

GUIDELINES ON MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT



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FOREWORD

War and violence destroy communities and countries all over the world, and have a devastating impact on the mental health and psychosocial well-being of millions of people. They lead to the breakdown of local systems and infrastructure. As a result, adequate assistance is often unavailable when people need it the most. People affected by conflict and violence are at risk of death, displacement, loss of loved ones and injury – among others – and need medical care for both physical and psychological conditions.

The International Committee of the Red Cross (ICRC) has developed these guidelines to outline the organization's approach to mental health and psychosocial support (MHPSS) during and after armed conflict and other situations of violence. These internal guidelines provide a framework for harmonizing MHPSS programmes within the organization, combining international, evidence-based recommendations and practices with the expertise of the ICRC's field teams. They seek to ensure the quality of the ICRC's interventions in order to effectively alleviate people's distress and improve their capacity to function in daily life, support individual and collective coping mechanisms and prevent any additional harm.

This publication is a needs-based MHPSS programmatic overview. It describes issues of concern, programme-specific needs assessment methods, the main programme activities and implementation strategies and monitoring and evaluation processes. In sharing these guidelines with an external audience, the ICRC aims to raise awareness of its approach among professionals and other interested parties and to promote coherent professional and operational programme standards by providing an insight into its strategic processes and field practices. *Nevertheless, this publication is not intended to serve as a training manual for specific MHPSS techniques.*

The ICRC has extensive experience in the area of MHPSS. Its field programmes respond to the needs of the families of missing persons, victims of violence (including sexual violence), people who have been wounded or acquired disabilities as a result of conflict, and those providing assistance within an affected community ("helpers"). The comprehensive nature of the chapters dedicated to these groups reflects the ICRC's vast humanitarian experience and lessons learnt. The chapters on MHPSS programmes that address the needs of current and former detainees set out the theoretical background to more recent activities, which will be further developed in the future.

Given the ICRC's experience of responding to diverse MHPSS needs in an ever-changing humanitarian landscape, these guidelines are designed to be further adapted and refined in the future.

ACKNOWLEDGEMENTS

These guidelines have been developed by the ICRC MHPSS team with valuable contributions from both staff in the field and other members of the Health Unit in the Department of Operations at headquarters. They build on a wealth of knowledge and expertise acquired through years of work with people affected by armed conflict and other violence.

The MHPSS team would like to express its sincere gratitude to everyone who has revised and helped to develop this document, particularly colleagues from the Assistance and Protection Divisions.



1.

INTRODUCTION

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN ARMED CONFLICT AND OTHER SITUATIONS OF VIOLENCE

Mental health and psychosocial support (MHPSS) services play a particularly important role during armed conflict and in other situations of violence¹ and emergencies. Violence, fear and uncertainty can create chaos and deplete community resources. As a result, people experience psychological distress that impairs their daily functioning and social interaction.

Rates of mental health problems often increase during these periods, and pre-existing disorders may also resurface or be exacerbated by conflict or violence. Although people with mental health disorders constitute a particularly vulnerable group, they are often neglected.

The incidence of psychosocial problems also significantly increases during armed conflict, other situations of violence and emergencies. Exposure to violence, the disruption of social networks, the loss of and/or separation from relatives and friends, deteriorating living conditions, poverty and limited access to support can have both a short- and a long-term impact on the well-being of individuals, families and communities.

In this document, the term “**mental health**” is used to denote psychological well-being. Mental health interventions aim to improve psychological well-being by reducing levels of psychological distress, improving daily functioning and ensuring effective coping strategies. Such interventions are overseen by a mental health professional and target individuals, families and/or groups.

The term “**psychosocial**” is used to describe the interconnection between the individual (i.e. a person’s ‘psyche’) and their environment, interpersonal relationships, community and/or culture (i.e. their social context). Psychosocial support is essential for maintaining good physical and mental health and provides an important coping mechanism for people during difficult times. Psychosocial interventions constitute the backbone of any MHPSS response and include a range of social activities designed to foster psychological improvement, such as sharing experiences, fostering social support, awareness-raising and psychoeducation.

Mental health and psychosocial needs often significantly exceed the response capacity of local services. Conflict situations may further strain the already scarce or inadequate resources of health systems, undermining their ability to provide quality care to those who need it the most. Mental health and psychosocial care is often a secondary concern in conflict settings, where initial relief efforts usually focus on more immediate and obvious health issues.

