoeducation;
- Detection and treatment of patients suffering from mental disorders;
- Referral to specialized MH care if available (or alternatives – for example providing training and supervision of one or more of the medical team in delivering an mhGAP approach);
- Training of clinical staff in the provision of the activities described above.

An MHAM is recommended for about three months to provide capacity-building, skills transfer and supervision to medical, nursing and other staff and assist in activity implementation (see [Section 2.3.1, Chapter 2](#)).

14.6.3 Comprehensive package

In addition to the activities included in the minimum package, the MHAM and MHPSS team can provide more specialized care within the program to support patients and their families.

Provision of MHPSS activities in this setting during hospitalization, at discharge, and during follow-up care can positively impact the care provided and should be considered in initial project planning.

During hospitalization

- The role of the psychologist/counsellor is a supportive one (rather than ‘psychotherapeutic’) for most patients.
- Psychosocial support activities should be included – such as schooling for children (particularly for those staying for weeks or longer), occupational activities for example art, physically adapted activities, group discussions and other recreational activities.

At discharge and follow up care

It is important that the MHPSS team are actively involved in discharge planning. The length of surgical care is in general shorter than the time required to fully address MHPSS needs. Follow up after discharge is essential for severely affected patients (psychologically and physically) who may face difficulties when readapting to family/social life. When planning for discharge and follow up care, the MHPSS team should contribute to:

- Draw up an individual care plan, considering follow up needs and limitations;
- Share any concerns about the patient’s discharge with the medical team (referral needs, social issues to consider, etc.);
- Assess follow up or referral possibilities for MH care (availability of out-patients clinic, distance from patient’s home, local services, etc.);
- Consider provision of mental health care;
- Consider referral to patient groups (working in collaboration with physiotherapists: a group for people with amputations, for example);
- Consider caregivers’ groups and family sessions.

Preparation for a mass casualty incident

As part of emergency preparedness, MHPSS concerns should be included in a mass casualty plan. Staff should be trained in PFA adapted to the specific context and situation, so that MHPSS can be provided to patients and their families in the event of a mass casualty incident.

Staff support

MSF clinicians and other staff are very often part of the communities they serve. In addition to the routine challenges of caring for patients with trauma and burns, at times they may also be called upon to care for perpetrators of violence. Considering the demanding and stressful work conditions faced by staff, it is important to discuss in advance (e.g. impact on their mental health, practice self-care) and ensure that support be provided to staff.

14.7 Special considerations for patients with amputations

Amputation, particularly of a limb – whether due to traumatic injury or following surgery – has a significant and usually life-changing impact on the affected person. The multifactorial issues listed in [Section 14.2](#), also apply to situations of amputation, though often with much greater intensity and impact.

14.7.1 Psychological impact of amputation

When providing counselling and psychological support for someone with an amputation, it can be helpful to consider the following additional psychological factors:

- The shock of an injury, coupled with pronounced changes in physical appearance and ability to function, can intensify trauma and delay adjustment.
- Body image is a significant issue in limb amputation. Patients can face stigma and the amputation can result in reduced self-esteem and an altered view of the self.
- It is common for someone who has lost a limb to experience grief, of the loss of the body part, the loss of capacity, and of the life they would have led. Understanding the varied responses that individuals have to grief can be helpful in the provision of psychological support for amputees.
- Patients experiencing amputation as a result of complications of a chronic disease often adjust more quickly than those experiencing traumatic amputation, due to the longer time period they have prior to the loss to come to terms with the impending operation.

14.7.2 Adaptation to prosthesis

Depending on which limb is amputated, prosthesis can be an option in some cases. This has its own benefits and difficulties. While there are social, occupational and psychological benefits to prosthesis, adaptation to prostheses raises unique challenges.

- MH clinicians working with patients with amputated limbs should familiarise themselves with some basic technical knowledge of rehabilitation and prosthesis – perhaps through liaison with physiotherapists specialised in rehabilitation for these patients. This can be done either within the clinical team if available or through other organisations. Improved knowledge can aid the development of empathy and help the MH clinician better provide timely and appropriate psychoeducation and support.
- Use of a prosthesis requires careful evaluation of the patient's home, social and occupational situation. A prosthesis can play a role in improved self-esteem and adjustment, as well as help the person regain some of their lost function.
- Challenges include practical issues such as the physical effects of wearing a prosthesis e.g. skin chaffing, infection, bruising, pain, and heat. Changes in posture, balance, and gait are not infrequent, particularly for lower limb prostheses.

14.7.3 Pain management in amputation

As with management of any patient who has experienced a traumatic injury, appropriate pain management in amputation is essential. The principles described in [Section 14.4](#) should form the foundations of care. People experiencing amputation require some specific additional considerations.

- Peri-operative pain: this should be managed assertively, with specific consideration taken prior to the surgery to ensure that pain and anxiety are as well controlled as possible pre and post-operatively.
- Residual limb pain: this can be due to tissue disruption as a result of surgery or occur long after recovery, as a result of poorly fitting prosthetics, chaffing, rubbing, or other mechanical factors.
- Phantom limb pain: as described in [Section 14.3.2](#) this is a form of neuropathic pain felt in the absent limb. It is extremely common. The cause appears to be a result of peripheral and central neural changes. The reorganisation of neurons in the region of the cerebral cortex linked to the missing limb is believed to be responsible. While it is known that anxiety and depression can worsen pain, there is little or no evidence of a psychogenic cause of phantom limb pain⁴. Treatment approaches include a strong focus on physiotherapy, with techniques such as ‘mirror’ therapy found to be helpful. Since phantom limb pain is neuropathic in origin, medications used to treat this type of pain can be effective. This includes tricyclic antidepressants and gabapentin.

14.7.4 Issues surrounding surgical consent for amputation

Gaining consent for surgical amputation is often a significant issue. In many situations the necessity for surgical amputation is either not immediately obvious or is delayed in order to stabilise the patient. When there is a delay between injury and amputation surgery, patients and family members can often find it very difficult to agree to surgery for amputation. This is even the case when expert opinion indicates it would be the most appropriate course of treatment. Refusal of surgery can sometimes have life-threatening consequences, or result in even lengthier hospitalisations, and ultimately reduced functioning.

Overwhelming emotions and fear about the social and occupational consequences can make it difficult for the patient and family to consent to amputation. MHPSS staff can help by listening, validating and re-assuring the patients. It is never the role of the MHPSS staff to “convince” a patient to consent to any medical procedure, included amputation.

As a result of their special status, people experiencing amputation require specific clinical approaches. The experience of amputation can be lonely and isolating. Peer workers – people who may have experienced a similar injury and have experienced treatment for similar conditions, can be particularly helpful in amputation. For the same reason, group therapy approaches can also be valuable.

14.8 Special considerations for children

As well as ensuring provision of adequate pain management² and see MSF Clinical Guidelines^a, children require psychosocial support to cope with medical procedures and to continue their developmental trajectory. All children require stimulating activities, and some children and caregivers might need specialized psychological support to deal with the traumatic event and life-threatening injuries.

Caregivers should be assessed (for distress, feelings of guilt regarding their child's accident, etc.) and supported during hospitalization in order to support the child's recovery process.

A dedicated counsellor should be appointed to prepare the child and family for the treatment and pain management. They follow the child during the first sessions to help with coping and controlling the fear and pain.

Children facing amputation require specific attention. Amputation can have different impacts and lead to different responses, depending on the stage of development of the child when the amputation is performed. As with adults, a specialised multidisciplinary approach is essential and should include a psychosocial component.

Amputation and other severe traumatic injury can lead to prolonged hospital stays, with the child being away from their usual environment. This can impact on normal development. It is important to establish and maintain regular routines alongside appropriate care including careful pain assessment and management, and physical rehabilitation appropriate to the child's developmental stage⁵.

Children admitted to hospital should have access to ongoing education, whether through a specific hospital school and teacher, or through liaison with the local education authorities. This is particularly important for children admitted for longer term treatment.

a MSF Clinical guidelines
<https://medicalguidelines.msf.org/viewport/CG/english/clinical-guidelines-16686604.html>

14.9 Monitoring

As well as routine monitoring of activities described in [Section 2.7](#), Chapter 2, consider monitoring:

- Proportion of hospital staff providing care who are trained in PFA, listening skills and breaking bad news.
- Early detection of MH symptoms with screening tools such as MHOS, GAD and PHQ.
- Integration of PFA training and implementation in the drafting of mass casualty plans (Yes/No, and what proportion of team members have completed training).
- Integration of routine multi-disciplinary team meetings where the patients' psychological status is considered.

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15.1 Introduction

During humanitarian emergencies, the prevalence of severe mental disorders (SMDs) increases from around 2% to up to 5%^{1,2} and patients with SMDs are highly vulnerable in these contexts. SMDs are a major cause of disability, hugely impact individuals' lives and place a significant burden on families, communities and health services where the presence of psychiatrists is generally far behind the needs³.

People with SMDs, especially those with chronic disabling disorders, are at particular risk of human rights abuses and poor or absent care, particularly during humanitarian crises. Violations can include abuse, neglect, social exclusion and other forms of discrimination. Care delivered must be empowering, ensure equal access, respect the dignity and autonomy of each person, and ensure advocacy for the person to their family, community and other key stakeholders⁴. Access to care for people with SMDs is a priority for MSF when developing mental health and psychosocial support (MHPSS) programs^a. It is essential to understand the context and culture in order to understand the meanings and traditional beliefs about mental disorders and psychiatric illnesses so that the approaches being provided are appropriate^b (see [Chapter 1](#)).

A lack of specialized human resources is not an obstacle to the integration of care of people with SMDs and psychosocial disability into MHPSS programs (and, more broadly, in all programs). To bridge the gap in skilled mental health professionals in many contexts, in MSF we follow the WHO mhGAP-IG 2.0 algorithm approach and associated tools (such as the mhGAP Humanitarian Intervention Guide)⁵ in order to task shift this care. The mhGAP-IG 2.0⁷ is an evidence based clinical algorithm tool and training package developed by WHO and other actors and used internationally as a clinical framework for assessment and treatment focusing on SMDs. Specific training based on the mhGAP tool must be followed by systematic clinical supervision of non-specialist medical staff and by psychiatrist (or other professional such as psychiatric nurse, where validated by the mental health (MH) advisor).

Pharmacological treatment is the first line response for SMDs, however it is never a standalone treatment. The aim of other core complementary non-pharmacological activities that should be implemented are:

- Building a trustful relationship with patients based on respect of their cultural environment and knowledge about traditional treatments and religious beliefs.
- Providing psychoeducation⁶, adherence counselling and counselling/support groups for patients and caregivers.
- Psychological care or psychotherapy and other psychosocial interventions.

For treatment protocols, refer to MSF Clinical Guidelines⁷, the WHO mhGAP intervention Guide V.2⁸ and MSF protocol for pharmacological management of priority Mental Health Conditions, MSF 2021⁹.

a If access does not already exist as part of the Ministry of Health (MoH) services or other (international) non-governmental organizations. Availability, accessibility and quality of these services, including drug availability, is assessed before developing any referral pathway.

b The term psychiatric illness will be used as synonym of severe mental disorder.

15.2 Risk factors for severe mental disorders

As for mild and moderate mental disorders, risk factors for SMDs usually arise out of a complex interaction between biological and life-stage factors, as well as psychological and social factors.

Some patients suffer from chronic and disabling disorders resulting from complex biological risk factors (such as schizophrenia, bipolar disorders, etc.). Others present with severe acute reactions to stressful events and are momentarily not able to cope with the situation. Others have symptom exacerbation due to the discontinuation of medications due to internal (lack of adherence, side effects, etc.) or external (shortage of drugs, migration or displacement, etc.) influences.

15.3 Clinical characteristics

Patients with SMDs present with symptoms as defined in international diagnostic classification systems (ICD-11 or DSM-V^a) and which often result in major impairments in social and occupational functioning and difficulty in achieving personally identified life goals^b.

SMDs include:

– **Psychosis (acute and chronic)**

The bulk of psychiatric treatment concerns this patient group. Patients may suffer from chronic psychosis (mainly schizophrenia) or from acute psychotic episodes (which can be trauma or stress related). People with chronic psychosis can experience acute episodes and relapse/s.

They can present to health services because either they themselves, or more often their family, identify symptoms and experiences which result in significant personal suffering. In some cases they may present with behaviour that is considered disruptive and sometimes due to concerns about danger they may be putting themselves and/or others in.

– **Major depressive disorders (and other mood disorders such as bipolar disorder)**

Patients with severe depressive disorders can be a hidden/misdiagnosed group. They may attend primary healthcare services reporting symptoms such as loss of energy, exhaustion, weight loss and various aches and pains. Very often these symptoms are misunderstood and risk being inappropriately treated.

Some patients may have experienced recent or chronic traumatic events, be living in precarious circumstances or have lost family and homes. Often with counselling and/or stabilization of living conditions, these patients recover without anti-depressant medication.

For patients with severe depression, which is defined by a significant deterioration in functioning and can also include suicidal ideation or attempts, anti-depressant medication is prescribed as part of the first-line response.

Remark: patients taking anti-depressant medication require close follow-up with appropriate monitoring and need to adhere to daily treatment for a minimum of 9 months.

– **Severe anxiety disorders/post-traumatic stress disorder (PTSD)**

For a more detailed description of trauma and PTSD see [Section 5.3](#), Chapter 5. Psychological distress is frequent in the aftermath of violence and potentially traumatic events or major loss. Some people manifest acute symptoms however their emotions usually normalize within a few weeks with appropriate psychological support^c. Severe PTSD requires specialized psychological care. Some patients need anti-depressive medication if not evolving with psychotherapy.

Remark: PTSD is often associated with severe depression.

a International classification of diseases 11th revision: the global standard for diagnostic health information and Diagnostic and statistical manual of mental disorders, 5th edition.

b Projects can request a copy of the DSM or ICD in their field library.

c Addressing grief processes and trauma related symptoms.

– **Neurological/medical differential diagnoses and epilepsy**

Epilepsy is a neurological illness but is still considered under neuro-psychiatry in many countries. Whether epilepsy is assessed and treated within an MSF MH activity will depend on both the country context (whether epilepsy is considered a mental disorder or managed by neurology services) and the availability of a qualified professional or team to treat it. For the treatment and management protocol, see MSF [Clinical Guidelines](#)^d.

Epileptic patients are often stigmatized and marginalized. They are frequently considered victims of demonic possession and/or contagious. Common cultural beliefs include these patients cannot be educated, hold jobs, marry and have children. Children who have seizures may not be allowed to attend school or socialize with other children--they may be hidden away.

In many contexts where MSF works misdiagnosis of epilepsy is quite common. Assessment of epilepsy should always consider differential diagnoses. There will be patients presenting seizures without epilepsy. These patients need to be identified and treated appropriately. These seizures can be related to important organic causes (brain infections, hypoglycaemia) or to psychological distress.

Remark: psychiatric presentations may be due to organic diseases (often associated with confusion). The first step in assessment of a patient with psychiatric symptoms is a medical examination to rule out an organic cause.

– **Psychiatric comorbidity with medical conditions** (HIV^e, tuberculosis, diabetes, patients hospitalized in trauma units, etc.)

Patients suffering from a chronic medical condition frequently develop mental disorders, most commonly depression (see [Chapter 13](#)). The converse is also true. Patients with chronic medical conditions and SMDs may exhibit poor adherence and high rates of treatment failure. Patients with a primary psychiatric disorder frequently neglect their physical health and present with co-morbid medical conditions. The first step is to rule out a treatable medical problem for those who present with psychiatric symptoms (see [Chapter 13](#)).

– **Children and adolescents with SMDs**

Children and adolescents can suffer from chronic disorders (developmental delays, autism, mental retardation, etc.) which cannot be properly addressed in humanitarian settings. Supportive sessions with the family can however be helpful. Families require explanations about these disorders and instruction about easy interventions in the home setting (appropriate stimulation, exercises, etc.).

For children under 15 years, medication is usually not the first line response (except in epilepsy). If the disorders are severe and impacting on siblings and or relatives, medication can be considered. A decision to initiate psychotropic medication should be validated by a psychiatrist (with child specialisation if possible) or the mental health advisor. The telemedicine platform could also be considered in these cases.

Remark: in some middle-income countries, there is a tendency to over-prescribe to children - due to lack of training about child psychopathology. Good therapeutic skills/capacities (play therapy, group therapy, etc.) should be developed for severely traumatized children (counselling is not enough).

d <https://medicalguidelines.msf.org/viewport/CG/english/clinical-guidelines-16686604.html>

e HIV: Human immunodeficiency virus

– **Substance use related disorders**

Psychiatric disorders are over-represented among people who use drugs. Drugs are often used as an auto-medication for the disorder or for comorbidities. Drugs are also a risk factor for mental disorders such as psychotic episodes due to drug abuse. Often, they are part of the most socially marginalized groups (see [Chapter 11](#)).

The list of diagnoses above illustrates the diverse variety of clinical presentations, most of them complex in humanitarian emergencies (experience of trauma, disorganized/precarious living conditions, disrupted families, etc.). For detailed information on symptoms of psychiatric disorders and pharmacological treatment, refer to the WHO mhGAP guide³.

15.4 Clinical assessment

Refer to patient assessment in [Chapter 3](#). Regarding SMDs, it is essential to understand the socio-cultural context/belief and care seeking behaviour for these conditions, the patient/family's understanding of the disorder, and to know if the patient has visited a traditional healer and what treatment was provided.

A thorough (specialized) **medical assessment** is required when patients display one or more of the following:

- Bizarre or abnormal behaviors
- Disorganised thoughts
- Incoherent speech
- Abnormal mood (elated, irritable, sad)
- Suicidal ideation and harm
- Self-neglect and neglect of others (including children)
- Significant difficulties coping with daily life
- Use of substances
- Medically unexplained physical symptoms

The medical assessment should:

- Rule out a medical condition as the origin of psychiatric symptoms (infections, trauma, stroke, endocrine disorders, substance use, side-effect of other medications the patient is taking, etc.).
- Record all current and previous medical and psychiatric disorders, look into family history and previous treatments (including traditional treatments).
- Complete a MH status exam (appearance, orientation, mood and affect, etc.).
- Establish the diagnosis.
- Develop a care plan, including social supports, counselling, psychological interventions, etc.

For severe depression, use of the patient health questionnaire (PHQ9) ([Appendix 3](#)) is recommended. A screening score helps clinicians assess the severity level and consider (or not) prescribing antidepressant treatment.

15.5 MHPSS assessment

For the general approach to MHPSS assessment, see [Chapter 1](#).

15.6 MHPSS activity response

15.6.1 General principles

Care should be provided to patients with SMDs: concerns about sustainability and length of mission may prompt managers to consider not providing treatment for SMDs. Despite this, access to care for patients with SMDs should be guaranteed in all MSF programs. Models of organization are dependent on the prevalence of SMDs and context (camps versus urban populations, emergency versus post emergency, available resources, etc.).

Before deciding whether to implement a minimum or comprehensive package, assess:

- National availability of MH services and resources using the WHO Atlas¹⁰ that includes specific country profiles.
- Local psychiatric facilities (psychiatric hospital, other services, etc.) or humanitarian actors providing psychiatric care, including the extent to which the local facilities take into account the rights of patients.
- MHPSS actors and medical actors (raising awareness and referral system).
- Administrative/importation procedures for psychotropic drugs and who has the right to prescribe (only medical doctors, nurses, etc.).