¹ “Other situations of violence” is used to designate “situations in which violence is perpetrated collectively but which are below the threshold of armed conflict. Such situations are characterized in particular by the fact that the violence is the work of one or several groups made up of a large number of people. The other types of violence (interpersonal or self-directed) are not what the ICRC understands by ‘other situations of violence’ in the mission statement.” Taken from “The International Committee of the Red Cross’s (ICRC’s) role in situations of violence below the threshold of armed conflict”, *International Review of the Red Cross*, Vol. 96, No. 893, March 2014, pp. 275–304.

In situations where MHPSS services are available, access may be limited by geographic location or security restrictions. A person's race or ethnicity, gender, disability, special health care needs or socio-economic status may have an impact on their access to care. Where mental health care is provided, its scope tends to be limited and discriminatory. Moreover, there is a tendency to view all people with MHPSS needs as mentally ill. Non-specialized health personnel may lack specific MHPSS knowledge or experience, or indeed the time to acquire the skills to address the impact of violence on mental health, while MHPSS experts are scarce. Social and cultural beliefs and/or preconceptions regarding mental health may also discourage patients from seeking help, as they might face stigma.²

In response to the needs on the ground, and given the increasing importance of MHPSS care, the ICRC has expanded and diversified its assistance programmes. In 2004, the ICRC's Assistance Policy³ included mental health as one of nine areas of primary health care for which the ICRC assesses needs and implements health activities. The organization was thus able to develop a small number of programmes to address mental health and psychosocial needs. Over time, the ICRC expanded its MHPSS programmes. Thus, the ICRC's 2014–2018 Health Strategy included MHPSS in its strategic objective, which aims to respond to new and emerging health needs among people affected by armed conflict and other situations of violence. In order to ensure a continuum of care,⁴ MHPSS programmes are, where necessary, integrated into the overall health response.

Mental health and psychosocial support (MHPSS) programmes refer to a wide range of interventions that address psychological and psychosocial difficulties that may be either triggered or exacerbated by armed conflict and other situations of violence. As mental health and psychosocial needs are inextricably interlinked, an effective intervention ought to address both components.

The ICRC's programmes are designed to build local capacity in order to stabilize and improve the mental health status and psychosocial well-being of individuals and communities. MHPSS programmes use an integrated, multidisciplinary approach to address specific needs, such as providing support to families of missing persons, to victims/survivors of violence (including children and victims of sexual violence), and to current or former detainees.

² Stigma is a perceived negative attribute that causes someone to devalue a person or group of people; stigma leads to discrimination, namely the act of being treated differently because of this perceived negative attribute. The majority of MHPSS interventions focus on addressing stigma. However, if necessary, discrimination may also be targeted specifically, particularly in cases where people with psychiatric disorders might be suffering physical and/or psychological ill-treatment as a result of their condition.

³ https://www.icrc.org/eng/assets/files/other/irrc_855_policy_ang.pdf

⁴ Continuum of care (ICRC definition): A continuum of care refers to an integrated system that guarantees a person secure and timely access to effective and impartial health services. It links first aid, prehospital care, primary health care, hospital and rehabilitation, including mental health and psychosocial support, as well as health in detention services, with functioning referral and counter-referral systems.

THE PURPOSE OF THIS DOCUMENT

These guidelines encompass internationally recognized, evidence-based MHPSS standards and practices, combined with the expertise, experience and views of mental health professionals who have worked in armed conflict and other violence. They are designed to be adapted and developed over time, and set out a framework of ethical principles, common definitions and recommended procedures to be applied to the ICRC's MHPSS activities.

The ICRC's MHPSS programmes provide psychological and psychosocial services using delivery models adapted to specific countries and settings, whereby the target groups, human resources, outreach efforts and way in which these MHPSS activities relate to and complement other ICRC activities vary from programme to programme.

Given the wide variety of contexts in which the ICRC operates, appropriate and effective MHPSS programmes need to be based on common professional standards and adapted to specific settings. Failure to adopt a coherent approach could harm the very people and communities the ICRC seeks to help. Thus, these guidelines seek to harmonize the ICRC's MHPSS programmes throughout the world, in order to ensure quality of care and to enhance synergy with other ICRC activities and other service providers worldwide.