Recovery model of care: people with SMDs can and do recover. Recovery is an active process and not a final outcome. It is highly personal, and its meaning can be different for each person. The recovery approach has some core considerations, elaborated in the WHO Quality Rights Tool Kit page 41 (Ref 4), including building hope and optimism about the future, finding meaning and purpose in life, empowerment of people with control and choice over their care and their lives, and connection with family, friends and community.

Recovery is defined by the persons themselves and not by clinicians or others such as family members. Recovery occurs when people can live their lives in the way that they choose and to strive for and achieve their personally identified goals in the presence or absence of any mental disorder or disability and the many losses that may come in its wake, such as isolation, poverty, unemployment and discrimination.

Individualized treatment plans (recovery plans) should be established by and with all people with SMDs and disability. Central to developing the plan is finding ways to support the person identifying their own goals, including identifying people, organizations and treatment approaches they would like included in the plan¹¹. Using the WHO QualityRights course guide on recovery¹² and associated course slides¹³, a recovery approach can be introduced and integrated into any project providing care.

Human rights abuses, stigma, lack of information about mental disorders and disabilities: families and individuals may not seek medical care due to traditional beliefs and lack of knowledge about efficiency of care or even its availability. Patients with SMDs may be stigmatized and ill-treated (restrained, abandoned). In many low to middle income countries, there is often no access to public psychiatric services. To improve team knowledge on the rights of people with mental health and psychosocial disability, the WHO QualityRights team have created a series of trainings¹⁴.

Outpatient focus: emphasis of care for people with SMDs should be on treatment in the community¹⁵. Community treatment allows patients to remain in their homes/communities and promotes integration and acceptance. Activities include:

- Identification
- Diagnosis
- Treatment or referral (according to available resources)
- Involvement of family and caregiver in the treatment plan

Interventions require local collaboration with a psychiatrist or a validated and trained/supervised “mhGAP clinician” (doctor/clinical officer/nurse) and the mental health activity manager (MHAM), if present. The program is under the supervision of the project medical advisor/medical coordinator who monitors prescriptions, drug consumption and importation.

Long term follow-up: psychiatric disorders may be acute, transitory or chronic. Treatment may be necessary for weeks, months or years. Continuity of care is challenging and has to be closely monitored (protocols for drop outs, outreach team for case finding, home visits for community support, etc.). The need for hospitalization concerns few patients. The quality of local capacities (if they exist) must be assessed to establish a referral pathway when possible.

Patient/clinician relationship: the effectiveness of psychiatric care is dependent on the interpersonal relationship established between the patient, their family, the prescribing clinician and the MHPSS team. Without the confidence of the patient and family little can be done. Adherence to treatment often relies on family support (dealing with non-cooperative families or isolated patients can be difficult). Education about treatment (effectiveness, length of treatment, side effects, etc.) is of primary importance. Education is delivered by the prescribing clinician and reinforced by trained counsellors. The treatment process is often challenged by patients’ ambivalence, delusional ideas, severe distress with suicidal risk, oppositional behaviours, etc.

First contact/welcome must be properly organized (general atmosphere of the waiting area, available team member for immediate assessment, protocol for emergencies, etc.).

Care plans are adapted to each patient with different components related to diagnosis, level of severity/disruptive behaviour, predictable length of treatment, family and socio-cultural situation and consideration of specific situations.

Safe prescribing principles:

- Exclusion of contra-indications
- Information about side effects and required length of treatment
- Involvement of a family member
- Close follow up for first days/weeks
- Medication should always be associated with psychosocial interventions

Regular follow-up and monitoring of:

- Changes in symptoms and/or in general condition
- Medication adherence and/or side effects
- Condition of caregiver
- Psychosocial interventions

When not to consider routinely starting psychotropic medication:

- Children under 15.
- Transit situation with no possibility of follow-up. Exceptionally, patients can be provided with three months of treatment in certain contexts, particularly those who were previously under treatment and want to continue^a.
- Predictable challenges with adherence (i.e. populations on the move, living in remote areas far from health facilities) and/or with supply of psychotropic drugs (i.e. availability of guaranteed safe medications, importation restrictions).
- When the person does not want treatment. Starting treatment without patient consent is a serious matter and requires consideration of the patient's rights, their autonomy and their right to healthcare.

For pregnant or breastfeeding women

Refer to the specific recommendations in MSF [Clinical Guidelines, Chapter 11](#).



For **emergencies**, the following five psychotropic drugs are available and easily deployable in the WHO's Interagency emergency health kit (WHO-IEHK)¹⁶:

- Haloperidol: 5 mg tablets and 5 mg ampoules for injection
- Amitriptyline: 25 mg tablets
- Biperiden: 2 mg tablets
- Diazepam: 5 mg tablets and 10 mg ampoules for injection
- Phenobarbital: 50 mg tablets

15.6.2 Minimum package

Treatment for patients with SMDs is affordable, cost-effective and generates good health outcomes through early identification and treatment. Activities are arranged according to resources available.

The minimum package of care for patients with SMDs includes identification and effective safe management of patients. Management of patients with severe disorders can be done by MSF or by other actors. The main challenge is that usually there are no actors able to provide quality care for people with SMDs (this is particularly the case in emergency settings). If referral options are not available or not effective, then the project should provide treatment. Assessment and treatment should be delivered by an mhGAP trained clinician, ensuring the clinicians receive continued technical supervision, even if this is only available from a distance. If there are not any mhGAP trained clinicians available, MSF should treat psychiatric emergencies and train at least one clinician in mhGAP as soon as possible (online or face to face depending on what is available).


15.6.3 Comprehensive package

Ideally an activity for psychiatric patients is part of an MHPSS response for those with moderate to SMDs, with a multi-disciplinary team providing specialized care (social and psychological support and medications when needed).

^a To be discussed with the project medical advisor, medical coordinator and MH advisor.

The MHPSS team includes, in addition to the MHAM:

Prescriber clinicians^b

 Every country has specific legislation or Ministry of Health policy concerning which types of clinician are allowed to prescribe psychotropic medicines. Psychiatrists will always have this capacity, though are rarely available. Depending on the location, psychotropic drugs may also be prescribed by primary care (general) doctors, mental health nurses, or other clinical officers. Prescribing clinicians may also be required by the responsible authority to have completed a designated course (for example the mhGAP intervention guide training) in order to prescribe. It is important every project checks country laws, policies and practices around this to ensure MSF adherence. MSF also requires clinicians to be trained in the mhGAP-IG, which includes capacity for:

- First assessment (see [Chapter 3](#)).
- Medical follow-up, including psychotropic medication adherence.
- Psychoeducation about diagnosis and treatment.
- Communication skills.

Clinicians will also benefit from training in some simple counselling approaches that can be integrated into routine psychiatric assessment and follow-up appointments e.g. aspects of structured problem solving, motivational interviewing and adherence counselling.

Psychiatrist to provide on-going supervision to the prescriber clinician(s). This psychiatrist can be permanently in the field, visit the field monthly/every 3 months and/or support remotely.

Dedicated psychologist/trained counsellor

- Identifies symptoms of severe disorder and refers to specialized medical team for further assessment. In MSF activities, psychologists are expected to provide differential diagnosis of mental disorders and discuss with the mhGAP clinician. Counsellors are expected to indicate the patient's syndrome cluster (i.e. depressive, anxious, traumatic, etc.).
- Supports patients to ensure adherence to medication, including treatment and interventions in the home setting.
- Develops a psychological support care plan discussed during team meetings, with patient and caregiver (when needed) supervision.
- Leads therapeutic interventions, individual/family or support groups for patients.
- Supports caregiver groups (education about treatment, adherence, sharing difficulties and solutions, etc.).

Psychosocial team (community mental health workers or psychosocial workers from the community/camp)

- Are the team members who are most likely to have first contact with each patient. They are responsible (along with all team members) for ensuring a calm and welcoming waiting area/triage assessment and internal referrals to psychiatrist or psychologist.
- Community-based support: home visits if approved by the patient and their family, link with other community-based resources, identification of protection issues, etc.
- Outreach activities: link with other psychosocial actors, community awareness about the services, etc.
- Contribute to stigma reduction in the community.

^b If prescriber clinicians are not psychiatrists, then medical staff (depending on the country they can be doctors, nurses or clinical officers) are trained in the mhGAP-IG algorithm and must be provided routine clinical supervision to ensure adequate quality of care.

In order to be able to provide effective and good quality care, it is necessary to have:


An adequate working place

- A quiet welcoming area.
- A large room able to accommodate small groups (and team meetings).
- Enough rooms for consultations (individual/family sessions).
- Dedicated space and materials for children (larger rooms, toys and material).
- A room for patients' day-stay.

Collective organization as a multidisciplinary team

- Weekly team meetings (clinical and organizational).
- Multidisciplinary case discussions (to develop a joint therapeutic plan with patients).
- Patient files/updated data, including pharmacological and non-pharmacological interventions (one patient, one or more mental disorders, one medical file).
- Project medical referent involvement.
- Regular clinical supervision for all team members.
- If project set-up allows and patient agrees it can be useful for the initial consultation with the psychiatrist or mhGAP clinician to be a joint session including the psychologist/counsellor. Very often it is the first consultation for the mhGAP clinician though may be the second or third for the counsellor/psychologist. Following the session, the two professionals should discuss together their understanding of the reasons the person has presented and agree on a differential diagnosis. Afterwards, they should also discuss together with the patient their recovery goals and establish a treatment plan.

Internal referral pathways

- Community workers need to receive specific training in psychiatric disorders and common symptoms. All MHPSS team members are properly trained and know the referral pathway to a psychiatrist, psychologist or other MH professional.
- In an effectively functioning multidisciplinary team, psychologists and counsellors should ensure that patients they are treating with SMDs, or mental health conditions, that are not responding to talking therapy are referred for shared care to the prescriber clinicians for assessment and treatment.
-  Prescriber clinicians should also ensure that patients who would benefit from talking therapy approaches are referred to counsellors or psychologists. This is often overlooked and requires close monitoring.
- Raising awareness and training in symptom detection should be provided to MSF medical team members or other medical actors to facilitate case detection and referral. This training should include psychological first aid, and knowledge about mental health disorder and psychosocial problems (NB. 30% or more of medical complaints in refugee settings, including very common somatic presentations such as headaches and other general aches and pains, can be closely linked to mental disorders and psychosocial problems¹⁷).

Special considerations for specific situations/vulnerable populations

- *Remark:* Always remember that people with the most SMDs are the least visible and at high risk of human rights violations.
- Disturbed behaviour (agitation, aggression, suicide attempt survivors, suicidal risk etc.). Patients with these presentations require consideration of how to best understand and communicate with the person, reduce their suffering and decrease any risk of any associated harm through effective, patient centred management approaches that respect the dignity of each person.

- Homeless or abandoned patients (e.g. living in the street). The prevalence of mental disorders and psychosocial problems, particularly chronic and disabling disorders, are significantly elevated in this population¹⁸. Mental disorder and disability can be both a cause of and result of homelessness. Due to the significant social and personal burdens faced by the homeless, specific additional support is required in order to improve outcomes. Care delivered by assertive outreach approaches that aim to engage the person are more appropriate and person centred than expecting the person to attend routine clinic appointments.
- Pregnant/breastfeeding mothers (care of neonate). For more information, see [Chapter 8](#).
- Children and adolescents. Worldwide, 10 to 20% of children and adolescents experience mental disorders. Half of all mental illnesses begin by the age of 14, and three quarters by mid-20s. Neuropsychiatric conditions are the leading cause of disability in young people in all regions¹⁹. For more information see [Where There is No Child Psychiatrist](#)²⁰ and [MSF MHPSS Guidelines for Children with Mental Disorder](#)²¹.

15.7 Monitoring

Routine activity monitoring is described in [Section 2.7](#), Chapter 2. Monitoring should include some of the indicators listed in that chapter.

In addition:

- Number of new patients by diagnosis and/or syndrome category as a proportion of total new patients
- Number of patients receiving psychotropic medications prescribed by MSF staff as a proportion of total patients under care
- Percentage of patients receiving psychotropic medications with previous psychiatric history/treatment
- Proportion of improved patients

Regarding clinical follow-up, patients should be reviewed regularly, and their treatment plan should be adapted as necessary along the course of care. Reduction in symptoms and improvement in the person's daily functioning can also be used to monitor improvement.

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Appendix 1. Paediatric generalities according to age (reactions and developmental milestones)^a

Table 1.1 - Paediatric reactions according to age groups

Age groups	Paediatric reactions
Infancy (< 1 year)	Clinging, developmental delays, failure to thrive, gaze aversion, inconsolability, irritability
Early childhood Pre-schoolers (1 to 4 years)	Aggression, anxious attachment (clinging, fear of being away from parents, etc.), decreased appetite, feelings of responsibility/guilt, irritability, mutism, re-enactments in play of the traumatic event, regression in development/behaviour, sleep disturbances, withdrawal from friends and routines
Middle childhood Elementary school (5 to 10 years)	Aggression, impaired concentration and learning (hyperactive and inattentive), difficulties with separation, feelings of responsibility/guilt, irritability, sleep disturbances (and nightmares), re-enactments in play of the traumatic event, regression in development, school avoidance, specific fears (triggered by traumatic reminders), somatic complaints, withdrawal from friends and routines/activities, withdrawn
Adolescents (11 to 21 years)	Agitation, detachment, flashbacks, guilt, irritability, poor concentration, increase in conflicts, lack of pleasure, physical complaints, shame, sleep and eating disturbances, risk taking behaviours (and/or self-harm), withdrawn

Developmental milestones in children 3 months to 5 years

Note: If not achieved, all the developmental milestones in the tables below can be considered RED flags and trigger an in-depth assessment of the child, caregiver and dyad.

Table 1.2 - Developmental milestones

	3 months	7 months	12 months
Movement	Raises head and chest when lying on stomach.	Rolls over both ways. Sits without support. Reaches with one hand. Transfers objects.	Crawls. Walks with support. Begins to take steps alone.
Language	Begins to babble, imitates some sounds. Turns head towards sound of voice, smiles at sound of voice.	Responds to own name. Can tell emotions by sound of voice, babbles chains of sounds.	Says dada and mama.
Social/ Emotional	Makes eye contact, social smile. Engages in interaction.	Enjoys social play. Laughs.	Has preferential attachments. Stranger + separation anxiety.
Cognitive		Finds partially hidden objects. Reaches for objects out of reach.	Finds hidden objects. Begins to use objects correctly (e.g. a cup).

^a MSF OCG-OCP-OCB Paediatric Guideline, 2015.

	3 months	7 months	12 months
Behavioural	Responds to comfort.	Social, responds to people with smiling and eye contact.	Initiates interaction by hitting, biting. Sleeps through the night.
RED FLAGS	Does not like to be held.	Gaze aversion; does not respond to sound; does not engage in social interaction.	Does not crawl or stand with support, lack of vocalizing.

	2 years	3 years	4 years	5 years
Movement	Walks alone, runs kicks a ball.	Climbs, runs.	Hops, jumps, throws a ball.	Hops, skips, uses table utensils, can dress and undress self.
Language	Says several words, 2-4 word sentences, follows simple instructions.	4-5-word sentences. Has understandable language.	Speaks clearly in 5-6-word sentences.	Sentences of more than 5 words. Can tell a story.
Social/ Emotional	Imitates behaviour of others. Shared interests. Engages others with pointing.	Expresses affection. Imitates. Plays with other children.	Has friends and family attachments.	Aware of gender, friends are important, wants to please friends, follows rules, knows difference between right and wrong.
Cognitive	Pretend play.	Understands objects of culture.	Understands daily routine, early learning, i.e. counting, colours.	Learning according to available stimulation, can understand daily routine.
Behavioural	Temper tantrums when not getting his way. Beginning interest in using toilet.	Decrease of temper tantrums. Uses language to express needs. Using toilet during the day.	Wants to help in family. Enjoys acting grown up. Can accept reason.	Cares during the day for own toilet needs, might be enuretic at night, able to cooperate with parents and in school.
RED FLAGS	Not interactive. No words.	Aggressive, regression in milestones. Not interested in social interaction. Absent speech.	No self-care. Unhappy. Not learning.	Hyperactive, easily irritated, not learning, does not understand daily routine, lack of self-care, lack of interaction with others, not meeting developmental milestones.

Appendix 2. Briefing paper: children in emergencies (psychoeducation and psycho-stimulation)

Children are among the most vulnerable groups during a disaster. They require caregivers who provide care and stimulation in order to grow and develop to their potential. During a disaster, caregivers might be stressed to the point that they are unable to comfort and care for their children. Daily routines, which organize children and help them feel secure, are disrupted. Often children “hang around” with nothing to do as schools are often closed. Some children may be unaccompanied and need to be connected with caring adults. Mental health and psychosocial support (MHPSS) interventions for children immediately post-disaster include psychological first aid (PFA), psychoeducation and stimulating activities.

- Crayons, small balls, etc. can be used initially in activities with children.
- Map other agencies that assist children (safe places for play, schools, connecting unaccompanied children with caregivers) and discuss possibilities for collaboration.

Psychoeducation for children who experience disasters

An early key intervention for populations experiencing both man-made and natural disasters (conflict, displacement, earthquake, etc.) is psychoeducation about symptoms related to stress and how to develop coping strategies to deal with these symptoms. For adults this activity is usually organised in group sessions. Illustrate symptoms and coping strategies using colourful posters.

Children do not manifest the same reactions to stress as adults. Their symptoms depend on their age and development ([Appendix 1](#)). Often the behaviour of a child reacting to a stressful situation is interpreted by caregivers as the child misbehaving (not listening to or obeying the caregiver) or acting ‘like a baby’ in the case of developmental regression (bed wetting, etc.).

Psychoeducation for adults includes informing them about the reaction’s children have to stressful situations and how parents/caregivers can intervene to help them cope with the changes in their lives. Children perceive their parents’ feelings. The reactions of and interventions for children and families can be illustrated with posters.

Psychoeducation can be offered to groups of children beginning at 4 to 5 years of age (when they are verbal). Children learn to recognize symptoms of anxiety, such as nightmares, heart beating fast, anger, not wanting to play, etc. They can be taught how to calm themselves by deep breathing, blowing on a homemade pinwheel, positive imagery, drawing, talking to their parents, playing with younger children.

Common symptoms of children:

- Developmental regression such as enuresis or thumb sucking.
- Irritability and crying.
- Temper tantrums.
- Aggressive behaviours, e.g. fighting with other children or siblings.
- Nightmares.
- Clinging and difficulties with separation, e.g. wanting to be with parent all the time.
- Appetite disturbances.
- Somatic complaints such as stomach aches.

Interventions:

- Connection with a caring parent/caregiver.
- Establish a family routine.
- Calm by holding, reassuring, gentle massage.
- Distraction with play.
- For older children, activities such as singing; for younger children, playing.

Suggestions of images for posters:

- **Symptoms** (crying child, child clinging to parent, older child who wets the bed, child waking up with a nightmare, etc.).
- **Interventions for parents to help children** (adult comforting a child – arm around child; family sitting on a mat eating - family routine; child in an activity with a caregiver such as cooking or walking together; adult teaching or playing with a group of children).
- **Coping strategies for children** (deep breathing; meditation or prayer if appropriate; singing with other children; helping younger children; thinking of happy times; talking to parents).

Always take into consideration and use the local culture and existing coping mechanisms as a starting point. For example, in some cultures meditation and prayer are common activities for all age groups and can be a means of calming and restoring normality to life.