INTERNATIONAL RED CROSS AND RED CRESCENT MOVEMENT

The ICRC is part of the International Red Cross and Red Crescent Movement, which also comprises 190 National Red Cross and Red Crescent Societies and the International Federation of Red Cross and Red Crescent Societies (known as the Federation). The ICRC, the Federation and each National Society are independent entities, with their own statutes and no authority over each other. They all implement a diverse range of MHPSS programmes, either independently or in collaboration with each other.⁵

OVERARCHING PRINCIPLES THAT GUIDE MHPSS INTERVENTIONS

To ensure the provision of quality mental health care and psychosocial support in armed conflict and other situations of violence, the ICRC's interventions follow a set of principles drawn from the 2007 *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*,⁶ the 2011 Sphere Project handbook,⁷ and the 2014–2018 ICRC Health Strategy. In addition to the seven Fundamental Principles of the International Red Cross and Red Crescent Movement – humanity, impartiality, neutrality, independence, voluntary service, unity and universality⁸ – the following five principles provide an ethical and professional framework for health professionals:

1. Upholding humanity, impartiality and non-discrimination
2. Ensuring community participation and cultural awareness

⁵ See ICRC, *The Fundamental Principles: The International Red Cross and Red Crescent Movement*, ICRC, Geneva, 2015; and www.ifrc.org, all internet references accessed February 2017

⁶ Inter-Agency Standing Committee (IASC), *IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings*, IASC, Geneva, 2007

⁷ The Sphere Project, *Humanitarian Charter and Minimum Standards in Humanitarian Response*, The Sphere Project, Geneva, 2011

⁸ ICRC, *The Fundamental Principles of the Red Cross and Red Crescent*, ICRC, 1996: https://www.icrc.org/eng/assets/files/other/icrc_002_0513.pdf

3. Complying with medical and health care ethics
4. Delivering quality of care in line with internationally accepted standards
5. Ensuring a continuum of care

Mental health professionals in the field endeavour to act in the best interests of patients. Implementing MHPSS activities in line with the above-mentioned principles helps to build trust and to ensure that people with MHPSS needs are fully invested in and engage with MHPSS programmes.

1. UPHOLDING HUMANITY, IMPARTIALITY AND NON-DISCRIMINATION

MHPSS interventions focus on meeting people's needs and providing humane treatment. The Sphere Project's *Humanitarian Charter and Minimum Standards in Humanitarian Response*⁹ are based on the principle of humanity and recognize a person's right to live with dignity, their right to protection and security, and their right to receive humanitarian assistance based on their needs. This principle is also at the core of the ICRC's mission to prevent and alleviate human suffering in armed conflict and other situations of violence.

By maintaining its impartial status, the ICRC aims to ensure that its interventions address the specific and most urgent needs of the worst-affected communities and individuals. All ICRC activities comply with the principle of impartiality, which stipulates that humanitarian support is provided solely on the basis of, and in proportion to, the needs of people on the ground.

By upholding the principle of non-discrimination, the ICRC strives to avoid all forms of discrimination, whether it be on the grounds of age, gender, race, colour, ethnicity, sexual orientation, language, religion, health status, political or other opinion, or national or social origin.

When applying the principles of humanity, impartiality and non-discrimination, individual factors (e.g. gender, age and exposure to violence) must also be taken into account. They help to identify specific vulnerabilities and are essential to understanding the needs of individuals and communities, in order to provide an effective response.

2. ENSURING COMMUNITY PARTICIPATION AND CULTURAL AWARENESS

Humanitarian interventions are more effective when the intended beneficiaries are actively engaged in the programme from the outset. As the ICRC describes, "the individuals and communities concerned must be consulted in order to better establish their needs and interests, and they should be associated with the intervention taken. Their value systems, their specific vulnerabilities and the way they perceive their needs must all be taken into consideration. The ICRC favours a participatory approach aimed at building local capacities."¹⁰

MHPSS interventions are therefore delivered in a manner that promotes dignity, enables beneficiaries to help themselves through meaningful participation, respects the importance of religious and cultural practices, and improves the overall well-being of communities. Interventions seek to take cultural considerations into account by engaging with key community members, including traditional and religious leaders, teachers and health professionals. It is crucial to identify and strengthen these local resources (both in government and civil society). The ICRC does this through specific

⁹ The Sphere Project, *Humanitarian Charter and Minimum Standards in Humanitarian Response*, The Sphere Project, Geneva, 2011

¹⁰ ICRC, *The ICRC: Its Mission and Work*, 2009: https://www.icrc.org/eng/assets/files/other/icrc_002_0963.pdf

modes of action: raising awareness of responsibility (persuasion, mobilization, denunciation); support; and substitution (direct provision of services).¹¹

If programmes fail to acknowledge the importance of community participation and cultural awareness, they may cause harm by overlooking existing coping mechanisms and prolonging distress. They are also likely to have limited local ownership. Conversely, programmes that involve the community and take cultural factors into account can provide effective support.

3. COMPLYING WITH MEDICAL AND HEALTH CARE ETHICS

There is, as yet, no global ethical code for mental health professionals, although numerous codes have been developed at the national and organizational level.¹² Codes of conduct for mental health practitioners, like those used by other health professionals, focus on preserving dignity, guaranteeing confidentiality, preventing illness, restoring health, alleviating suffering and, above all, “doing no harm.”

Compliance with these principles requires effective MHPSS programmes designed and delivered by qualified professionals with specific skills in the field of mental health and psychosocial support. These health practitioners must work within their fields of expertise and continue to further their professional development.

4. DELIVERING QUALITY OF CARE IN LINE WITH INTERNATIONALLY ACCEPTED STANDARDS

The ICRC’s interventions are based on internationally recognized, evidence-based MHPSS standards and practices. This document sets out guidelines for implementing programmes that reflect established best practices among humanitarian actors. All interventions adopt a long-term view of recovery, irrespective of the length of a given programme, and support is provided to local actors to apply these concepts in their work to help affected communities.

5. ENSURING A CONTINUUM OF CARE

As outlined in the ICRC’s Health Strategy, all health programmes must ensure a continuum of care. This means that the services provided form part of an integrated system that ensures secure and timely access to effective and impartial health services. MHPSS activities and programmes are integrated, insofar as possible, into the health service framework, in order to provide holistic care along the entire patient and/or beneficiary management chain. The continuum of care links first aid and pre-hospital care, primary health care, hospital and rehabilitation services, including mental health and psychosocial support, and health services in detention centres, with functioning referral and counter-referral systems.

THE ICRC’S MHPSS FRAMEWORK

The ICRC’s programmes include both mental health and psychosocial components.

MAIN OBJECTIVES

1. address psychological and psychosocial needs at the individual, family and community level;

¹¹ Ibid.

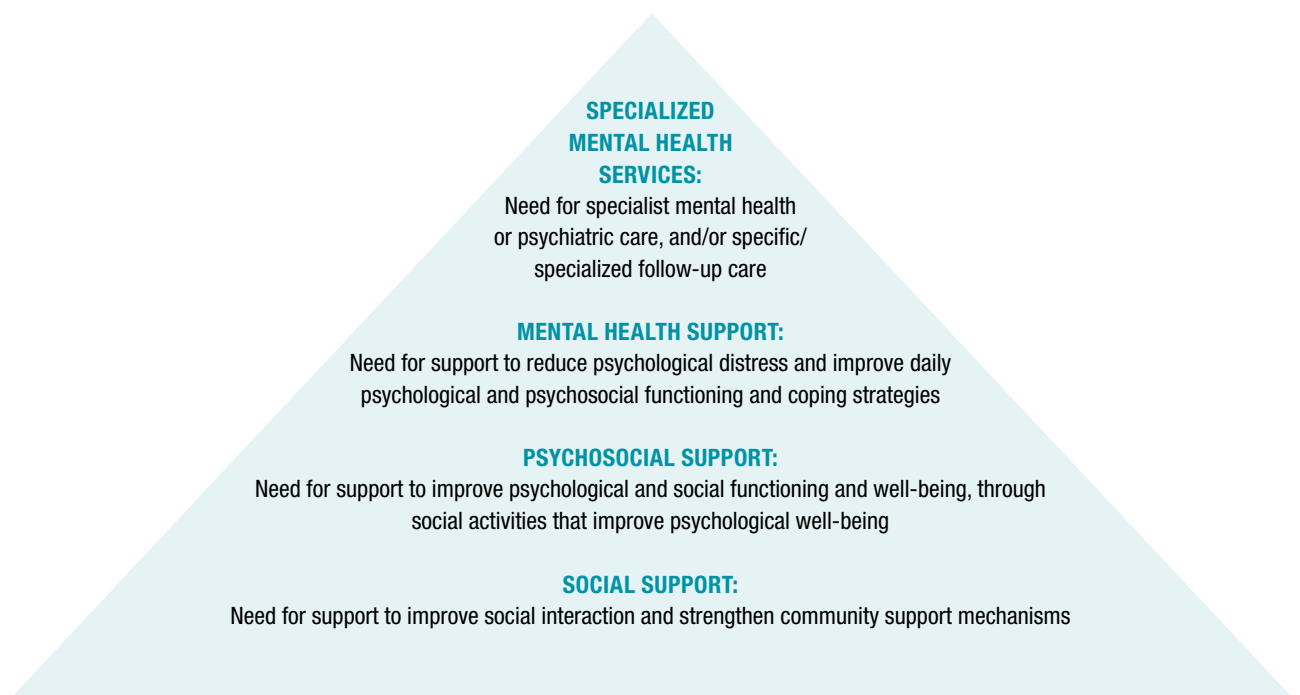
¹² See, for example, American Psychological Association, *Ethical principles of psychologists and code of conduct*, American Psychological Association, 2010; The British Psychological Society, *Code of Ethics and Conduct: Guidance published by the Ethics Committee of the British Psychological Society*, The British Psychological Society, Leicester, 2009; and European Federation of Psychologists Associations, *Meta-Code of Ethics*, European Federation of Psychologists Associations, Athens, 1995.