Psychosocial stimulation for children who experience disaster

Psychosocial stimulation for children promotes speech, cognitive, motor and interpersonal development. Ideally for children under 5 years of age, this occurs in the context of the parent-child relationship. Older children benefit from stimulation in the school setting and with peers as well as with their parents/caregivers. During a disaster, however, activities of daily life are disrupted (school closures, etc.). Children of all ages, even in the direst of circumstances respond to play and having fun.

Promoting psychosocial stimulation for children post disaster:

- Find caregivers to supervise stimulating activities (such as teachers, etc.). Activities to consider include play groups for small children; singing, dancing, drawing, story-telling for middle-aged children; athletics, music, dancing, discussion, writing for adolescents.
- Children helping children: older children can be organized to teach and play with younger children. This is helpful for both groups; younger children have fun and older children feel useful.
- Consider having adolescents and adults craft toys for children from local and available materials. Introduce music with local instruments (if available).

Appendix 3. Mental health screening tools

Please discuss the use of any screening tool with the mental health advisor prior to its implementation. Certain screening tools require authorization from the developers for their use (including a fee).

1. WHO, Patient Health Questionnaire (PHQ9), PHQ-2 or PHQ-4
<http://www.agencymeddirectors.wa.gov/Files/depressooverview.pdf>
<https://www.phqscreeners.com/select-screener>
2. GAD-7 (General Anxiety Disorder -7)
<https://www.phqscreeners.com/select-screener>
3. SRQ-20 (WHO, Self-Reporting Questionnaire)
<https://apps.who.int/iris/handle/10665/61113>
4. Generalized health questionnaire (GHQ 28, GHQ 12)
<https://www.gl-assessment.co.uk/products/general-health-questionnaire-ghq/>
5. Edinburgh postnatal depression scale (EPDS)
http://www.perinatalservicesbc.ca/Documents/Resources/HealthPromotion/EPDS/EPDSScoringGuide_March2015.pdf
6. Harvard trauma questionnaire (HTQ); Hopkin's symptoms checklist (HSCL 25)
<http://hpert-cambridge.org/screening/harvard-trauma-questionnaire/>
7. Morisky medication adherence scale
<http://psnc.org.uk/greater-manchester-lpc/wp-content/uploads/sites/118/2016/12/Questionnaires.pdf>
8. MSF -Psychological screening for young children aged 6 - 36 months
 MSF- Psychological screening for young children aged 3 - 6 years old (PSYCa 3-6)
9. Trauma screening questionnaire (TSQ)
https://www.cambridge.org/core/services/aop-cambridge-core/content/view/0D4F877175666B158D4D43C8A81011B7/S0007125000238270a.pdf/predictive_validity_of_the_trauma_screening_questionnaire_in_detecting_posttraumatic_stress_disorder_in_patients_with_psychotic_disorders.pdf
10. Child trauma screening questionnaire (CTSQ)
<https://www.ementalhealth.ca/index.php?m=survey&ID=31>
11. Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)
<https://www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf>
12. RHS-15 (Refugee Health Screener -15)
http://refugeehealthta.org/wp-content/uploads/2012/09/RHS15_Packet_PathwaysToWellness-1.pdf
13. IES-R (Impact of events scale revised)
<https://consultgeri.org/try-this/general-assessment/issue-19.pdf>
14. Children's Revised Impact of Events Scale
<https://www.childrenandwar.org/wp-content/uploads/2019/11/English-CRIES-8.pdf>
15. AUDIT: The Alcohol Use Disorders Identification Test, WHO
<https://apps.who.int/iris/handle/10665/67205>
16. CAGE (Substance abuse screening tool)
https://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/all_plans/CAGE%20Substance%20Screening%20Tool.pdf

MSF Psychological screening for young children aged 6 - 36 months old (PSYCa 6 - 36)

Always ask the questions in the same way, allow the parent (or caregiver) to think and to ask you questions if there is something they do not understand. Only circle one number per question: **0 for no or never, 1 for sometimes or occasionally, 2 for often, frequently or always.** **All the questions must be answered.**

During the last month,

0	1	2	1.	Your child has difficulty falling asleep and only sleeps for short periods
0	1	2	2.	Your child seems to be scared a lot
0	1	2	3.	Your child refuses to eat
0	1	2	4.	Your child has uncontrolled tantrums
0	1	2	5.	Your child does not smile
0	1	2	6.	Your child is easily startled
0	1	2	7.	Your child refuses to play a lot
0	1	2	8.	Your child is clingy, refuses to separate from you
0	1	2	9.	The child eats far too much
0	1	2	10.	Your child has difficulties to calm down, console after separation with you
0	1	2	11.	Your child cries a lot
0	1	2	12.	Your child does not communicate with sounds
0	1	2	13.	Your child is restless or cannot sit still
0	1	2	14.	Your child reacts inadequately when hurt
0	1	2	15.	Your child needs to be encouraged to make eye contact with you
0	1	2	16.	Your child hurts himself or others on purpose
0	1	2	17.	Your child reacts too emotionally to small things
0	1	2	18.	Your child approaches strangers for comfort
0	1	2	19.	Your child avoids contact with you
Y		N		Since his/her birth, your child witnessed or had a stressful or violent event (if yes, see item 20, if no quote 0 to item 20)
0	1	2	20	Your child's behavior changed since the event and this change is still present now
				Number of answers per column
				Scores for each column
				Overall score

To calculate the total score:

Once all questions are answered, to avoid miscalculation:

- First the interviewer calculates the number of 0, 1 and 2 per column (number of answers per column) = the total number of 0, 1 or 2 (must be 20).
- Second, s/he calculates the scores for each column.
- Third, he/she adds the 3 numbers obtain to have the global score (between 0 to 40).

If the total score is superior or equal to 8, ensure the child is referred to a psychologist.

MSF Psychological screening for young children aged 3-6 years old (PSYCa 3-6)

The PSYCa3-6 is a scale that was designed for assessing psychological difficulties in young children (3-6) but can be helpful for children up to 10 years old. It is a tool for screening and orientation and not a diagnostic tool.

Always ask the questions in the same way, allow the parent (or caregiver) to think and to ask you questions if there is something they do not understand. Only circle one number per question: **0 for no or never, 1 for sometimes or occasionally, 2 for often, frequently or always.** **All the questions must be answered.**

0	1	2	1.	The child stammers
0	1	2	2.	The child refuses to eat, repeatedly and over a long period
0	1	2	3.	The child often wakes up, suffers from insomnia and gets up in the night
0	1	2	4.	The child is absent, seems to be somewhere else or in his/her own world, s/he has trouble connecting with you
0	1	2	5.	The child has a frequently recurring bad dream or nightmare
0	1	2	6.	The child is frightened, nervous and anxious
0	1	2	7.	The child has trouble with going to the toilet (peeing and pooing)
0	1	2	8.	The child refuses to be separated from one of his or her parents, brothers, sisters, etc.
0	1	2	9.	The child eats far too much
0	1	2	10.	The child hardly speaks or not at all, using very different language from other children of the same age
0	1	2	11.	The child refuses to eat certain foods and chooses what s/he wants to eat at every meal
0	1	2	12.	The child has trouble falling asleep
0	1	2	13.	The child jumps and has uncontrolled movements without any apparent reason
0	1	2	14.	The child is in pain or complains about his/her body without any obvious medical cause
0	1	2	15.	The child cannot keep still and moves all the time
0	1	2	16.	The child refuses to leave the concession or house
0	1	2	17.	The child is tired, disheartened
0	1	2	18.	The child behaves too aggressively, fights too much, is violent (at home and/or outside the home)
0	1	2	19.	The child keeps to him/herself and often stays away from other people
0	1	2	20.	The child is easily carried away by emotions such as anger, sadness and fraternal jealousy
0	1	2	21.	The child's games and activities are repetitive
0	1	2	22.	The child runs away from or avoids specific noises, images or situations
			Number of answers per column	
			Scores for each column	
			Overall score	

As far as you know, has the child been a victim of, witness to or directly confronted by violent events, threats, injuries, accidents, sudden death of a close relative in his/her presence, family or conjugal violence or other events that could endanger her/his life: natural catastrophes, war, fire or other events?

If yes, please specify _____

To calculate the total score:

Once all questions are answered, to avoid miscalculation:

- First the interviewer calculates the number of 0, 1 and 2 per column (number of answers per column) = the total number of 0, 1 or 2 (must be 22).
- Second, he/she calculates the scores for each column.
- Third, he/she adds the 3 numbers obtain to have the global score (between 0 to 44).

All scores 9 and above need to be referred to a clinical psychologist for further evaluation and care.

Appendix 4.1. Leaflet - Reactions after a trauma

- There are certain things that you can do to feel better:**
- Do share your emotions (talking about the difficulties that you have gone through is helpful to reduce the suffering).
 - Sleep and eat well.
 - Make some physical exercise (walk).
 - Be with your family & friends.
 - Do take the time to think about what happened, allow yourself to feel sad.
 - Do let the children talk about what happened and their emotions .
 - Do think about future plans.
- What will not help you to feel better:**
- Don't try to push your feelings away.
 - Don't avoid talking about what happened.
 - Don't expect the memories to go away.
 - Don't turn to khat or drugs for relief.

5/6



Following these recommendations you will feel better with the time, so you will be able to carry on with your life
 Many people even come out wiser and stronger after having faced very painful experiences.

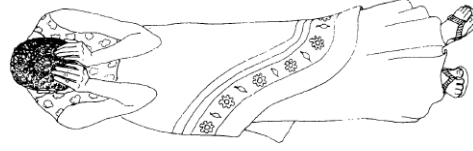
However, if the symptoms are so intense that you cannot do the usual activities or the symptoms don't heal (they have the same intensity) after some days/weeks, you can benefit from Counselling.

MSF offers free counseling in Degahbur Hospital (our office is in the Nutrition Building).

6/6



MSF (Doctors without borders) is an international medical and humanitarian organization. MSF is currently working in Degahbour, providing medical and humanitarian assistance.



The information contained in this leaflet, aims to help you to feel better after the violent experience you have faced.

1/6

4/6

Suffering from a difficult experience, or witnessing it, is very harmful.

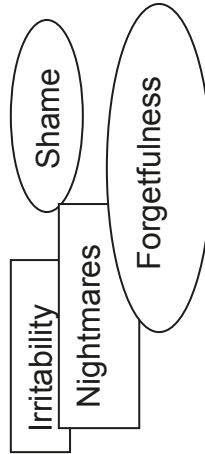
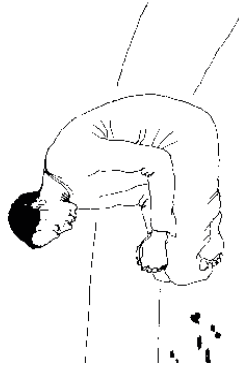
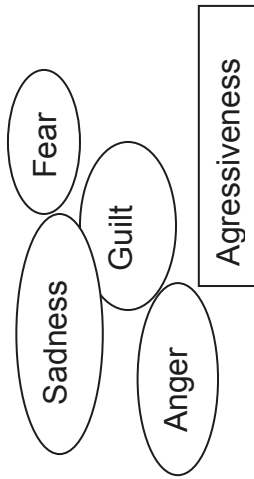
If you have suffered any violent event (related to armed conflict, domestic violence or sexual violence) you may find useful information in this leaflet

Although you have survived, these experiences might have had a negative impact on your health. It is normal that you have some reactions after you have been in this difficult situation. Others in similar situations experience them as well.

If you see yourself having these reactions it doesn't mean that you are sick or you are crazy it's just normal after the experience you have faced. Your body and mind need to recover and this healing process will take some time.

2/6

Normal Reactions after violent events:



These symptoms are annoying, but are also normal after the violent event you have faced and their intensity will decrease with the time.

3/6

Children reactions:

It is important for parents to see how their children have been affected

- Nervousness.
- Jumpiness
- Fears
- Getting upset easily
- Quickly angry/fighting a lot
- Sleeping problems
- Bed-wetting



Appendix 4.2. Leaflet - Stress



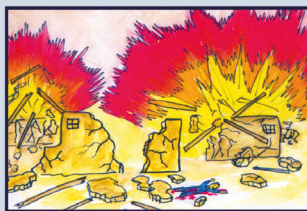
**MEDECINS
SANS FRONTIERES**

طیبیان بے سرحد

Stress: Causes, Signs and Coping Strategies

Stress is normal part of our everyday lives, and is not an illness itself, However, if signs of ongoing stress are not managed it can result in physical and mental health problems.

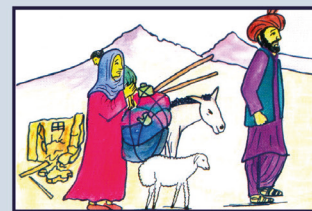
Causes Of Stress To Women, Men and Children



WAR/CONFLICT



DEATH OF FAMILY MEMBER



DISPLACEMENT



SEPARATION OF FAMILY MEMBER



LACK OF FOOD



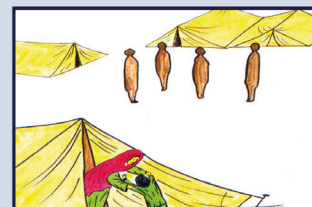
JOBLESS



DEPENDENT ON OTHERS FOR SURVIVAL



FAMILY CONFLICT



LIVING AMONGST STRANGERS



SOCIAL ISOLATION

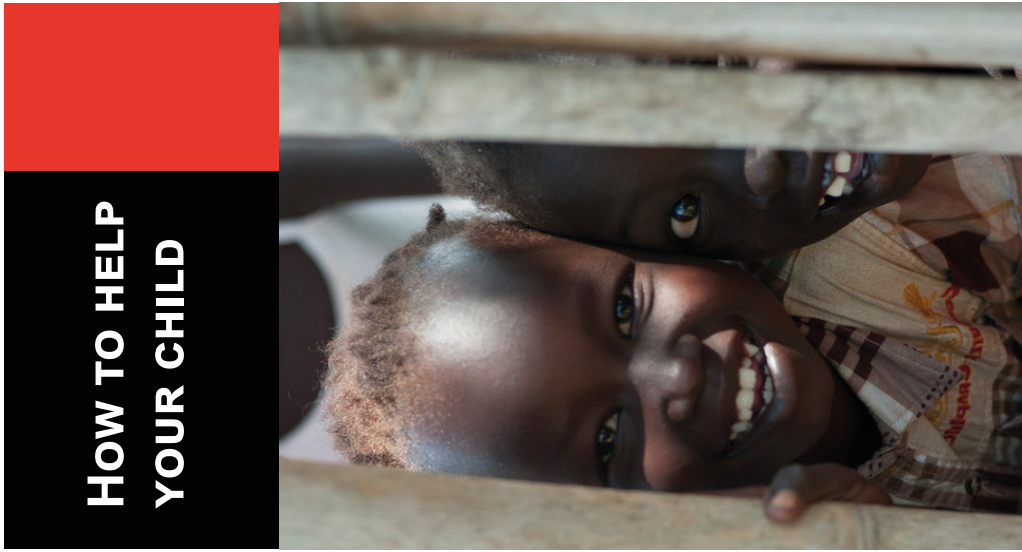


UNCERTAIN FUTURE



OTHER CAUSES OF STRESS

Appendix 4.3. Leaflet - How to help your child



**HOW TO HELP
YOUR CHILD**






Do something fun.



HEALTH CENTER

Visit the health center for more information and help. Visiting the center is free of charge.


Address:




COPING SKILLS FOR YOUR CHILD

Your child can use the following strategies to cope with his/her emotions.


Think of happy times.




Talk to parents.



Take a deep breath.



Sing with other children.

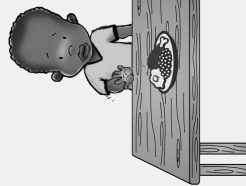


SYMPTOMS

Following a disaster your children might experience the following symptoms coping with this traumatic experience.



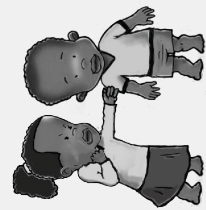
Irritable and crying, temper tantrums.



Appetite disturbance.



Somatic complaints; stomach aches.



Aggressive behaviour, hitting other children or siblings.



Nightmares.



Child clings to parent.

Other symptoms can be loss of developmental achievements.

HOW TO HELP YOUR CHILD

You can help your child cope with his/her feelings by doing the following activities.

1. Create a family routine; have meals together.



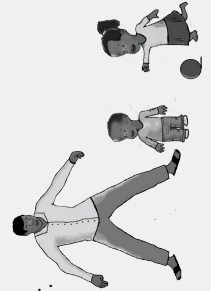
2. Comfort child by holding or giving a gentle massage when he/she is upset or has a nightmare



3. Do an activity together like cooking.



4. Go for a walk together.



5. Play together.

Appendix 4.4. Leaflet - How are you

MEDECINS SANS FRONTIERES
無國界醫生

HOW ARE YOU?

I feel nervous, too. But I have some ideas what we can do.

I feel scared about this virus! And you?

Me, too. Now I know what I can do. TAKE A BREATH, TAKE A BREAK AND TAKE CARE.

I think these easy tips can really help me to cope with stress. I feel a little bit better already.

If you think that despite everything you have tried, you are not feeling better or even getting worse, please reach out to a health professional for help. **You are not alone!**

TAKE A BREATH, TAKE A BREAK AND TAKE CARE.

ARE YOU FEELING _____?



afraid of getting infected or maybe infecting others



stressed, restless or having tension in your body



helpless or uncertain about what the future will bring



tired, or having difficulties in falling asleep or relaxing



angry or sad because so many things happen that you cannot control

WHAT WE CAN DO:

TAKE A BREATH



Close your eyes



Inhale deeply and slowly into your belly for 5 seconds



Exhale slowly for 5 seconds



Repeat this until you feel a bit more calm

TAKE A BREAK FROM THE THINGS THAT WORRY YOU



Turn off your phone notifications



Put your devices on silence or even turn them off, especially at night



Feed your mind with joyful activities, such as listening to music, reading a good book, etc.

TAKE CARE OF YOUR BODY



Healthy diet



Exercise regularly

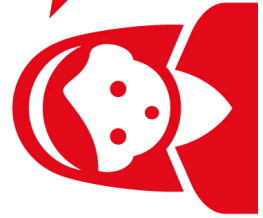
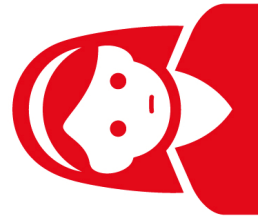


Good sleep



TAKE CARE of each other

Small little things can have a big impact.



Many people may have these feelings, or even more. But these reactions are normal in abnormal situations.

Do you know that when we help others, it makes you feel better, too? Just try it.

Appendix 5. Relaxation techniques for stress relief

For many people with stressful lives, relaxation means zoning out in front of a television at the end of the day or some extra sleep on the weekend. Unfortunately, this does little to reduce the damaging effects of stress on the mind and body.

Relaxation techniques include deep breathing, visualization, meditation, yoga, performing rhythmic exercise (running, cycling, etc.) or mindful walking achieve this. These activities help reduce everyday stress and boost energy and mood. They help in staying calm in the face of life's unexpected events.

The relaxation response: bringing the nervous system back into balance

Stress is necessary for life, creativity, learning and survival. Stress is only harmful when it becomes overwhelming and interrupts the healthy state of equilibrium that the nervous system needs to remain in balance. Overwhelming stress has become an increasingly common characteristic of contemporary life. When stressors throw the nervous system out of balance, relaxation techniques can bring it back into a balanced state by producing the relaxation response, a state of deep calmness that is the polar opposite of the stress response.