2. promote individual, family and community coping mechanisms;
3. prevent further mental health and psychosocial problems.

ENABLING ACTIONS

- reduce distress by decreasing the intensity and frequency of psychological and psychosocial symptoms;
- improve psychological and psychosocial daily functioning;
- enhance the coping mechanisms of individuals and communities.

Pyramid of mental health and psychosocial needs and the corresponding support provided in the ICRC's MHPSS programmes



TYPES OF INTERVENTIONS

The ICRC's MHPSS programmes cover the following activities:

- **Mental health activities**

MHPSS programmes provide mental health support mainly through capacity-building activities that enhance the psychological support skills of key community actors, including local health workers and local mental health care professionals. Training sessions are provided by mental health professionals, such as MHPSS delegates or local psychologists, and are adapted to the specific role of the care providers, the psychological needs of the affected community and the local culture and context. Capacity-building activities include training in basic psychological support skills and/or psychotherapeutic support skills. In general, basic psychological support training is provided to actors whose current roles involve addressing victims' needs, and who may require further support to perform that task effectively. These actors may include emergency care responders, hospital staff and teachers, who usually have high workloads and only have the time to commit to basic skills training. Meanwhile, psychotherapeutic support training is provided to actors who already possess more advanced skills, e.g. local mental health practitioners, social support actors, and/or community actors who have both the relevant competences and the time to be trained.

In order to build capacity and ensure the quality of MHPSS interventions, it is essential to ensure proper follow-up and supervision for all capacity-building activities. In addition to addressing immediate mental health needs, capacity-building activities have the broader aim of establishing or strengthening existing mental health systems.

- *Basic psychological support (individual and group)*

People caught up in situations of conflict and violence might need support to overcome immediate, mild psychological difficulties. Basic psychological support primarily focuses on helping people to improve their immediate functioning.

Depending on people's needs and the human resources available, selected community actors (e.g. community leaders, religious leaders or teachers) or health service providers (e.g. community health workers, nurses or doctors) receive training, support and supervision from mental health professionals (e.g. MHPSS delegates, field officers or local psychologists) to provide basic psychological support. The level and type of support they provide depends on the needs on the ground and on their knowledge, skills and availability. Although some of these actors may be qualified professionals or respected community members whose existing roles already have a support component, others may need additional training to independently provide this kind of assistance. Often these people are members of the affected community who have a caring disposition. The basic skills these actors are taught include learning how to create a safe environment, build trust and enhance their active listening and communication skills. Other basic areas covered include psychoeducation (i.e. providing information about specific psychological reactions and sharing positive coping strategies) and normalization (i.e. providing information about common psychological reactions to abnormal situations). Peer support groups with a basic psychological support component are facilitated by a trained community actor with experience of similar difficulties.

- *Psychotherapeutic support (individual and group)*

In settings where mental health needs are more severe, skilled and trained community actors, local psychologists and other mental health practitioners (e.g. counsellors, some social workers and, in certain cases, suitably skilled community actors) are trained to provide psychotherapeutic support. They are taught to identify symptoms of psychological distress and their impact on daily functioning, as well as to explore individual and social resources and foster positive coping strategies. Psychotherapeutic support aims to reduce the symptoms of distress and to improve people's daily functioning and psychological coping strategies. Where necessary, group psychotherapeutic support may be provided to people with similar mental health needs, in order to address a specific mental health issue and/or share experiences.

- *Specialized care and referrals*

Psychiatric and specialized support is facilitated in specific programmes and contexts (such as in detention facilities and hospitals) mainly through capacity-building, advocacy and sensitization of local resources. It is essential to map existing mental health service providers in order to facilitate the referral of severe or complex cases. Mental health professionals provide training and support to equip other trained actors involved in basic psychological and/or psychotherapeutic support to identify needs and make appropriate referrals.

- **Psychosocial support activities**

Key community actors are trained and supported by mental health practitioners (e.g. MHPSS delegates, local psychologists or trained counsellors) to identify psychosocial needs and provide an appropriate response. This response may include facilitating psychosocial support groups, running information and/or sensitization activities, or making referrals to quality service providers. Psychosocial capacity-building training may also be provided to specialists, for example to help local psychiatrists incorporate psychosocial elements into the care they provide. As with all capacity-building activities, it is essential to ensure monitoring, follow-up and supervision.

- *Psychosocial group activities*

Key community actors are trained by mental health practitioners (e.g. MHPSS delegates, local psychologists or trained counsellors) to implement activities that address psychosocial problems through psychoeducation and by building trust, solving problems and sharing experiences and information. Group activities, such as peer support groups or social activities, help to combat isolation, as they provide an opportunity to meet people who have been through similar experiences and to build a social support network. The link between psychosocial problems and psychological distress is given in these activities, meaning that the activities contribute to improving psychological well-being.

- *Information and sensitization activities*

Information and sensitization activities often feature a psychosocial aspect, but the aim in implementing them is to raise awareness of both mental health and psychosocial issues. Although they often cover technical aspects, the aim of these activities is to transmit information in a comprehensible, engaging and culturally-appropriate way. Information activities target a variety of audiences and aim to provide general information on MHPSS issues, such as the impact of violence and the availability and accessibility of services. Sensitization activities target a specific group of people, usually those with influence in the community or who have direct contact with people with MHPSS needs. Sensitization activities are tailored to the target group and aim to positively influence attitudes and behaviours towards people with MHPSS needs, in order to address the stigma that these people often face. Information and sensitization activities are often implemented as part of a community mobilization strategy, in an effort to engage community members and strengthen new and existing community support networks.

- *Referrals*

A multidisciplinary referral network is created and timely referrals are made in cases where further protection, health, economic or legal needs are identified. The ICRC provides training and support to enable psychosocial support actors to identify needs and make appropriate referrals.

THE ICRC'S MHPSS RESPONSE TO TRAUMA

The definition and usage of the term “trauma” ranges from the excessively broad to the extremely specific. It can refer to any adverse life event or describe a group of clinical conditions that meet specific diagnostic criteria. Neither definition covers the complex interplay of biological, psychological and social factors before, during and after traumatic experiences. Trauma may be exacerbated by situations involving severe, ongoing and unpredictable violence. For example, people may be wounded, threatened with death, experience sexual violence, witness the death of a loved one and hear about other people's traumatic experiences.

People can experience trauma as a result of threats to life or physical and/or psychological integrity, or by witnessing violence, injury or death. The stress and emotional intensity of a traumatic event is overwhelming and can cause extreme fear and horror. The social context in which traumatic events take place is vitally important. It shapes our assumptions and expectations with regard to ourselves and others, and has an impact on how the traumatic event – which usually shatters these assumptions – is integrated into our worldview. One of the main determining factors in traumatic stress reactions is the feeling of extreme helplessness at the time of the event(s). In such circumstances, people may experience paralysis, confusion, shock or numbness. This coping process is a normal reaction to an abnormal event and, if provided with a supportive environment, most people successfully recover. However, not everyone reacts in the same way to adverse events. Recovery becomes even more difficult in cases where social support networks have broken down, as is often the case in armed conflict and other situations of violence. Traumatic events often involve abuse of power, betrayal of trust, entrapment, pain and loss. If victims are unable to integrate these events into their worldview, the imprint of trauma dominates the way in which they organize their lives.

The *Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5)*¹³ and the World Health Organization (WHO) *International Classification of Diseases-10 (ICD-10)*¹⁴ provide diagnostic criteria for trauma and stressor-related disorders, including post-traumatic stress disorder (PTSD). Recognizing patterns of reactions to extreme events makes them easier to classify. However, applying such criteria limits the definition of trauma to a specific diagnosis. Cultural and environmental factors that influence survivors' experiences of trauma and their MHPSS needs are diverse and context-dependent, and may not be properly taken into account when providing a diagnosis. Given the instability and insecurity caused by armed conflicts and other situations of violence, and the devastation they leave behind, it is imperative to find an adaptable and practical approach that addresses the diverse needs of people experiencing trauma.

With these details in mind, the ICRC's approach to trauma does not focus on diagnosing mental health disorders. Instead, its interventions seek to reduce people's psychological and psychosocial symptoms and suffering, and to improve their daily functioning and coping mechanisms.

EVIDENCE-BASED MONITORING AND EVALUATION

It is important to assess and adapt activities in order to ensure their continued effectiveness. Monitoring and evaluation involves an ongoing, systematic process of recording, collecting, measuring, analysing and transmitting information in order to identify areas for improvement and, ultimately, to achieve defined objectives more efficiently. Additionally, the lessons learnt can be applied to future programmes.