When stress overwhelms the nervous system, the body is flooded with chemicals that prepare for “fight or flight”. This response can be lifesaving in emergency situations, however, it wears the body down when constantly activated by the stresses of everyday life. The relaxation response puts the brakes on this heightened state of readiness to bring body and mind back into a state of equilibrium.

Producing the relaxation response and finding a relaxation technique

Different relaxation techniques can produce the relaxation response. The relaxation response is a mentally active process that leaves the body relaxed, calm and focused.

Learning the basics is not difficult but does take practice. Set aside at least 10-20 minutes a day for relaxation practice (for more stress relief, aim for 30-60 minutes). Many of these techniques can be incorporated into an existing daily schedule—practiced at a desk over lunch or on the bus during a commute.

There is no single relaxation technique that is best for everyone. When choosing a technique, consider specific needs, preferences, fitness level and personal reactions to stress. The right relaxation technique resonates, fits lifestyles and focuses the mind, interrupting everyday thoughts and eliciting the relaxation response. Alternating or combining different techniques may provide the best results.

Table 6-1 - Personal reactions to stress and techniques

Stress Response	Symptoms	Relaxation Technique
Overexcited	Tendency to become angry, agitated or 'keyed up' under stress	Techniques that are quieting, such as meditation, deep breathing, or guided imagery
Under excited	Tendency to become depressed, withdrawn, or spaced out under stress	Techniques that are stimulating and energize the nervous system, such as rhythmic exercise
Frozen (overexcited and under excited at the same time – like pressing on the brakes and gas simultaneously)	Tendency to freeze: speeding up in some ways while slowing down in others	Techniques that provide both safety and stimulation to help "reboot" such as mindfulness, walking or power yoga

Relaxation technique 1: breathing

Focus on full, cleansing deep breaths for a simple powerful relaxation technique that can be practiced almost anywhere. It provides a quick way to get stress levels in check and is the cornerstone of many other relaxation practices. Consider combining with other relaxing elements such as aromatherapy and music.

Breathe deeply from the abdomen, getting as much fresh air as possible into the lungs. The more oxygen inhaled, the less tension, shortness of breath and anxiety.

- Sit comfortably with your back straight. Put one hand on your chest and the other on your stomach.
- Breathe in through your nose. The hand on your stomach rises while the hand on your chest moves very little.
- Exhale through your mouth, pushing out as much air as possible while contracting your abdominal muscles. The hand on your stomach should move in when you exhale while the other hand moves very little.
- Continue. Try to inhale enough so the lower abdomen rises and falls. Count slowly as you exhale.

If abdominal breathing is difficult while sitting up, try lying on the floor. Put a book on your stomach, breathing so the book rises when you inhale and falls when you exhale.

Relaxation technique 2: progressive muscle relaxation

Progressive muscle relaxation involves systematic tension and relaxation of different muscle groups in the body. With regular practice, an intimate familiarity with what tension—as well as complete relaxation—feels like in different parts of the body is observed. This awareness helps identify and counteract the first signs of muscular tension accompanying stress. And as the body relaxes, so does the mind. Combine with deep breathing for additional stress relief.

Before practicing, consult a doctor if there is a history of muscle spasms, back problems or other serious injuries that may be aggravated by tensing muscles. Most practitioners start at the feet and work their way up to the face.

- Loosen clothing, take off shoes and get comfortable.
- Take a few minutes to breathe in and out in slow, deep breaths.
- Then shift your attention to your right foot. Take a moment focusing on the way it feels.
- Slowly tense the muscles in your foot, squeezing as tightly as possible. Hold for a count of 10.
- Relax the right foot. Focus on the tension flowing away and how the foot feels as it becomes limp and loose.
- Stay in this relaxed state for a moment, breathing deeply and slowly.
- Then shift your attention to your left foot. Follow the same sequence of muscle tension and release.
- Move slowly up through the body, contracting and relaxing the muscle groups.
- Try not to tense muscles other than those intended.

The most popular sequence:

- | | | |
|----------------|----------------------|------------------------|
| 1. Right foot | 6. Left thigh | 11. Right arm and hand |
| 2. Left foot | 7. Hips and buttocks | 12. Left arm and hand |
| 3. Right calf | 8. Stomach | 13. Neck and shoulders |
| 4. Left calf | 9. Chest | 14. Face |
| 5. Right thigh | 10. Back | |

Relaxation technique 3: body scan meditation

A body scan is like progressive muscle relaxation except, instead of tensing and relaxing muscles, the focus is on the sensations in each part of the body.

- Lie on the back, legs uncrossed, arms relaxed at the sides, eyes open or closed. Focus on breathing, allowing the stomach to rise when you inhale and fall when you exhale. Breathe deeply for about two minutes.
- Shift your focus to the toes of your right foot. Notice any sensations while continuing to focus on breathing. Imagine each deep breath flowing to the toes. Remain focused on this area for 1-2 minutes.
- Shift your focus to the sole of your right foot. Tune in to any sensations in that part of your body. Imagine each breath flowing from the sole of the foot. After 1-2 minutes, shift your focus to your right ankle and repeat. Move to your calf, knee, thigh, hip, and then repeat the sequence for your left leg. Then, move up your torso, through your lower back, abdomen, upper back and chest, and shoulders. Pay attention to any area that causes pain or discomfort.
- Shift your focus to the fingers on your right hand. Move up to your wrist, forearm, elbow, upper arm and shoulder. Repeat for your left arm. Then move through your neck and throat, all the regions of your face, your back and the top of your head. Pay attention to your jaw, chin, lips, tongue, nose, cheeks, eyes, forehead, temples and scalp. When the very top of your head is reached, let the breath reach beyond your body and imagine hovering above your body.
- After completing the body scan, relax in silence and stillness, noting how your body feels. Open your eyes slowly and take a moment to stretch, if necessary.

Relaxation technique 4: mindfulness

Mindfulness is the ability to remain aware of how one feels right now, the “moment-to-moment” experience, both internal and external. Thinking about the past (blaming, judging, etc.) or worrying about the future often leads to overwhelming stress. By staying calm and focused in the present moment, the nervous system comes back into balance. Mindfulness can be applied to activities such as walking, exercising, eating or meditation.

Mindfulness meditations bring oneself into the present by focusing attention on a single repetitive action, such as breathing, a few repeated words or flickering light from a candle. Others encourage the following and then releasing of internal thoughts or sensations.

- **A quiet environment.** Choose a secluded place in the home, office, garden, place of worship or outside to relax without distractions or interruptions.
- **A comfortable position.** Get comfortable but avoid lying down as this may lead to falling asleep. Sit up with your back straight, in a chair or on the floor (try a cross-legged or lotus position).
- **A point of focus.** This point can be internal (a feeling or imaginary scene) or external (a flame or meaningful word or phrase repeated) throughout the session. Meditate with eyes open (focus on an object in the surroundings to enhance concentration) or closed.
- **An observant, noncritical attitude.** Do not worry about distracting thoughts or about how well it is going. If thoughts intrude, do not fight them. Instead, gently shift your attention back to the point of focus.

Relaxation technique 5: visualization meditation

Visualization, or guided imagery, is a variation on traditional meditation that employs the visual, taste, touch, smell and sound senses. When used as a relaxation technique, visualization involves imagining a peaceful scene, where one is free to let go of all tension and anxiety.

Do this exercise alone in silence, while listening to soothing music or with a therapist (or an audio recording of a therapist) guiding through the imagery. Sounds can be incorporated to help employ the sense of hearing (the sound of ocean waves, for example).

Find a quiet relaxed place. Avoid lying down, as beginners sometimes fall asleep. Close the eyes and let worries drift away. Imagine a calming setting, whether a tropical beach, a favourite childhood spot or a quiet wooded glen. Picture it as vividly as possible. Incorporate as many sensory details as possible, using at least three senses. Choose appealing imagery. Do not select images because someone else suggests them, or because they should be appealing. If the setting is a dock on a quiet lake, for example:

- Walk slowly around the dock noticing the colours and textures.
- Spend time exploring each of the senses (see the sun setting over the water; hear the birds singing; smell the pine trees; feel the cool water; taste the fresh clean air, etc.).

When ready, gently open the eyes and come back to the present. Do not worry if you sometimes zone out or lose track during a guided imagery session. An experience of stiffness or heaviness in the limbs, minor involuntary muscle-movements, coughing and yawning are all normal responses.

Make relaxation techniques part of your daily routine

The best way to start and maintain a relaxation practice is to incorporate it into your daily routine. It can be tough to find the time. Fortunately, many of the techniques can be practiced while doing other things.

Rhythmic exercise as a mindfulness relaxation technique

Rhythmic exercise—such as running, walking, rowing, or cycling—is most effective at relieving stress when performed with relaxation in mind. As with meditation, mindfulness requires being fully engaged in the present moment, focus the mind on how the body feels right now. Focus on the physicality of the body's movement and how breathing complements that movement. If the mind wanders to other thoughts, gently return to focusing on breathing and movement. If walking or running, for example, focus on each step—the sensation of the foot touching the ground, the rhythm of breath while moving and the feeling of the wind.

Tips for fitting relaxation techniques into your life

- **If possible, schedule a set time to practice each day.** Set aside 1-2 periods each day. It may be easier to stick with the practice first thing in the morning, before other tasks and responsibilities get in the way.
- **Practice relaxation techniques while doing other things.** Meditate while commuting to work on a bus or train or waiting for a dentist appointment. Try deep breathing while doing housework or mowing the lawn. Mindfulness walking can be done while exercising the dog, walking to the car or climbing the stairs at work instead of using the elevator. Techniques such as tai chi, can be practiced in the office or in the park at lunchtime.
- **Improve the relaxation benefits by adopting mindfulness while exercising.** Instead of zoning out or staring at a TV, focus attention on the body. For example, focus on coordinating breathing with movements. Pay attention to how the body feels when raising and lowering weights.
- **Avoid practicing when sleepy.** These techniques can make one very sleepy, especially close to bedtime. The practice with the most benefits is upon being fully awake and alert. Do not practice after eating a heavy meal or while using drugs, tobacco or alcohol.
- **Expect ups and downs.** Do not be discouraged if a few days or even a few weeks are skipped. Restart and slowly build up to the old momentum.

Appendix 6. Therapeutic techniques

The following therapies have been intersectionally validated for use in the specific circumstances elaborated after each description. If there is a specific therapy type that a field would like to use, if it is not on this list or otherwise mentioned in the guideline, then a request should be made to the section Mental Health Advisor for prior technical validation.

For additional information, see [Appendix 1](#) and mental health and psychosocial (MHPS) reference reading toolbox for concept papers related to the following therapies.

Cognitive processing therapy (CPT)

CPT is a 12-session therapy that is effective for post-traumatic stress disorder (PTSD) and other corollary symptoms following traumatic events (including comorbid depression). CPT can be provided in individual and group treatment formats.

The primary focus of the treatment is to help the patient understand and re-conceptualize their traumatic event in a way that reduces its ongoing negative effects on their current life. Decreasing avoidance of the trauma is necessary for the patient to examine/evaluate their meta-emotions and beliefs generated by the trauma.

CPT incorporates trauma-specific cognitive techniques to help individuals with PTSD more accurately appraise these «stuck points» and progress toward recovery. The treatment process involves 5 major dimensions that may be disrupted by traumatic events (Safety, Trust, Power and Control, Esteem, Intimacy).

Advantages:

- Has shown efficacy in treating certain mental health (MH) symptoms and disorders related to trauma (including the comorbidity of depression).
- Can be practiced with patients who are still under a certain level of stress (soldiers redeployed to a combat zone, etc.).
- Reduces the possibility of having additional trauma(s).
- Can be practiced with people coming from different cultures and with different intellectual backgrounds.

To practice CPT, the following criteria have to be met:

- Presence of an MSF mental health activities manager (MHAM) certified as a CPT trainer, who has been trained in CPT for more than one year + one year of supervision. The MHAM supervises and monitors patient outcomes of the intervention.
- National staff psychologists performing CPT are trained in psychotherapeutic treatment of patients (with clinical psychology specialization knowledge and training in psychotherapy practices).
- For use with beneficiaries who have not been exposed to multiple traumas.
- 12 follow up appointments can be ensured (via phone, home visit or in the clinic).
- Cultural adaptation needs to be assessed to ensure this model can be setup in a given specific context.

Eye movement desensitization and reprocessing (EMDR)

EMDR is a type of psychotherapy for PTSD and treatment of other psychiatric disorders, MH problems and somatic symptoms. It can be provided in individual and group formats. EMDR is an information processing therapy that posits that much of psychopathology is due to the maladaptive encoding and/or incomplete processing of traumatic or disturbing adverse life experiences. This impairs the client's ability to integrate these experiences in an adaptive manner.

The eight-phase, three-pronged process of EMDR facilitates the resumption of normal information processing and integration. This treatment approach incorporates dual focus of attention and alternating bilateral visual, auditory and/or tactile stimulation targeting past experience, current triggers, and future potential challenges. It results in the alleviation of presenting symptoms, a decrease or elimination of distress from the disturbing memory, improved view of the self, relief from bodily disturbance and resolution of present and future anticipated triggers.

To practice EMDR, the following criteria have to be met:

- Stable contexts (not ongoing conflict/crisis areas).
- Presence of an MSF MHAM certified as an EMDR trainer and trained in EMDR for more than one year + one year of supervision. The MHAM supervises and monitors patient outcomes of the intervention.
- National staff psychologists able to perform psychotherapeutic treatment (with clinical psychology specialization knowledge and training in psychotherapy practices).
- Beneficiaries who have not been exposed to multiple traumas.
- Patient follow-up can be ensured (via phone, home visits or in the clinic).
- The MH advisor agrees on the relevance of the technique in the context before implementation.

Interpersonal psychotherapy (IPT)

IPT targets a variety of psychiatric disorders including disorders mainly related to trauma including affective disorders, anxiety disorders, PTSD and eating disorders. It is a time-limited (4 to 16 sessions), interpersonally focused, psycho-dynamically informed psychotherapy that has the goals of symptom relief, improved interpersonal functioning and social support network. It is divided into 5 phases (assessment, initial, middle, termination and maintenance sessions) delivered individually and in groups. It can be provided by MH professionals, non-MH nurses and lay counsellors.

Constraints include difficulties determining whether the patient is a suitable candidate for IPT.

To practice IPT, the following criteria have to be met:

- There is a clear identification of inter-personal conflicts.
- Counsellors are trained on the basics of supportive counselling, before beginning IPT approach training.
- IPT is not a stand-alone MH intervention but combined with other models, mainly supportive counselling.
- When a minimum number of follow-up sessions is expected.
- The MH advisor agrees on the relevance of the technique in the context before implementation.

Mindfulness

Mindfulness is an integrative, mind-body based approach that helps people change the way they think and feel about their experiences. It is a way of paying attention to the present moment by using meditation, breathing techniques, and yoga. Mindfulness involves consciously bringing awareness to thoughts and feelings, without making judgments, allowing the individual to become less enmeshed and better able to manage them.

Mindfulness refers to a state of consciousness that is characterized by the self-regulation of attention towards present-moment experiences coupled with an accepting, non-judgmental stance towards these experiences. Mindfulness-based interventions are typically eight sessions delivered in a group setting, incorporating mindfulness meditation practice and principles.

- Mindfulness-Based Stress Reduction (MBSR): helps people manage stress associated with physical health conditions such as chronic pain, anxiety disorders and depression (common comorbidities with PTSD).
- Mindfulness-Based Cognitive Therapy (MBCT) targets people with a history of depression and current depressive or anxiety disorders.
- Mindfulness-Based Relapse Prevention: helps people cope with urges to use substances following treatment for drug abuse and addiction (and other behaviours used to avoid trauma related experiences).

To practice mindfulness based interventions, the following criteria have to be met:

- The MH advisor agrees on the relevance of these techniques in the context before implementation.

Narrative exposure therapy (NET)

NET is a treatment for trauma-spectrum disorders in survivors of multiple and complex trauma and PTSD. NET contextualizes the particular associative elements of the fear network, the sensory, affective and cognitive memories of trauma to understand and process the memory of a traumatic event in the course of the particular life of a client. The patient constructs a chronological narrative of their life story with a focus on the traumatic experiences. Fragmented reports of the traumatic experiences are transformed into a coherent narrative. It is a short term approach (4-6 sessions) delivered in 4 parts (diagnostic interview/psychoeducation; laying out the lifeline; NET therapy sessions/flowers and stones; final session rituals).

Advantages:

- Can be practiced with patients who are still under a certain level of stress.
- Can be practiced individually.
- Can be practiced with people coming from different cultures and with different intellectual backgrounds.

To practice NET, the following criteria have to be met:

- Available psychologist trained in and with clinical practice of NET of at least 6 months for supervision.
- The MH advisor agrees on the relevance of these techniques in the context before implementation.
- Training and use of NET techniques are only for psychologists or trained counsellors.
- Not used in contexts of ongoing or active conflict/violence.
- Ability to ensure return for follow-up sessions.

Appendix 7. Definitions related to population on the move^a

Terminology	Definition	Comments
Legal status and categories		
Migrant	<p>“A migrant is any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, and his/her children, regardless of (1) a person’s legal status; (2) whether the movement is voluntarily or involuntarily; (3) what the causes for the movement are; or (4) what the length of the stay is.” (IOM).</p>	<p>Not defined under international law. The term encompasses diverse categories of people moving for diverse reasons, both within and between countries and for variable periods of time. People also shift from one category to another. There is an increasing focus on “unsafe migration” and “migrants in vulnerable situations” as certain migratory movements face more restrictions and expose people to hardship and dangerous journeys.</p> <p>Refugees are also migrants, but they benefit from specific rights attached to the refugee protection regime (see refugee definition below).</p>
Undocumented migrant	<p>“A person who does not have the necessary documentation to enter or remain legally in a country. Undocumented migrants cross international borders outside the regulatory norms of the sending, transit and receiving countries. This includes people who, owing to unauthorized entry, breach of a condition of entry, or the expiry of their visa, lacks legal status in a transit or host country.” (IOM).</p>	<p>MSF staff should NEVER use the term ‘illegal’ migrants or ‘illegal’ migration, it is legally incorrect and contributes to criminalisation and stigma. A person can never be illegal. Migration is not a crime. Migrants who lack the proper documentation to enter or stay in a given country can be referred to as “undocumented migrants” or “migrants in an irregular situation.”</p>
Internal/domestic migrant	<p>National who moves from one area (a province, district or municipality) to another within one country.</p>	
Internally Displaced Person (IDP)	<p>“Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border.” (IOM)</p>	<p>IDPs are protected by international human rights law and domestic law; and in situations of armed conflict, they are protected by international humanitarian law (IHL). The UN Guiding Principles on Internal Displacement also restate and compile human rights and humanitarian law relevant to internally displaced persons. Many states have incorporated them into domestic legislations.</p> <p>The African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa (Kampala Convention) is the first legally-binding instrument on IDPs.</p>

^a «Overview of international migration definitions (revised February 2020). Forced Migration Team – Analysis Department OCB»

Terminology	Definition	Comments
Asylum seeker	“A person who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status under relevant international and national instruments. In case of a negative decision, the person must leave the country and may be expelled, as may any non-national in an irregular or unlawful situation, unless permission to stay is provided on humanitarian or other related grounds” (IOM).	
Refugee	The most universally applied definition is the following: a person who, «owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.” (Art. 1(A)(2), Convention relating to the Status of Refugees, Art. 1A(2), 1951 as modified by the 1967 Protocol). Other – more generous - definitions exist at regional levels, for example the 1984 Cartagena Declaration and the 1969 OAU convention Governing the Specific Aspects of Refugee Problems in Africa.	It is important to note that refugee status is declaratory, meaning that a refugee is a refugee because he or she fulfils the criteria of the definition regardless of the fact he or she has been recognised as such by a state. Refugee Status Determination (RSD) and asylum procedures only confirm this status and provide the legal framework for the refugee to access specific rights in the country of refuge and be protected from refoulement.
Return migrants	People who return to their countries of origin after a period in another country.	
Migration contexts*		
Forced migration	“A migratory movement in which an element of coercion exists, including threats to life and livelihood, whether arising from natural or man-made causes (e.g. movements of refugees and internally displaced persons as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects)” (IOM).	This is not a legal definition, but the concept reflects well the context of MSF’s interventions.
Mixed Migration	“Mixed migration refers to cross-border movements of people including refugees fleeing persecution and conflict, victims of trafficking and people seeking better lives and opportunities. Motivated to move by a multiplicity of factors, people in mixed flows have different legal statuses as well as a variety of vulnerabilities. Although entitled to protection under international human rights law, they are exposed to multiple rights violations along their journey. Those in mixed migration flows travel along similar routes, using similar means of travel – often travelling irregularly and wholly or partially assisted by migrant smugglers” (MIMC).	