Standardized scales are used in the ICRC's MHPSS programmes for evidence-based monitoring and evaluation of activities. Due to the diversity of countries and communities in which the ICRC operates, the scales used in MHPSS programmes need to be cross-culturally validated and translated into local languages. As existing scales cannot always be applied to non-Western conflict settings, the ICRC uses scales that can be adapted. Scales are used to measure changes in psychological distress, daily functioning, and the coping strategies of individuals and communities over time.

¹³ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, 5th ed., American Psychiatric Association, Arlington, VA., 2013

¹⁴ WHO, *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines*, WHO, Geneva, 1992

Examples of the scales used in MHPSS programmes include:

Distress

- Impact of Events Scale – Revised (IES-R)¹⁵
- Children’s Revised Impact of Event Scale (CRIES)¹⁶

Functioning

- WHO Disability Assessment Schedule 2.0 (WHODAS 2.0)¹⁷
- Professional Quality of Life Questionnaire (ProQOL)¹⁸
- Self-Reporting Questionnaire 20 (SRQ 20)¹⁹

Coping

- Brief COPE Inventory²⁰

Indicators are quantitative or qualitative factors or variables that provide a simple and reliable basis for assessing or measuring change or performance. Quantitative data is used to provide information on the number of people receiving support and any changes in their psychological and psychosocial well-being over time (i.e. comparing one point in time to another point in time). Qualitative data is gathered from group or individual interviews; individuals and communities are given an opportunity to express their views and experiences, thereby adding meaning and detail to the numeric data. Outcomes and output indicators are used to gauge the effectiveness of interventions. The combined data is used to ensure that programmes are further adapted and honed. The ICRC has developed its own MHPSS data collection tools, which provide a consolidated platform for data storage and analysis.

PROGRAMME REQUIREMENTS

MHPSS FIELD TEAM

The ICRC’s MHPSS team is made up of almost one hundred mental health professionals²¹ around the world, including international and local field staff. This number varies from year to year, depending on global needs and the number of MHPSS programmes implemented. The number of ICRC MHPSS programmes rolled out worldwide has grown rapidly in recent years, rising from 10 in 2010 to 77 in 2017.

MHPSS delegates are psychologists and psychiatrists recruited for their professional qualifications and ability to provide successful MHPSS support to communities affected by conflict and violence. They have experience in the fields of mental health care and emergency response, as well as specific skills to address the psychological impact of violence. They may have worked with victims of violence (including victims of sexual violence and children), in health care settings, and/or with the families of missing

¹⁵ See www.emdrhap.org/content/wp-content/uploads/2014/07/VIII-E_Impact_of_Events_Scale_Revised.pdf

¹⁶ See Children and War Foundation, *CRIES 13*, Bergen/Norway, 1998: <http://www.childrenandwar.org/measures/children%E2%80%99s-revised-impact-of-event-scale-8-%E2%80%93-cries-8/ies13/>

¹⁷ See <http://www.who.int/classifications/icf/whodasii/en/>

¹⁸ See http://www.proqol.org/ProQol_Test.html

¹⁹ See WHO, *A User’s Guide to the Self-Reporting Questionnaire (SRQ)*, WHO, Geneva, 1994: http://whqlibdoc.who.int/hq/1994/WHO_MNH_PSF_94.8.pdf

²⁰ See Department of Psychology, College of Arts & Sciences, University of Miami: <http://www.psy.miami.edu/faculty/ccarver/sclBrCOPE.html>

²¹ In this document, the term “mental health professional” is used to denote psychologists and psychiatrists; the term “mental health practitioner” is used to denote psychologists and psychiatrists as well as people who have been trained by a mental health professional to develop their psychological and psychosocial support skills but are not mental health professionals (this includes community actors trained as counsellors).

persons. MHPSS delegates' competences also include supervisory, training, and team-management skills.

Delegates are responsible for assessing psychological and psychosocial needs and for designing and managing programmes. Although the main programme specifications are outlined in these guidelines, individual programmes need to be context-specific. MHPSS delegates also help to select and train local staff to implement the programmes. Training periods vary and may last more than 12 months, depending on the staff member's qualifications and experience and on the complexity of the programme.

Since 2013, the ICRC Health Unit has organized an annual training workshop known as the MHPSS Consolidation Week. It provides MHPSS delegates and local field staff responsible for coordinating and implementing programmes with an opportunity to share experiences and lessons learnt, and to harmonize their MHPSS approaches within the framework of the ICRC's Health Strategy. The workshop has also become a platform that allows participants to contribute to the development of these MHPSS guidelines.