Terminology	Definition	Comments
Refugee repatriation	Return to the country of origin on the basis of the freely expressed willingness of the refugees (UNHCR). The returns must take place in conditions of safety, dignity and security. Of the three durable solutions to refugee situations – repatriation, integration and resettlement – repatriation is seen by UNHCR and by many states as the “most desirable solution”.	Important to understand that there are certain conditions for a return or repatriation process to be truly voluntary. The principle of ‘voluntariness’ must be viewed in relation to both: conditions in the country of origin (calling for an informed decision) and the situation in the country of asylum (permitting a free choice). UNHCR has guidelines on how to assess the voluntariness of repatriation processes for refugees. Handbook on voluntary repatriation (1996): http://www.unhcr.org/afr/3bfe68d32.pdf Handbook for Repatriation and Reintegration activities (2004): http://www.refworld.org/docid/416bd1194.html
Assisted Voluntary Return and Reintegration (AVRR)	Administrative, logistical, financial and reintegration support to rejected asylum seekers, victims of trafficking in human beings, stranded migrants, qualified nationals and other migrants unable or unwilling to remain in the host country who volunteer to return to their countries of origin (IOM).	
Labour migration	“Movement of persons from one State to another, or within their own country of residence, for the purpose of employment-addressed by most States in their migration laws. In addition, some States take an active role in regulating outward labour migration and seeking opportunities for their nationals abroad” (IOM).	The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICRMW) is the only international instrument establishing a framework to protect the rights of migrant workers. It has only been ratified by 54 states. This Convention has not been signed by any industrial nation with immigrants in the western world.
Reception facilities	“All forms of premises used for the housing of applicants for international protection and other categories of migrants and refugees” (European Commission).	These facilities may be open, semi-open or closed reception facilities, thereby determining the migrants’ freedom of movement.
Transit migration	“Transit migration is an umbrella concept that embraces transit, transit migration, temporary immigration or forced stay, on-migration or even continuous trajectories as well as a certain mental unrest” (Oxford, COMPAS). See definition of transit country below.	There is no authoritative definition and the time period that is considered to be “transition” varies widely from a few months to over ten years. For MSF operations it is a temporary migration context where a migrant stay for some period of time while seeking to migrate permanently to another location. This includes all legal categories, and migrants may fall in and out of different legal categories while in transit. It can be divided into two types: a) Short transit – a time period of a few hours and up to a few days. b) Long transit – a time period of more than a few days and up to months or years.

Terminology	Definition	Comments
Country of destination	“The country that is a destination for migratory flows (regular or irregular)” (IOM Migration Glossary).	An alternative definition is that of a Receiving Country: “Country of destination or a third country. In the case of return or repatriation, also the country of origin” (IOM Migration Glossary).
Country of transit	The country through which migratory flows (regular or irregular move” (IOM Migration Glossary).	Although the definition of a country of transit is well accepted, the terminology for ‘transit migration’ is not well defined. One example is: the assembly of Inter-Parliamentary Union in Geneva (2005: 4) states that ‘transit migrants are ...[those] who stay in the country for some period of time while seeking to migrate permanently to another country’.
Country of origin	The country that is a source of migratory flows (regular or irregular) (IOM Migration Glossary).	However, it is important to note that with migrants and refugees spending longer in the transit stage, there may be many countries that migrants have stayed in for varying lengths of time, between leaving their country of origin and arriving at their country of destination.
Migration settings*		
Informal settlements	“Informal settlements – are residential areas where 1) inhabitants have no security of tenure vis-à-vis the land or dwellings they inhabit, with modalities ranging from squatting to informal rental housing, 2) the neighbourhoods usually lack, or are cut off from, basic services and city infrastructure and 3) the housing may not comply with current planning and building regulations, and is often situated in geographically and environmentally hazardous areas”(UN Habitat).	There are no international recognised definitions for informal/urban settlements, and none which directly refer to those settlements which are formed of undocumented migrants.
Closed/detention setting	Closed settings can be defined as any setting which a person is unable to move from i.e. detention facility. They may be formal or informal, meaning that closed settings may also be coordinated by a State actor or a non-State actor such as a militia, smugglers or criminal networks. “Immigration detention refers to the government practice of detaining asylum seekers and other migrants for administrative purposes, typically to establish their identities, or to facilitate their immigration claims resolution and/or their removals. It is an administrative process rather than a criminal procedure” (The Migration Observatory, Oxford University).	Immigration detention should never be arbitrary; it should be limited in time; should be a measure of last resort; should have a legitimate aim; be proportionate to the purpose and based on individuals’ circumstances. Non-custodial measures should always be considered first. There is also a requirement to first assess the effect of detention on the person’s physical and mental health. Additionally, immigration detention should take place in adequate facilities and not in prisons. Living conditions must meet international standards.

Appendix 8. Care for child development

Counselling Cards, Care for Child Development Package. UNICEF and WHO, 2012.
https://www.unicef.org/earlychildhood/index_68195.html



Counsel the Family about Problems in Care for Child Development

If the mother does not breastfeed, counsel the mother to:

Hold the child close when feeding, look at the child, and talk or sing to the child.

If caregivers do not know what the child does to play or communicate:

- Remind caregivers that children play and communicate from birth.
- Demonstrate how the child responds to activities.

If caregivers feel too burdened or stressed to play and communicate with the child:

- Listen to the caregivers' feelings, and help them identify a key person who can share their feelings and help them with their child.
- Build their confidence by demonstrating their ability to carry out a simple activity.
- Refer caregivers to a local service, if needed and available.



If caregivers feel that they do not have time to play and communicate with the child:

- Encourage them to combine play and communication activities with other care for the child.
- Ask other family members to help care for the child or help with chores.

If caregivers have no toys for the child to play with, counsel them to:

- Use any household objects that are clean and safe.
- Make simple toys.
- Play with the child. The child will learn by playing with the caregivers and other people.

If the child is not responding, or seems slow:

- Encourage the family to do extra play and communication activities with the child.
- Check to see whether the child is able to see and to hear.
- Refer the child with difficulties to special services.
- Encourage the family to play and communicate with the child through touch and movement, as well as through language.

If the mother or father has to leave the child with someone else for a period of time:

- Identify at least one person who can care for the child regularly, and give the child love and attention.
- Get the child used to being with the new person gradually.
- Encourage the mother and father to spend time with the child when possible.

If it seems that the child is being treated harshly:

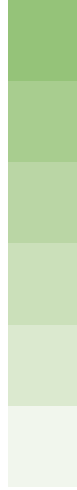
Recommend better ways of dealing with the child.

- Encourage the family to look for opportunities to praise the child for good behaviour.
- Respect the child's feelings. Try to understand why the child is sad or angry.
- Give the child choices about what to do, instead of saying "don't".





Recommendations for Care for Child Development



NEWBORN, BIRTH UP TO 1 WEEK

Your baby learns from birth



PLAY Provide ways for your baby to see, hear, move arms and legs freely, and touch you. Gently soothe, stroke and hold your child. Skin to skin is good.



COMMUNICATE Look into baby's eyes and talk to your baby. When you are breastfeeding is a good time. Even a newborn baby sees your face and hears your voice.

1 WEEK UP TO 6 MONTHS



PLAY Provide ways for your child to see, hear, feel, move freely, and touch you. Slowly move colourful things for your child to see and reach for. Sample toys: shaker rattle, big ring on a string.



COMMUNICATE Smile and laugh with your child. Talk to your child. Get a conversation going by copying your child's sounds or gestures.

6 MONTHS UP TO 9 MONTHS



PLAY Give your child clean, safe household things to handle, bang, and drop. Sample toys: containers with lids, metal pot and spoon.



COMMUNICATE Respond to your child's sounds and interests. Call the child's name, and see your child respond.

9 MONTHS UP TO 12 MONTHS



PLAY Hide a child's favourite toy under a cloth or box. See if the child can find it. Play peek-a-boo.



COMMUNICATE Tell your child the names of things and people. Show your child how to say things with hands, like "bye bye". Sample toy: doll with face.

12 MONTHS UP TO 2 YEARS



PLAY Give your child things to stack up, and to put into containers and take out. Sample toys: Nesting and stacking objects, container and clothes clips.



COMMUNICATE Ask your child simple questions. Respond to your child's attempts to talk. Show and talk about nature, pictures and things.

2 YEARS AND OLDER



PLAY Help your child count, name and compare things. Make simple toys for your child. Sample toys: Objects of different colours and shapes to sort, stick or chalk board, puzzle.



COMMUNICATE Encourage your child to talk and answer your child's questions. Teach your child stories, songs and games. Talk about pictures or books. Sample toy: book with pictures.

• Give your child affection and show your love • Be aware of your child's interests and respond to them • Praise your child for trying to learn new skills

Checklist for Counselling on Care for Child Development

Date: ____ / ____ /20____
(Day / Month / Year)

Completed by ____

Child's name: First _____ Family _____ Age: ____ Years/____ Months Boy/Girl

Caregiver's name: _____ Relationship: Mother / Father / Other: _____

Address, Community: _____

1. Identify practices to support the child's development and counsel the caregiver

Look		Praise the caregiver if caregiver:	Advise the caregiver and solve problems if caregiver:
All children	How does caregiver show her or she is aware of child's movements?	<input type="checkbox"/> Moves towards and with child, and talks to or makes sounds with child.	<input type="checkbox"/> Does not move with child, or controls child's movements: Ask caregiver to copy child's movements, to follow child's lead
	How does caregiver comfort the child and show love?	<input type="checkbox"/> Looks into child's eyes and talks softly to child, gently touches child or holds child closely.	<input type="checkbox"/> Is not able to comfort child, and child does not look to caregiver for comfort: Help caregiver look into child's eyes, gently talk to child and hold child.
	How does caregiver correct the child?	<input type="checkbox"/> Distracts child from unwanted actions with appropriate toy or activity.	<input type="checkbox"/> Scolds child: Help caregiver distract child from unwanted actions by giving alternative toy or activity.
Ask and listen		Praise the caregiver if caregiver:	And advise the caregiver and solve problems if caregiver:
Child age less than 6 months	How do you play with your baby?	<input type="checkbox"/> Moves the baby's arms and legs, or gently strokes the baby. <input type="checkbox"/> Gets baby's attention with a shaker toy or other object.	<input type="checkbox"/> Does not play with baby: Discuss ways to help baby see, hear, feel, and move, appropriate for baby's age.
	How do you talk to your baby?	<input type="checkbox"/> Looks into baby's eyes and talks softly to baby.	<input type="checkbox"/> Does not talk to baby: Ask caregiver to look into baby's eyes and talk to baby.
	How do you get your baby to smile?	<input type="checkbox"/> Responds to baby's sounds and gestures to get baby to smile.	<input type="checkbox"/> Tries to force smile or is not responsive to baby: Ask caregiver make large gestures and cooing sounds; copy baby's sounds and gestures, and see baby's response.
Child age 6 months and older	How do you play with your child?	<input type="checkbox"/> Plays word games or with toy objects, appropriate for age.	<input type="checkbox"/> Does not play with child: Ask caregiver to do play or communication activity, appropriate for age. <input type="checkbox"/> Does not talk to child, or talks harshly to child: Give caregiver and child an activity to do together. Help caregiver interpret what child is doing and thinking, and see child respond and smile.
	How do you talk to your child?	<input type="checkbox"/> Looks into child's eyes and talks softly to child, asks questions.	
	How do you get your child to smile?	<input type="checkbox"/> Draws smile out from child.	
	How do you think your child is learning?	<input type="checkbox"/> Says the child is learning well.	<input type="checkbox"/> Says the child is slow to learn: Encourage more activity with the child, check hearing and seeing. Refer child with difficulties.

2. Ask to see child again in one week, if needed (circle day):

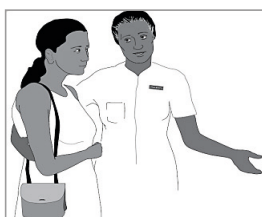
Monday Tuesday Wednesday Thursday Friday Weekend

Appendix 9. MSF guide to medication abortion counseling

MSF Guide to Medication Abortion Counseling

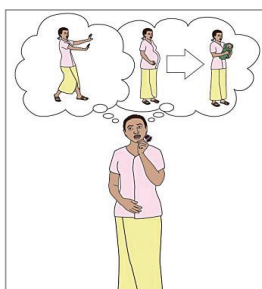
This guide is designed as a companion to the MSF Medication Abortion FlipBook. It offers recommendations to health care providers about how to talk to women during an abortion consultation and suggestions for simple, patient-centered language.

Women undergo abortions for many different reasons. Most women have already thought about their options and made the decision to have an abortion before seeking medical care. Some women may ask for more information before deciding. Our role is to listen and to provide the appropriate level of support and information, respecting her decision without judging or influencing her. **Routine consultation with a mental health counselor is not required.**



Welcome the patient

- Move to a **private, confidential** place.
- Use **open-ended questions** like “How can I help you today?”
- If she is alone, ask if she would like to invite a support person to be with her.
- If she is already with someone, speak to her alone and ask if she’s okay with this person staying or not.



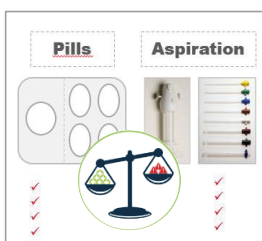
Ask, listen and support

- **Ask** her what she thinks and feels about the pregnancy:
“How do you feel about this pregnancy?” “What do you think about your situation?”
- **Listen and support:** Reassure, validate and normalize.
“It’s normal to feel different emotions – like feeling scared, nervous, sad or relieved – even at the same time.”
“Many women decide to end their pregnancies. You are not alone.”
“It sounds like you are making a thoughtful decision based on what’s best for you and your family at this time.”
- Refer patients who may need additional psychological support (e.g. sexual or domestic violence, trauma, extreme distress, etc.) to a counselor if available.



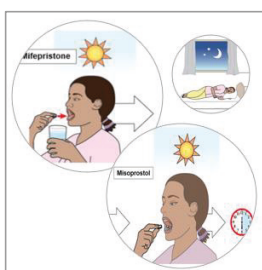
Determine eligibility

- **Medical history:** “Do you have any other health problems?”
- Pregnancy test if needed.
- Determine **gestational age:** “What was the first day of your last menstrual period?”



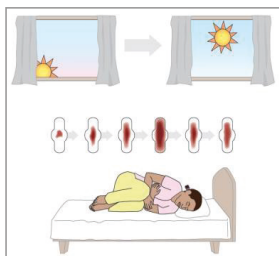
Informed consent

- Review the 2 options for safe abortion care: abortion pills and vacuum aspiration.
- Explain the **risks and benefits:**
 - ✓ “Abortion pills are very safe and very effective. They work to end a pregnancy without a problem almost all of the time.”
 - ✓ “There is a small chance that the pills might not fully work right away, and that you may need more pills or an aspiration to finish the abortion.”
 - ✓ “Severe complications are extremely rare.”
 - ✓ “Abortion does not cause infertility and does not affect future pregnancies.”
- Ensure the patient’s consent is **clearly expressed** and **voluntary**.



Explain how to take the pills

- Today you will swallow **1 mifepristone pill** with water.
→ This stops the pregnancy and starts the abortion process.
- Tomorrow or the next day at home, you will put **4 misoprostol pills** under your tongue and keep them there until they dissolve. After 30 minutes, swallow any little pieces of pills that are still there.
→ This will make your uterus contract. Bleeding will start within 3 hours.
- After 3 hours, if you haven’t started bleeding, put 2 more misoprostol pills under your tongue and keep them there for 30 minutes.



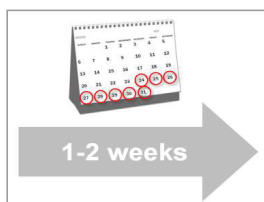
Describe what she will experience

- The amount of pain and bleeding is different for every woman:
*Most women have **bleeding and cramping for a few hours that is like a very heavy menstrual period**. Some women may have more or less bleeding and cramping, which is also normal.*
- You may see large clots of blood or tissue.
- Bleeding decreases 1-2 hours after the expulsion.
- Most women **feel better in less than 24 hours**.
- To help with pain, swallow the **ibuprofen** pills just after taking the misoprostol.
- It also helps reduce pain to be in a comfortable place, have a support person, and put a hot water bottle wrapped in a towel on your belly.



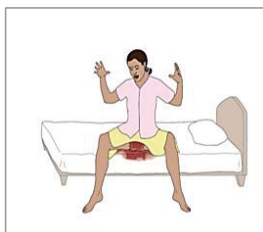
Possible side effects

- Fever, chills, nausea, vomiting, diarrhea, and headache are normal side effects of misoprostol and don't need treatment.
- Drinking water and eating light foods helps to reduce these effects.
- They will usually last 1 day or less and go away on their own.
- If they last for more than 1 day, you should come back to the clinic.



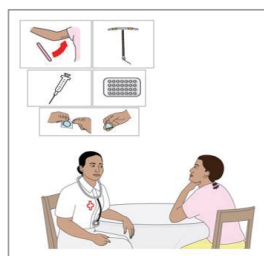
What will happen afterwards

- The bleeding and pregnancy symptoms should decrease little by little over the next 1-2 weeks.
- Some women have light bleeding or spotting for **up to 1 month**.
- Come back to or call the clinic (not emergency) if you have:
 - Very little or no bleeding at all after taking all the abortion pills
 - Moderate bleeding +/- abdominal pain that doesn't decrease after a few days
 - Pregnancy symptoms that don't go away (you still feel pregnant)



Emergency warning signs

- Go to the hospital **immediately** if you have:
 - Very heavy bleeding** - 2 fully soaked pads per hour for 2 hours in a row or bleeding with dizziness and/or lightheadedness
 - Severe pain or feeling very sick** for more than 1 day
 - Unusual or bad-smelling vaginal discharge**
- Discuss how she would get to the hospital in case of emergency (transportation plan) and what she will say to the doctor once she's there.
There is no need for her to say that she took the pills. She can just say, "I am bleeding too much from my vagina."



Contraception

- Offer to discuss her **post-abortion contraceptive options**:
"Would you like to talk about preventing unwanted pregnancies in the future?"
- Some women may want to talk about contraception and choose and start a method that same visit.
In this case, discuss her options and provide the method that she chooses that day.
Exception: IUDs can only be inserted after 1-2 weeks.
- Other women may want to think about it more and come back later, or they may not want discuss contraception at all that day, which is also fine.
Let her know she can come back to the clinic at any time to discuss and/or start contraception.



Questions & Concerns

- Ask her if she has any questions or concerns about the abortion.
- You can ask her to repeat what she will do at home to confirm she understands.
- Remind her she can call or come back at any time if she has any questions, concerns, or problems.**

Images courtesy of Ipas

Appendix 10. WHO neuroscience of psychoactive substance use and dependence 2004^a

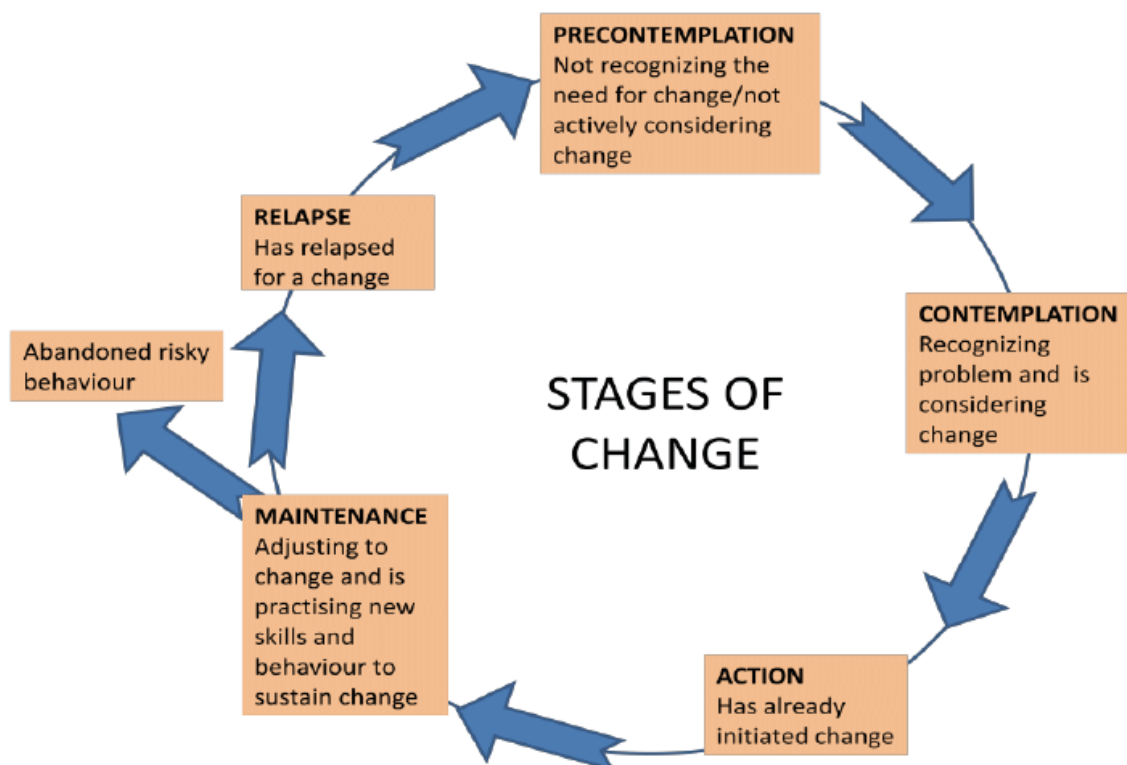
Substance	Behavioural effects	Withdrawal	Effects of prolonged use
Ethanol (Alcohol)	<ul style="list-style-type: none"> • Sedation • Impaired memory • Motor incoordination • Anxiolytic 	<ul style="list-style-type: none"> • Shaking • Weakness • Agitation • Headache • Nausea • Vomiting • Seizures • Delirium tremens 	<ul style="list-style-type: none"> • Altered brain function and morphology • Cognitive impairments • Decreased brain volume
Hypnotics and sedatives (Benzodiazepines, barbiturates)	<ul style="list-style-type: none"> • Sedation • Anaesthesia • Motor incoordination • Cognitive impairments • Memory impairment 	<ul style="list-style-type: none"> • Anxiety • Arousal • Restlessness • Insomnia • Excitability • Seizures 	Memory impairment
Opioids (Heroin, opium, codeine, morphine, prescription pain relievers, methadone)	<ul style="list-style-type: none"> • Euphoria • Analgesia • Sedation • Respiratory depression 	<ul style="list-style-type: none"> • Watery eyes • Runny nose • Yawning • Sweating • Restlessness • Chills • Cramps • Muscle aches 	<ul style="list-style-type: none"> • Long-term changes in opioid receptors • Adaptation in reward, learning, stress responses
Cannabinoids (Hashish, marijuana)	<ul style="list-style-type: none"> • Relaxation • Increased sensory awareness • Decreased short term memory • Motor incoordination • Analgesia • Antiemetic and antiepileptic effects • Increased appetite 	Rare, perhaps due to long half-life of cannabinoids	<ul style="list-style-type: none"> • Cognitive impairments • Risk of relapse and exacerbation of mental illness
Cocaine	<ul style="list-style-type: none"> • Increased alertness, energy, motor activity • Feelings of competence • Euphoria • Anxiety • Restlessness • Paranoia 	Not much, except "post-high down"	<ul style="list-style-type: none"> • Cognitive deficits, abnormalities on PET with orbitofrontal cortex • Impaired motor function • Decreased reaction times • EEG abnormalities • Cerebral ischaemia, infarcts, haemorrhages

a WHO, 2004. Neuroscience of psychoactive substance use and dependence. https://www.who.int/substance_abuse/publications/en/Neuroscience.pdf?ua=1

Substance	Behavioural effects	Withdrawal	Effects of prolonged use
Amphetamines	<ul style="list-style-type: none"> • Increased alertness, arousal, energy, motor activity, speech, self-confidence, concentration, feelings of well-being • Decreased hunger, increased heart rate, increased respiration, euphoria 	<ul style="list-style-type: none"> • Fatigue • Increased appetite • Irritability • Emotional depression • Anxiety 	<ul style="list-style-type: none"> • Sleep disturbances • Anxiety • Decreased appetite • Increased blood pressure • Decreased brain dopamine, precursors, metabolites and receptors
Ecstasy	Increased self-confidence, empathy, understanding, sensation of intimacy, communication, euphoria, energy	<ul style="list-style-type: none"> • Nausea • Muscle stiffness • Headache • Loss of appetite • Blurred vision • Dry mouth • Insomnia • Depression • Anxiety • Fatigue • Difficulty concentrating 	Neurotoxic to brain serotonin systems, leads to behavioural and physiological consequences
Volatile solvents	<ul style="list-style-type: none"> • Dizziness • Disorientation • Euphoria • Light headedness • Increased mood • Hallucinations • Delusions • Incoordination • Visual disturbances • Anxiolytic • Sedation 	Increased susceptibility to seizures	<ul style="list-style-type: none"> • Changes in dopamine receptor binding and function • Decreased cognitive function • Psychiatric and neurological sequelae
Hallucinogens (LSD, Mescaline Psilocybin “magic mushrooms”, Phencyclidine PCP, “angel dust”)	<ul style="list-style-type: none"> • Increased heart rate, blood pressure and body temperature • Decreased appetite, nausea, vomiting • Motor incoordination • Papillary dilations • Hallucinations 	No evidence	<ul style="list-style-type: none"> • Acute or chronic psychotic episodes • Flashbacks or re-experiencing of drug effects long after drug use

Appendix 11. Prochaska and DiClemente's stages of change model

Change is seen as a process involving progress through a series of stages:



Stage of change	Characteristics	Appropriate techniques
Pre-contemplation	Not currently considering change: "Ignorance is bliss".	Validate lack of readiness. Clarify: decision is theirs. Encourage re-evaluation of current behaviour. Encourage self-exploration, not action. Explain and personalize the risk.
Contemplation	Ambivalent about change: "Sitting on the fence". Not considering change within the next month.	Validate lack of readiness. Clarify: decision is theirs. Encourage evaluation of pros and cons of behaviour change. Identify and promote new, positive outcome expectations.

Stage of change	Characteristics	Appropriate techniques
Preparation	Some experience with change and is trying to change: "Testing the waters". Planning to act within 1 month.	Identify and assist in problem solving re: obstacles. Help patient identify social support. Verify that patient has underlying skills for behaviour change. Encourage small initial steps.
Action	Practicing new behaviour for 3-6 months.	Focus on restructuring cues and social support Bolster self-efficacy for dealing with obstacles. Combat feelings of loss and reiterate long-term benefits.
Maintenance	Continued commitment to sustaining new behaviour. Post-6 months to 5 years.	Plan for follow-up support. Reinforce internal rewards. Discuss coping with relapse.

Appendix 12. Living well-patient support groups

Living well groups are established to cover core topics relevant to the management of life-threatening conditions.

These groups are usually closed groups with 8-10 participants and sessions are organised weekly (over the course of 6-8 weeks), adapted to the context. Participants are newly diagnosed patients and/or those struggling to manage their illness. Participants can suffer from different non-communicable diseases (NCDs) (common issues that apply to all NCDs) or participants can all have the same NCD (allows specific information on the management of the condition, etc.). Always be culturally sensitive for group interventions. For example, groups can be mixed or gender specific depending on what is appropriate. The groups can be mixed-age or specific to an age group (adolescents, etc.). The counsellor and health promotion team facilitate the sessions.

The purpose of the sessions is to help participants:

- Identify their personal wellbeing aims.
- Set small steps each week towards their goals.

The program is tailored to each participant's needs. Each person learns a process for goal setting, developing action plans and solving some of their problems. The focus of patient support groups is to meet others, learn and share information/experiences from each other.

In each session, a limited amount of information is provided--as patients will only remember a few essential points. Most importantly, involve the patients and prompt discussion on the topic.

Sample content and structure for a six-week living well group program:

- **Adjustment to NCD:** what is it like to have an NCD? Focus on physical, social, psychological and practical implications of having the illness. Encourage patients to identify the changes they struggle with most and to work on these during the session. Identify symptoms according to illness (pain? sleeping problems? breathing difficulties? etc.). Include self-management of these symptoms. Provide hand-outs with the NCD definition: physical, social, psychological and practical implications of having the illness; adjustment strategies/ coping mechanisms; etc.
- **Motivation:** explain the steps involved in changing behaviour and strategies on how to not relapse into old and unwanted behaviour. Encourage patients to develop an individual relapse-plan. Provide hand-outs with stages of change, motivational strategies, etc.
- **Living well with a chronic illness:** explain healthy diet and changing diet, the benefits of regular exercise (focus on strength, flexibility and endurance). Discuss how to implement the recommendations in daily life. Provide hand-outs on healthy diet and healthy lifestyle examples.
- **Adherence** to treatment/being a responsible patient: invite doctors to talk about the importance of adherence. Include barriers to adherence and strategies to overcome these. Adherence covers behaviour change, lifestyle changes, and appropriate use of medication. Medication is not the only solution to problems. Provide hand-outs with information about the importance of adherence.
- **Improve communication skills:** how does the patient communicate effectively with the doctor to understand everything and be an informed patient? How to communicate effectively with family, friends and other healthcare professionals? Do exercises and role plays. Provide hand-outs with examples of good communication skills.
- **Managing emotions** due to having an NCD. Provide hand-outs with a list of emotions and possible coping strategies.

Appendix 13. Breaking bad news (ABCDE)

In an MSF mission, expect to deliver a multitude of bad news (test results, death, etc.). Breaking bad news provokes fear for many reasons but it is important to ensure trust, support and adaptation. The aim is to deliver bad news clearly, honestly and sensitively ensuring the patient understands and feels supported.

General Principles

- Give the news using reliable information as early as possible, considering that there may be moments that people cannot listen to sensitive information.
- If you feel the patient or family has difficulties understanding or are in shock, repeat the information as many times as needed.
- Use tone of voice and gestures to express sympathy and warmth.
- Make eye contact, face the patient/family, nod and give full attention.
- Even if the disease is too far advanced reassure the patient/family you will provide physical and psychological support to make life as comfortable as possible. Explain the treatment is supportive and not curative.
- In case of death, prepare the family for the funeral and explain why special procedures are needed.
- It is normal for the patient/family to be upset, angry, in denial when receiving bad news.
- Assure confidentiality and privacy for the patient and/or family.
- Always check with your own feelings. If dealing with more than one patient, deal with the following patient sensitively as they may have been neglected.

Responsible team: doctor responsible for the patient/medical team leader, if required they can be accompanied by a psychosocial counsellor.

Procedure/technique - ABCDE

Advance Preparation

- Arrange adequate time and privacy.
- Review relevant data and confirm medical facts.
- Emotionally prepare for the encounter.
- Work in tandem (medical staff/counsellor).

Build a therapeutic relationship

- Identify patient/family preference and cultural approaches regarding disclosure of bad news. For example, in some cultures only men should deal with the information, and women are not allowed to receive this information.
- Prepare introductory phrases to start the conversation.
- Make sure patient/family know your names, roles, and designations.
- Explore the readiness of the patient/family.

Communicate effectively

- Be direct. Use clear precise words and short sentences. Avoid technical terms.
- Determine patient/family's knowledge and understanding of the situation.
- Proceed at patient's pace, allow silence and tears, answer questions.
- Avoid medical jargon.

Deal with patient and family reactions

- Assess and respond to emotional reactions.
- Show empathy with the patient/family.

Encourage and validate emotions

- Offer realistic hope based on patients' goals.
- Listen and clarify what the patient is expressing and then respond empathically.
- Whilst a person is experiencing strong emotions it is difficult to go on to discuss anything further as they will be finding it difficult to hear anything.
- Allow silence: empathy allows the patient to express their feelings and worries and provides support.
- Do not argue: allow expression of emotion without criticism.
- Deal with your own needs.

After breaking bad news

- Explain to the patient/family how the treatment unit is organized.
- Explore their needs, questions, and concerns at this moment.
- Explain what kind of care and support they will receive.
- Give regular updates about the situation.
- Explain the procedure after discharge.
- Give information about locally available support services, if present.
- Reinforce that the whole team will always be a support.
- Explain what a counsellor does and when to ask for their help.

Appendix 14. Key communication skills

It is crucial to provide humanity and compassion in the patient/caregiver relationship based on empathy, respect, acceptance and dignity. Good communication is about building bridges between the patient and themselves, their family, their needs, and humanity (you). Good communication needs time and space.

Ask open-ended questions

Ask questions in a way that encourages the person to speak openly. Asking questions helps to identify, clarify, and break down problems into smaller, more manageable parts.

- In general, it is best to use open ended questions (those beginning with “*how*”, “*what*”, “*when*”, “*where*” or “*why*”) as they lead to more discussion. It gives the patient the opportunity to explore their thoughts, emotions, etc. and allows them to better express their needs.
- Closed-ended questions tell a person the answer that you expect, and the person will answer them with “*Yes*” or “*No*”. They usually start with words like “*are you?*”, “*did he?*”, “*has he?*”, “*does she?*”. There are times when closed-ended questions can be used to get specific information, such as “*Did you attend the funeral?*”. Then, you can follow-up with an open-ended question, such as “*How have you been feeling recently?*”.

Use gestures and responses that show interest

Healthcare providers need to show that they are listening and interested in what a patient is saying. This will encourage them to keep talking and sharing.

- “**Attending skills**” demonstrate that the healthcare worker is actively listening to the patient and include gestures such as nodding and smiling, responses such as “*Mmm*”, “*Ho-o*”, or “*Aha*”, clarifying, and summarizing. These behaviors invite the patient to relax and talk about themselves and their problems.
- **Clarifying** prevents misunderstanding and helps sort out what has been said. For example, if a patient says “*I can’t get out of bed in the morning*”, the healthcare worker may ask “*In what ways is it difficult for you to get up in the morning?*” or “*It sounds like you are having a lot of challenges getting up in the morning. Tell me more*”.
- **Summarizing** pulls together themes of a counseling discussion so that the patient can see the whole picture. It helps ensure understanding between the patient and the healthcare worker. Review the important points of the discussion and highlight any decisions made. Summarize key points at any time during the discussion, not only at the end. Summarizing can offer support and encouragement to patients to help them carry out the decisions they have made.

Reflect back what the patient has said

Reflect back what a patient has said to encourage them to say more. It shows the healthcare worker understands and leads the patient to say what is important to them.

- When reflecting back, try to say it in a slightly different way. For example, if a patient says “*I’m not able to tell my family that I am not feeling well*”, the healthcare worker may paraphrase by saying “*Talking to your family about how you feel sounds like something that you are not comfortable doing*”. Then say “*Let’s talk about that*”.

- Reflecting back shows that the healthcare worker is actively listening, encourages dialogue, and gives the healthcare worker an opportunity to understand the patient’s feelings in greater detail.
- Reflecting back, although an important listening and learning skill, should not be used every time. Mix reflecting back with other responses, such as *“Oh, really?”* or an open-ended question.

If the patient says...	The healthcare worker could respond
I’ve been drinking this month to cope with the death of my wife.	It seems you have had some challenges, so you are drinking to cope with the situation.
My husband doesn’t know I’m coming to the health centre to be tested.	It seems you are afraid of your husband finding out about you coming to the health centre.
My daughter is crying all the time.	So, your daughter seems to be upset about something?
My family has been so sad since our father died last month.	It seems like this event is affecting all of you.
My sister says the white people have brought Ebola to the village.	Your sister believes that the white people brought the disease. What do you think?
I can’t sleep at night since I’ve been admitted into the treatment centre.	It seems you feel anxious or nervous about something.

Empathize—Show that you understand how they feel

- Empathizing is a skill used in response to an emotional statement.
- Empathy shows an understanding of how the patient feels and encourages the person to discuss the issue further.
- Empathy is different than sympathy. When you sympathize, you feel sorry for a person and look at it from your own point of view, empathy is being able to put in the “other person” shoes.
- For example, if the patient says *“My baby is crying all the time and it makes me feel so tired”*, the healthcare worker could respond by saying *“You are feeling very tired all the time then?”*. If the healthcare worker responds by saying *“I know how you feel. My baby also cried a lot and I was exhausted!”*, this is sympathizing because attention is on the counsellor and not on the patient.

If the patient says...	The healthcare worker can reply...
I am so dizzy and weak since I started taking these pills. I am going to have to stop.	So, these feelings of dizziness and weakness are really bothering you and making you want to stop the medicine?
I’m worried my son hasn’t been eating well since his father died two weeks ago.	You seem worried about your son?
I am really scared of telling my family that I’m coming to the health centre.	You are worried about what will happen if you tell your family that you are coming to counselling?
It is so hard for me to get up in the morning as I feel so tired and sad.	You are struggling to get up in the morning because of your fatigue and sadness after your loss?

Avoid words that sound judgmental

- Judging words are words like: *right, wrong, well, badly, good, enough, properly*.
- If a healthcare worker uses these words when asking questions, the patient may feel that they are wrong or that there is something wrong with their actions/feelings.

Common mistakes in communication with patients

The principles of listening and learning are easy to learn but difficult to apply. Some common mistakes include:

- Controlling the discussion, instead of encouraging the patient's open expression of feelings and needs.
- Judging the patient—making statements that show that the patient does not meet the counsellor's standards.
- Preaching to a patient—telling patients how they should behave or lead their lives, like saying *"Well, it seems now you have created a big problem for yourself"*.
- Labelling a patient instead of finding out their individual motivations, fears, or anxieties.
- Reassuring a patient without even knowing their health status—for example, telling a patient *"You have nothing to worry about"*.
- Not accepting the patient's feelings—saying *"You shouldn't be upset about that"*.
- Advising, before the patient has collected enough information or taken enough time to arrive at a personal solution.
- Interrogating—asking accusatory questions or too many questions. Questions that start with *"Why...?"* can sound accusatory.
- Encouraging dependence—increasing the patient's need for the healthcare worker's presence and guidance.
- Persuading or coaxing—trying to get the patient to accept new behaviour by flattery or fakery. *"I know you are a strong girl and you will be fine, like I have told you"*.

Appendix 15.1. Grief

Grief refers to the normal process of reacting to loss. Grief may be experienced as a mental, physical, social or emotional reaction. Loss is not only experienced when a loved one dies. We may feel intense loss from losing a relationship, our sense of self, our job, our home, our freedom, our health or a limb, among many other things that we hold precious and important. Most of this appendix will refer to grief when a person dies but it is applicable to all kind of losses.

Bereavement is the period after a loss during which grief is experienced and mourning occurs. The time spent in a period of bereavement depends on how attached the person was to the person who died, and how much time was spent anticipating the loss.

Mourning is the process by which people adapt to a loss. Mourning is also influenced by cultural customs, rituals and society's rules for coping with loss. In this document we will mainly use the term "grief".

General principles:

- Everyone's experience of grief is unique. The impact of grief depends on an individual's past life experiences with loss, culture, coping skills, belief systems, and faith. It will also depend on pre-existing mental health conditions, accumulation of stressors, circumstances of death, etc.
- Usually grief reactions gradually decrease in intensity over a period of weeks/months after the loss. But, for some people, grief may become complicated or chronic and may lead to severe depression. There may be recurrences at the time of anniversaries of the loss.
- It is important to understand local ways of grieving and mourning.

Grief explanatory models

There are several explanatory models for grief. We will focus on two main models: Worden and Kübler Ross.

Tasks according to Worden (no specific order):

Task 1: To accept the reality of loss.

Task 2: To work through the pain of grief.

Task 3: To adjust to an environment in which the deceased is missing.

Task 4: To find an enduring connection with the deceased while embarking on a new life.

Kübler-Ross Model (initially described for dying patients):

- Anxiety: due to uncertainty
- Denial, refusal, isolation (*"No, not me!"*)
- Anger and aggressiveness (*"Why me?"*)
- Bargaining and negotiating (*"If I am good, then can I live?"*)
- Depression and sadness: connecting to all the losses to be faced (*"What's the use?"*)
- Acceptance

The following box shows an example of the 4 tasks of Grief when someone dies^a:

Task 1. Accept the reality of the loss

When someone dies there is a sense that it hasn't happened. The first task of grieving is to face the reality that the person is dead, that the person is gone and will not return, that reunion in this life is impossible. Denying the facts of the loss, the meaning of the loss, or the irreversibility of the loss only serves to prolong the grief process. Though denial or hope for reunion is normal immediately after the loss, this illusion is usually short-lived.

Task 2. Experience the pain of grief

Many people try to avoid the painful feelings by various ways such as «being strong», moving away, avoiding painful thoughts, «keeping busy», etc. There is no adaptive way of avoiding it. You must allow yourself to experience and express your feelings. Anger, guilt, loneliness, anxiety, and depression are among the feelings and experiences that are normal during this time. Recall and relate both pleasant and unpleasant memories of the deceased. Ask for the support of friends. Tell them what you need from them, because people often misunderstand the needs of grieving. Be assured that the memory of your loved one will continue, but the pain will lessen in time and will finally disappear.

Task 3. Adjust to an environment with the deceased missing

This means different things to different people, depending on what the relationship was. Many survivors, especially widowed persons, resent or fear having to develop new skills and to take on roles that were formerly performed by the deceased. There may be many practical daily affairs you need help and advice with, but there will be a great sense of pride in being able to master these challenges. The emotions involved in letting go are painful but necessary to experience. By not doing so, you will remain stuck in the grief process and unable to resolve your loss.

Task 4. To find an enduring connection with the deceased while embarking on a new life

The final task refers to finding an appropriate, ongoing connection in our emotional lives with the person who has died while allowing the people grieving to continue living. This means allowing for thoughts and memories, while beginning to meaningfully engage in things that bring pleasure, new things, or new relationships. Affect an emotional withdrawal from the deceased person so that this emotional energy can be used in continuing a productive life. This does not necessarily mean finding a new spouse, surrogate mother, etc. This is not dishonouring the memory of the deceased and doesn't mean that you love him or her any less. It simply recognizes that there are other people and things to be loved and you are capable of loving.

Understanding grief within a cultural context

Many people experience **grief and a sense of loss** after the death of a loved one. The way in which they experience and express these feelings may differ across cultures. Culture is the mix of beliefs, values, behaviors, traditions, and rituals that members of a cultural group share. Each culture has its own rituals that influence the expression of grief.

These rituals and the grief/bereavement process can be disrupted for example during emergencies.

^a <https://www.alzwa.org/files/2015/01/06-The-Four-Tasks-of-Mourning.pdf>

We need to take into consideration:

Cultural Rituals	To consider
Care	How should the person be cared for before/during death? Who should be present? What ceremonies need to be performed before/during/after death?
Body	How should the body be handled, cleansed, dressed, buried, cremated?
Grief	How is grief expressed? Quietly, publicly, crying, wailing?
Gender/Age	Do men/women/children/older people grieve differently?
Ceremonies	What ceremonies/rituals are there performed at individual/family/community levels? Who should participate?
Time	How long are you expected to grieve? How are you expected to dress over time?
Memories	How should the deceased be remembered? Are there ongoing rituals, communication?
Roles	What new roles do family members take on? Do widows remarry? Does the eldest son become head of family?

Reactions to loss

Grief is unique to the person feeling it and there is no timetable for completing it. It is a process, not an event. And it can include different type of reactions.

Reactions to loss:

Behavioral	Physical
<ul style="list-style-type: none"> • Agitation, tenseness, restlessness • Fatigue • Overactivity • Searching • Weeping, sobbing, crying • Social withdrawal • Aggressive behavior 	<ul style="list-style-type: none"> • Loss of appetite • Sleep disturbances • Energy loss, exhaustion • Somatic complaints • Physical complaints similar to the deceased's
Psychological	Cognitive
<ul style="list-style-type: none"> • Sadness, despair, dejection, distress • Worry, anxiety • Guilt, self-blame, self-accusation • Anger, hostility, irritability • Anhedonia—loss of pleasure • Loneliness • Nostalgia, envy • Shock, numbness 	<ul style="list-style-type: none"> • Preoccupation with thoughts of the deceased, intrusive ruminations • Sense of presence of the deceased • Suppression, denial • Lowered self-esteem • Self-blame • Helplessness, hopelessness • Suicidal ideation • Sense of unreality • Memory, concentration difficulties

People in grief may have intense emotional suffering or significantly impaired functionality and may require help. For grief interventions the best option is to use a short-term counselling or psychological intervention.

Complicated grief: recognizing the symptoms

During the first few months after a loss, many signs and symptoms of simple grief are the same as those of complicated grief (CG), although for the latter, they linger and worsen. CG refers to a clinical condition of intense, prolonged and impairing grief (see below). It includes both ICD-11 Prolonged Grief Disorder (6B42) and DSM-V Persistent Complex Bereavement Disorder (309.89). The distinction between grief and CG is due to the complexity in terms of intensity, duration and functional impact of symptoms, and the need for more specialized psychological care.

Though the rise in mental health problems following natural disasters and pandemic outbreaks is documented, there are few studies focused on grief and CG.

Complicated grief after illnesses requiring intensive care unit (ICU) treatment.

Relatives of patients admitted to ICU are at risk of psychological morbidity during and after the hospital stay.

The ICU environment may be quite a traumatic experience for both patients and relatives: people are admitted, often unable to communicate, hooked up to machines, ventilated or intubated with restrictions on visits and contact with the social network of the person, which deprives the person of support.

During the COVID-19 pandemic, most deaths occurred in ICUs after the development of acute respiratory distress syndrome: this ICU mortality is especially associated with a high incidence of grief reactions, including post-traumatic stress disorder, anxiety, depression, and CG.

Main characteristics of complicated grief:

- Follows the death of a partner, parent, child, or other person close to the bereaved.
- Longing/yearning for the deceased or persistent preoccupation with the deceased.
- Intense emotional pain, e.g. sadness, guilt, anger, denial, blame, difficulty accepting the death, feeling one has lost a part of one's self, an inability to experience positive mood, emotional numbness, difficulty in engaging with social or other activities.
- Lasts **over 6 months** and clearly exceeds expected social, cultural or religious norms for the individual's culture and context. Grief reactions that persist for longer than 6 months but that are within a normal period of grieving in the person's cultural and religious context are viewed as normal bereavement responses and are not assigned a diagnosis. The 6 months period is flexible because each person grieves in a different way and in a different culture.
- Causes **significant impairment** in personal, family, social, educational, occupational or other important areas of functioning.

What to do:

- Encourage family members to talk and share feelings if culturally appropriate.
- Listen rather than talk and advise a bereaved person against taking important decisions.
- Complicated grief requires specialized psychological intervention.

Always remember that: patient assessment by a psychiatrist or mhGAP clinician should take place if symptoms persist 6 months after loss, in people with a history of depressive episodes, or people presenting suicidal ideation, strong held beliefs of self-worthlessness, psychotic symptoms or slowing of speech or movements. In these situations, depressive disorder should be considered as an alternative diagnosis.

Anticipatory grief

Anticipatory grief is a normal process associated with grieving the loss of loved ones in advance of their inevitable death, as in the course of terminal illness. Anticipatory grief is becoming increasingly recognized as an issue that can heighten distress for both patients and their social networks.

This process can apply to the families of people who are dying and the dying individuals themselves. Anticipatory grief includes many of the same symptoms of grief after a loss. Anticipatory grief has been defined as “the total set of cognitive, affective, cultural, and social reactions to expected death felt by the patient and family.”

These reactions are observed in many cases of patients that cannot be cured or adequately treated and are reasonably expected to result **in death of the patient. This term is commonly used in progressive diseases such as cancer or advanced heart disease, HIV, Ebola/VHF, and may include COVID-19.**

The symptoms of anticipatory grief can appear even when no one in the social network has been affected. They can arise as the product of a constant feeling that significant losses will soon come. That clarification will help to understand the following symptoms/reactions:

Main characteristics of anticipatory grief

- **Sadness and tearfulness:** sadness and tears tend to rise rapidly and often when least expected.
- **Fear:** feelings of fear are common and include not only the fear of death but also fear about all the changes that will be associated with losing a loved one.
- **Irritability and anger:** the experience of anger can be accompanied by the difficulty of coping with the anger of the person who is dying. Despite love, there can be feelings of anger towards the loved one (that he/she will leave you alone soon, feeling obliged to take care of the loved one etc.).
- **Loneliness:** a sense of intense loneliness is often experienced by the close family caregivers of someone dying. Unlike grief after a loss, the feeling that it is not socially acceptable to express anticipatory grief can add to feelings of isolation.
- **A desire to talk:** loneliness can result in a strong desire to talk to someone—anyone—who might understand the expressed feeling and listen without judgment. If there is not a safe place to express the grief, these emotions can lead to social withdrawal or emotional numbness to protect against the pain.
- **Anxiety:** when you are caring for a loved one who is dying, it’s like living in a state of heightened anxiety all the time. Anxiety, in turn, can cause physical symptoms such as tremulousness, palpitations, and shaking.
- **Guilt:** for some people, the time prior to a loved one’s death can be a time of great guilt—especially if the loved one is suffering. The patient may also be experiencing guilt that they will be able to continue with their life while the loved one will not.
- **Intense concern for the person dying:** an extreme concern about the loved one and this concern can revolve around emotional, physical, or spiritual issues.
- **Rehearsal of the death:** the patient may find himself visualizing what it will be like to have their loved one gone. Or if the patient/beneficiary is dying, visualizing how your loved ones will carry on after your death. Many people feel guilty about these thoughts, but they are very normal and are part of accepting the inevitability of death.
- **Physical problems:** physical problems such as sleep difficulty and memory problems.

Appendix 15.2. Helping bereaved to cope with loss

1. How can families/friends support a grieving person?

- Invite the grieving person to talk and share their feelings, if culturally appropriate.
- **Listen rather than talk.**
- **Advise a bereaved person against taking important decisions.**
- **Communication/ expression:** be there, talk to them (even if you don't know what to say, say something from your heart or show your concern), listen, try not to avoid strong emotional reactions/ respond to them, express them).
- **Support:** offer your support, assist in tasks (take initiative to help, but careful not to take over too much). Try to help the person in structuring daily/weekly activities. After the initial period of grief continue paying attention to the person. e.g. anniversaries/holidays/special events.
- **Other Tips**
 - Do not minimize or exaggerate the person's loss and their reactions to it.
 - Don't judge, respect the emotion (like guilt, aggression, shame).
 - Encourage and comfort the person ("you have experienced a similar situation, and you managed, you are strong/ brave through this experience...", "and you can count on me"). Avoid 'prescribing' emotions "you must feel depressed now".
 - Allow individual differences in grieving: people have different ways of grieving. Not expressing emotion (not crying, less sadness...) does not necessarily mean a person is suffering less. These differences should be allowed and accepted without judgement, and people should not blame themselves for it. (e.g. case of a loss in a family, each member might have a different way of expressing their grief).

2. How can mental health (MH) professionals help with loss?

What helps people to go through a healthy grieving process? With respect to people's differences and different ways of adapting to a loss, this list of recommendations aims to help the bereaved go through the process of grief. These recommendations must take into consideration and be adapted to the cultural practices.

Keep up your daily activities	<ul style="list-style-type: none"> • Avoid unhealthy behavior (e.g. alcohol consumption). • Try to make a structured plan for each day/week. • Basic activities may help you to feel more under control. • Take good care of yourself (e.g. eat well, sleep enough, relax, ask for help, talk to others).
Perform grieving rituals	<ul style="list-style-type: none"> • Visit the grave site. • Keep/hold pictures of the deceased person. • Light a candle at certain times (e.g. when you miss the deceased person...). • Make a scrapbook of memories (with photos, letters, postcards, notes, or other significant memorabilia from your life together).

Keep in contact with social network	<ul style="list-style-type: none"> • Family and friends, try not to get isolated (but also have some moments of privacy).
Communication	<ul style="list-style-type: none"> • Be able and allowed to ask questions about the deceased person, hear stories and to talk about them (if it's accepted or suitable).
Expression of feelings	<ul style="list-style-type: none"> • Through communication or other, e.g. writing. • Feelings of sorrow, distress, anger, anxiety, guilt.
Prevent denial of feelings	<p>Examples of denial which may block the grieving process:</p> <ul style="list-style-type: none"> • Being hyperactive, working all the time, in order to try to avoid the pain. • Minimizing the loss ("it's part of life").
Some special advice	<ul style="list-style-type: none"> • Pay extra attention when driving a car or carrying out risky activities (loss of concentration and attention). • Avoid making important decisions not directly related to the stressful situation. If possible, postpone them till you feel calmer. • Avoid taking drugs/alcohol/ medicines (without a medical examination and prescription).

The most important points are:

1. Try to find a balance between feeling/expressing the pain of loss and simultaneously investing in life (social network, letting go).
2. Give the grieving process time.
3. Remember that grief is necessary to finally reach acceptance.

3. Grief intervention, for MH counselors

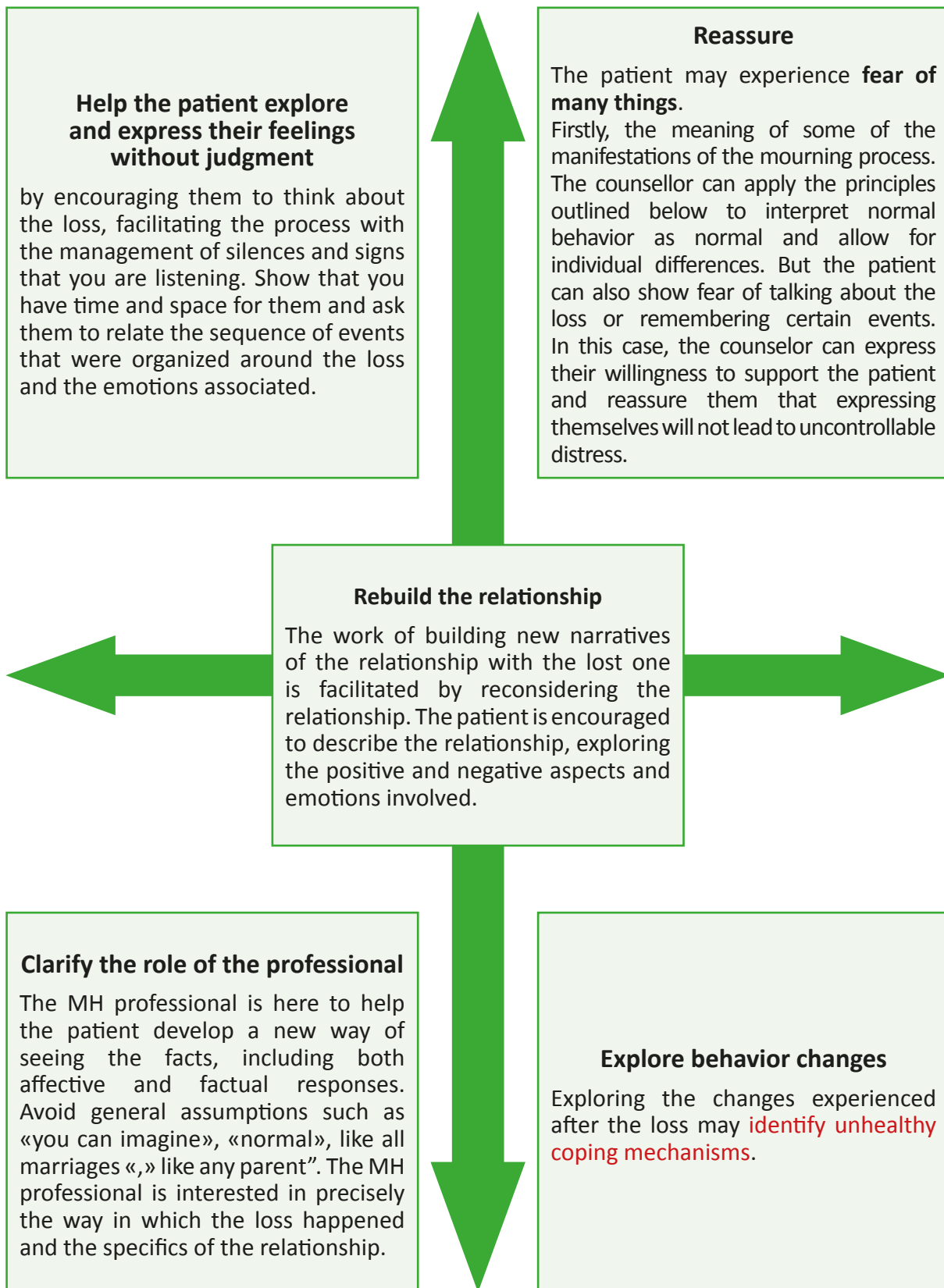
1. Level of intervention

Many authors make a distinction between **grief counseling** and **grief therapy**. Counseling or grief counseling is an intervention that non-MH professionals (including MH lay counselors), who frequently interact with people who face grieving processes (nurse, doctors, social workers, aid workers etc.) should be able to carry out and apply to people who are going through a normal grieving process. This type of support should be offered to people at risk (loneliness, lack social support, lack of resources, special circumstances of loss - disappearance, massacre, torture, suicide etc.) or when the person or their family request this support.

The second modality of intervention, **grief therapy**, is indicated in cases of complicated grief and is performed by MH professionals (psychologist/psychiatrist/professional counselor) with a framework as similar as possible to other psychological therapies.

This level of support is recommended **(1)** when **difficulties in the grieving/mourning** process have already developed into moderate to severe mental health reactions that put the beneficiary/their environment at risk (psychotic reactions, depressive reactions with suicide ideas, aggressive behavior etc.), **(2)** when **grief counseling** has failed to solve the problem or has triggered unexpected reactions.

2. Objectives of grief/bereavement intervention



3. Principles of grief/bereavement intervention

Principle 1: Help the patient to accept the reality of the loss

- In the initial moments, the feeling of everything being surreal is the norm. Talking about loss helps the patient express their feelings. The MH professional can ask the patient how they learnt of the death, how they reacted, what they thought, what they felt.
- Explore behavior versus rituals that facilitate fulfillment of this task, such as the contemplation of the corpse in funeral rituals, visits to the grave. If the patient says that they have not been able to do them, explore ideas about these rituals.

Principle 2: Help the patient identify and express their feelings

- The loss can evoke very painful feelings from which the patient may try to protect themselves unconsciously. The MH professional can facilitate the expression of these feelings. Sometimes this task can be hampered by the fact that the person may ask for precisely the contrary, a remedy to avoid the pain (e.g. in the form of medicine, religion).
- Explain to the patient that: “it’s very hard to lose a beloved person, especially if you had a very affectionate relationship”. There are many things that they will miss a lot, but it’s helpful for them to remember all the good moments.
- Feelings can be very diverse. Of course, there is the feeling of sadness for the loss. Feelings of rage, guilt and helplessness are also frequent and often associated with problems in the mourning process.
- Often the patient will have ambivalent feelings. First give them the opportunity to express positive feelings towards the lost one and listen empathically to them, afterwards you can ask for the negative feelings. For example, the counselor can ask “What will you miss most about the lost one?”, and after listening empathetically the counselor can ask “Maybe there are also some things that you will not miss, what are they?”.
- The survivor usually feels anxiety from the reactivation of the consciousness of their own death, but it is usually transient. If not, it can be helpful to talk and share fears.

Principle 3: Help the patient cope with solving their daily problems without the lost one

- Help the patient cope with practical problems and make decisions without the lost one. The difficulty of this task depends a lot on the kind of relationship that existed between the deceased person and the patient.

Principle 4: Facilitate the emotional relocation of who/what is lost

- Relocation is often perceived by the patient as a way of replacing or forgetting the lost one, betraying them. In these cases the patient may stop the progression of the grieving process
- Relocating does not mean replacing (replacing is impossible). However, it means giving the lost one a place in memory so that the memory does not block the possibility for the patient to feel interest and affection for other things or people. People who go through a grieving process often say that as they make progress on this task, they feel a clearer and more grateful memory of the lost one.

Principle 5: Provide time for grief

- As explained earlier, grief takes time.

Principle 6: Avoid typical sentences

- Sentences such as “You have to be strong”, « You have to keep going », are not useful and the patient has already heard them, so if their problem persists it means these sentences didn’t help them.
- If the counselor does not know what to say, it is preferable to recognize and say, «I don’t know what to tell you».

Principle 7: Interpret normal behavior as normal

- The phenomena of presence (feeling that the lost one is still present), ideas of suicide, and feelings of unreality are among those that most frequently provoke reactions of fear and overwhelming feelings. In these situations, the professional can reassure the patient by explaining that the patient's reactions are normal, frequent phenomena at that point in the grieving process.

Principle 8: Allow individual differences.

- Discuss and anticipate different possibilities with the patient.

Principle 9: Offer ongoing support

Principle 10: Identify harmful coping mechanisms to prevent complications

- There are people who may use alcohol or drugs.

Principle 11: Identify complicated or severe patients and refer them to specialized care

- People that are not functioning at all. People that have overwhelming feelings and do not feel they can cope alone. People that do not progress in the grieving process at all.

Appendix 16. Identification of patients/relatives in need of MHPSS

Observed signs:

- An isolated person
- A person who seems scared (always on alert looking around)
- A person who stays silent (does not talk at all), who stays abnormally quiet (does not interact with anyone else)
- A person who cries for long periods over the day or gets emotional very easily
- A person who presents extreme or abnormal unexplained somatic complaints after the medical check-up such as extreme weakness or pain, difficulty breathing, feeling of heart beating
- Victims of intentional violence: contusions, bruises, burns, purposeful physical mutilations, sexual violence etc.
- Unclear/confused speech
- Body language: signs of anxiety, apathy, depression
- Irritability and aggressiveness

Previously known cases of mental disorders: as mentioned in the beginning of this sub-module, some disaster-affected people are likely to have been suffering from mental disorders prior to the disaster. Patients with known mental illnesses may experience exacerbation or relapse in symptoms. Similarly, patients suffering from epilepsy may relapse due to discontinuation of antiepileptic medication during this. Ask all the families in the area if there are any known cases of epilepsy or psychoses and ensure the continuation/restarting of the treatment of these cases through proper referral.

Individuals who are grossly dysfunctional in activities of daily living based on the following observations:

- Remain isolated and inactive
- Extremely poor self-care
- Loss of sense of responsibility for self and others
- Problems in daily functioning such as eating, sleeping, learning, working

Suicidal ideation/intent

People who talk about committing suicide or have attempted suicide should be immediately identified and referred to a trained professional. Community members should be able to identify such people. Such people should never be left alone.

Withdrawal symptoms or increased consumption of alcohol and substance abuse: whenever a patient complains of severe body aches, restlessness, insomnia, muscle cramps, running nose and excessive watering of eyes or tremors, restlessness, irritability, insomnia, anxiety and craving for alcohol/drugs, enquire if the person is a habitual user of alcohol or drugs. If yes, refer the patient to a medical doctor and if available, to the specialist.

If a patient presents with excessive drowsiness, slurring speech, unstable gait or disorientation, ask if they have increased their consumption of alcohol/drugs. If yes, ask them to see a professional and refer to a specialist if available.

Appendix 17. Motivational interviewing

Motivational interviewing (MI) is a counselling approach that is both a philosophy and a broad collection of techniques employed to help people explore and resolve ambivalence about behavioural change. In brief, the philosophy of MI is that people approach changes with varying levels of readiness. The role of helping professionals is thus to assist patients to become more aware of the implications of change and/or of not changing through a non-judgmental interview in which patients do most of the talking.^a

It is an approach to discussing substance use in a non-judgemental way. It encourages a person to reflect on their own substance use choices.^b It can be used as part of a very brief encounter for addressing risks or harmful substance use. It can also be used as part of a longer discussion that takes place over several sessions that address dependent patterns of substance use. This is referred to as Motivational Enhancement Therapy.

Throughout the discussion it is important to include all parts of the process: expressing empathy and building an atmosphere of trust, while also pointing out contradictions in their narrative, and challenging false beliefs. Avoid arguing with the person. They should feel that the practitioner is there to support them and not to criticize them. If the person is unable to commit to ending their harmful pattern of substance use at this time, discuss why this is the case, rather than forcing the person to say what they think is expected.

Techniques for more in-depth discussions

1. Provide personalised **feedback** to the person about the risks associated with their pattern of substance use, whether or not they have a pattern of HARMFUL USE or DEPENDENCE, and the specific harms they may be experiencing or causing to others.
2. Encourage the person to **take responsibility** for their substance use choices, and the choice of whether or not to seek assistance for their substance use. Do this by asking them how concerned THEY are about their substance use.
3. Ask the person the **reasons for their substance use**, including as a response to other issues such as mental health problems or specific stressors, and the perceived benefits they have from substance use, even if only in the short term.
4. Ask about their perception of both the positive and negative **consequences of their substance use** and, if necessary, challenge any overstatement of the benefits and understatement of the risks/harms.
5. Ask about the person's **personal goals**, and whether or not their substance use is helping them or preventing them from reaching these goals.
6. Have a **discussion** with the person based on the statements about their substance use, its causes, consequences and their personal goals, allowing exploration of apparent inconsistencies between the consequences of substance use and the person's stated goals.

a Brad W. Lundahl, Chelsea Kunz, Cynthia Brownell, Derrik Tollefson and Brian L. Burke. *Research on Social Work Practice*, 2010, 20: 137. DOI: 10.1177/1049731509347850

b WHO 2016. mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP) – version 2.0.

7. **Discuss options** for change based on the choice of realistic goals and try to find a mutually agreed course of action.
8. **Support the person to enact these changes** by communicating your confidence in them to make positive changes in their life, by providing information on the next steps as needed (further review, detoxification, psycho-social support), and by providing the person with take-home materials if available.

Examples of questions to ask

Non-judgmentally elicit from the person their own thoughts about their substance use by asking the following questions:

- Reasons for their substance use (Ask: “Have you ever thought about why you use [substance]?”).
- What they perceive as the benefits from their use (Ask: “*What does [substance] do for you? Does it cause you any problems?*”).
- What they perceive as the actual and potential harms from the substance use (Ask: “*Has [substance] use caused you any harm? Can you see it causing harm in the future?*”).
- What is most important to the person (Ask: “*What is most important to you in your life?*”).

Appendix 18. Indicators used in MHPSS activities

Quality of service

- Proportion of improved patients with closed files and/or discharged that show score improvement of 25% in assessment scales (patients with a minimum of two sessions and measurements taken in at least two sessions) between the first and last recorded session
- Proportion of patients with closed files with at least 2 sessions and measurements taken in at least 2 sessions
- Proportion of lost to follow-up cases: total number of patients lost to follow up/total number of closed files
- Number of severe medical adverse events^a related to MHPSS activity

Use of service

- Total number of individual consultations: total count (new consultations + follow ups)
- Total number of new patients
- Proportion of new patients with SMDs
- Total number of psychotherapeutic and non-psychotherapeutic group sessions
- Total number of participants attending the group sessions
- Proportion of patients treated pharmacologically for a mental disorder by MSF compared to total number of active patients
- Number of patients referred
- Average number of sessions per patient

Surveillance

- Proportion of main morbidities
- Proportion of main precipitating events

^a MSF has an international policy on medical error and each OC has a specific protocol for this.

Core or optional	Indicator heading	Description	Numerator	Denominator	Breakdown	Suggested performance target	Data Source
Core	N° of psychotherapeutic group sessions ^{a,b}	Total N° of psychotherapeutic group sessions performed over X period of time	Total N° of psychotherapeutic group sessions over X period of time		Type of psychotherapeutic group session: psychotherapy, counselling.	No target (project dependent)	Database/HMIS ^c /Excel sheets/ reports
Core	N° of non-psychotherapeutic group sessions	Total N° of non-psychotherapeutic group sessions over X period of time	Total N° of non-psychotherapeutic group sessions over X period of time		Type of non-psychotherapeutic groups ^d	Specifically, for non-psychotherapeutic groups expected target: 3 group sessions per counsellor/psychologist per week	Database/HMIS/ reports
Core	N° of participants in group sessions	N° of participants present in a session	Total N° of participants attending the sessions		Age, gender, psychotherapeutic group or non-psychotherapeutic group	No target (as it is group dependent)	Database/HMIS/ reports/
Core	N° of consultations ^e	Total count (first consultation + follow ups) over X period of time	Total count (first consultation + follow ups) over X period of time		Age, gender, follow-up/first consultation, diagnosis, category of symptoms	25 sessions expected per week per counsellor/psychologist	Database/HMIS
Core	Proportion of lost to follow-up cases	Proportion of patients that didn't come back to services and no information is available after 2 months since last visit, or after missing 2 consecutive appointments	Total N° of patients lost to follow up in X period of time	Total number of closed files over X period of time	Age, gender, diagnosis, category of symptoms	(< 20% in general or < 30% for schizophrenia patients)	Database/HMIS

^b A psychotherapeutic group session should have defined objectives, rules and specific methodology, with defined number of sessions. Expected number of participants no more than 15, and minimum 2.

^c HMIS: Health Management Information System

^d Non-psychotherapeutic group session has objectives and structure, but number of participants is not limited, number depends on type of session e.g. psycho-stimulation, psychoeducation, etc. New members or participants can be incorporated at any given moment.

^e Number of individual sessions will depend on specific contexts, type of diagnosis and access to services. To be constantly monitored.

Core or optional	Indicator heading	Description	Numerator	Denominator	Breakdown	Suggested performance target	Data Source
Core	Proportion of improved patients ^f	Proportion of patients with closed file and/or discharged that show score improvement of 25% in assessment scales (patients with a minimum of 2 sessions) between the first and last recorded session. Measurement through scales like: CGI, GAF, SRQ, visual scale, MHOS, other	No of patients with closed file/ discharged that had ≥ 2 sessions AND had at least 2 scale measurements AND improved $\geq 25\%$ in X period	No of patients with closed file/ discharged that had at least ≥ 2 sessions + have 2 scale measurements	By diagnosis, or by specific population, by age, by scale	75% of total patients with an improvement of 25% in the scale scores	Database/HMIS
Optional	Proportion of patients with closed files with at least 2 sessions and the measurements done in at least 2 sessions.	Proportion of patients with closed file and/or discharged that had a minimum of 2 sessions and a minimum of measurements done in 2 sessions. Measurement through scales like: CGI, GAF, SRQ, visual scale, MHOS, other	Number of patients with closed file and/or discharged that had a minimum of 2 sessions and a minimum of measurements done in 2 sessions. Measurement through scales like: CGI, GAF, SRQ, visual scale, MHOS, other	Total of patients with closed file and/or discharged	By counselor		Database/HMIS/ reports
Core	N° of patients with psychotropic treatment for a mental disorder prescribed by MSF ^g	Patients treated pharmacologically for a mental disorder by MSF over X period of time	N° of patients treated pharmacologically for a mental disorder prescribed by MSF	Total number of active patients over X period of time	Age, gender, diagnosis		Database/HMIS

^f Improved patients: improvements in score can help us to understand the impact of the intervention and how patients are recovering or not from their initial impairment and the affection of symptoms. According to each project, patient needs and feasibility of use, specific scales will be recommended to assess initial severity and the evolution. Examples: SRQ20, visual functionality scale, PsyCa, PHQ9, PHQ-A, PHQ, GAF, GAD7, CAGE, CTSC, etc (Scales need to be validated by MH advisor).

^g Patients treated by MSF: when prescription and treatment are provided directly by MSF or external staff paid by MSF.

Core or optional	Indicator heading	Description	Numerator	Denominator	Breakdown	Suggested performance target	Data Source
Optional	Average N° of individual sessions per patient ^h at the moment of closing file	Average N° of individual sessions that a patient follows in the program	Total N° of sessions performed for all closed files	Total N° of patients with a closed file	Age, gender, diagnosis, category of symptoms		Database/HMIS patient files
Optional	Proportion of main morbidities	Proportion of main diagnosis/category of symptoms	N° of new patients diagnosed/per symptom cluster	Total N° of new patients	Age, sex, diagnosis, category of symptoms		MH Database, HMIS, OPD morbidity sheet
Optional	Proportion of main precipitating events	Proportion of main category of precipitating events/risk factors	N° of new patients reporting a specific precipitating event/risk factor	Total N° of new patients	Age, gender, diagnosis, precipitating event/risk factor		
Optional	N° patients presenting with severe mental disorders ⁱ	Patients presenting severe mental disorders over X period of time Measurement: CGI≥5 or similar	N° of new patients with severe mental disorders	N° of total new patients included in X service	Age, gender, diagnosis, per service		Database/HMIS/ reports
Optional	N° of patients referred	N° new patients referred to MHPSS by different facilities, MSF medical activities, or other actors	No of new referred patients per each source of referral	Total N° of new patients over X period of time	Age, gender, different sources of referrals (HP, social workers, other medical services, etc.)	Depends on the focus of the activity service	Patient files / Database/HMIS/ reports

^h Number of individual sessions will depend on specific contexts, type of diagnosis and access to services. To be constantly monitored.

ⁱ SMDs: these are disorders that usually require medication as first-line response, particularly psychosis, severe depression and mania. (also when CGI-S is =5-7.

Core or optional	Indicator heading	Description	Numerator	Denominator	Breakdown	Suggested performance target	Data Source
Optional	N° of new patients	Total count of patient files opened (who came to the services and receive a first consultation)	No of opened files (patients)	Total N° of patients over X period of time	Age, gender/psychologist or counsellor		Database/HMIS
Optional	Number of severe medical adverse events ¹ related to MHPSS activity	Total count of severe medical adverse event related to MH reported	No of severe medical adverse events related to MH reported	No of severe medical adverse events related to MH reported over X period of time	Professional		Database/HMIS/ reports

j MSF has an international policy on medical error and each OC has a specific protocol for this.

Glossary

Mental health

Mental health, according to WHO, is a “state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”¹.

Mental disorder

In this guide the term ‘mental disorders’ refers to diagnosable mild, moderate and severe mental disorders as described in DSM and ICD.

Psychosocial

In the field of humanitarian response it is used to “emphasize the close connection between psychological aspects of experience and wider social aspects of experience, inclusive of human capacity, social ecology, and culture and values”². The term “psychosocial” is the subject of international debate. MSF understands that a psychosocial approach targets both individual and community factors.

Psychosocial well-being

Psychosocial well-being highlights the interaction between the psychological aspects of people’s functioning, beliefs, thoughts, emotions and behaviours, and their social surrounding including relationships, family and community networks, cultural traditions, economic status, and ability to participate in public affairs, decision making, daily activities and tasks such as school or work³. It is similar to the WHO definition of mental health with special emphasis on family and community.

Psychosocial problems

Psychosocial problems refer to social, emotional and personal difficulties that do not reach the threshold of disorders but can benefit from supportive interventions targeting individuals, families and communities.

MHPSS

Humanitarian agencies, including MSF, use the term ‘Mental Health and Psychosocial Support’ (MHPSS) to encompass all the mental health assistance they provide. The composite term MHPSS is used in this document to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders⁴.

It is helpful to distinguish psychosocial support from MH care:

- Psychosocial support’ includes a specific list of non-specialized interventions in response to problems, stress and difficulties experienced by a large proportion of people in humanitarian contexts. Psychosocial support can also be considered as “a process of facilitating resilience within individuals, families and communities”⁵. Some examples of psychosocial activities include psychological first aid (PFA) and psychoeducation.

- Mental health care includes clinical interventions that require training and supervision such as counselling psychological care, psychotherapy, pharmacological interventions and low-intensity psychological interventions.

However, different organizations define these concepts differently. For example, WHO considers all non-pharmacological interventions as “psychosocial interventions”, including psychoeducation, stress reduction, strengthening of social support, promotion of functioning in daily life, psychological interventions and psychosocial interventions to promote adherence to treatment (particularly important for the physical health of people with mental, neurological and substance use conditions).

For a detailed description of MHPSS interventions, see [Chapter 2](#).

Psychosocial disabilities

Refer to people who have received a mental health diagnosis, and who have experienced negative social factors including stigma, discrimination and exclusion. People living with psychosocial disabilities include former and current users of mental health care services, as well as people that identify themselves as survivors of these services or with the psychosocial disability itself².

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