TIME FRAME FOR PROGRAMMES

It is difficult to define the ideal length of a MHPSS programme. However, it is rarely a short-term endeavour. For example, emergency interventions and assessments may last approximately three months, while MHPSS programmes that address specific needs may last at least 12 months.

The length of time during which MHPSS is required depends on several factors, including the nature and number of traumatic events and the availability of psychological and psychosocial support. It is not unusual for symptoms of distress to remain widespread in communities for many years after the end of a conflict or period of violence.

As a result, all MHPSS responses implicitly adopt a long-term approach, regardless of the actual length of the programme. The modes of action that the ICRC uses in its MHPSS activities are: support, mobilization and persuasion.²² They contribute to establishing a sustainable framework that can be incorporated into existing formal and informal support systems.²³ This process takes time. In situations where mental health and psychosocial services and resources are poorly developed and there is social stigma surrounding mental health and psychosocial issues, programmes are often launched in an environment with little, if any, existing capacity. Training programmes, tools and teams need to be created from scratch.

The process of transferring MHPSS knowledge and skills in conflict situations depends on more than training alone. It involves the supervised application of the skills taught and appropriate follow-up. Effective training is an ongoing process that requires thorough practice and close mentoring, monitoring and supervision, provided by qualified trainers.

This long-term objective should be incorporated into all programmes, so that beneficiaries will not feel abandoned. If a programme is implemented to reduce vulnerabilities and strengthen coping responses but support services are withdrawn shortly after the intervention ends, the community is likely to be severely disappointed. This can damage trust and harm community relations, potentially leaving affected people worse off than before. These risks can be avoided by planning exit strategies at an early stage, with the aim of ensuring that a local framework exists to ensure that support programmes continue to operate after the end of the intervention.

²² ICRC, *The ICRC: Its Mission and Work*, 2009: https://www.icrc.org/eng/assets/files/other/icrc_002_0963.pdf

²³ Formal support systems are health care services, while informal systems involve various forms of community support.



2. FAMILIES OF MISSING PERSONS

ISSUES OF CONCERN

Throughout the world, hundreds of thousands of people have lost touch with their relatives as a consequence of armed conflict, natural disaster or migration. Their loved ones may have been killed in mass executions and their bodies thrown into unmarked graves; they may have been captured or abducted; they may have been arrested and died in custody; or they may be held incommunicado in a secret location. Missing persons may be civilians fleeing conflict, children separated from their families, combatants missing in action or those killed in combat whose remains have not been recovered.

A missing person is a person whose whereabouts are unknown to his/her relatives and/or who, on the basis of reliable information, has been reported missing in accordance with the national legislation in connection with an international or non-international armed conflict, a situation of internal violence or disturbances, natural disaster or any other situation that may require the intervention of a competent State authority.

ICRC Advisory Service on International Humanitarian Law definition²⁴

Every missing person has a unique, sometimes devastating, story. Family members often find themselves caught in limbo following the disappearance of a loved one and face a range of potential challenges. Their need to know the truth may give rise to financial, legal or administrative problems; they may also face psychological and psychosocial difficulties. In addition to the pain they feel following their separation from a loved one, often under very difficult circumstances, their social and economic situation may also become more precarious, as the missing person may have been the main breadwinner in the family. Family members may not know how to search for a missing relative, apply for financial or material support, or obtain legal advice. As a result, they may become isolated from their social environment. They may lose confidence in the national legal system, they may find it hard to trust other members of their community or, if someone has disappeared in the context of violent tensions between two or more opposing groups, they may fear the stigma of being associated with opposition groups.

In these circumstances, it is extremely useful that any interventions to help the families of missing persons have a psychosocial framework. In order to make sure that no further harm comes to these families, psychosocial strategies must be established and maintained throughout the entire programme cycle. The process begins with identifying the families of missing persons, assessing their needs and inviting them to take part in the programme. Next, steps are taken – in cooperation with the families themselves – to determine the best, culturally-appropriate means of addressing their needs, and of strengthening their individual, family and social resources.

²⁴ ICRC, *Guiding Principles / Model Law on the Missing – Principles for Legislating the Situation of Persons Missing as a Result of Armed Conflict or Internal Violence: Measures to prevent persons from going missing and to protect the rights and interests of the missing and their families*, ICRC, Geneva, 2009

Relative of the missing person: Unless otherwise specified, the term “relative” shall be understood in accordance with provisions of the [Civil Code/Family Law]. It shall include, at a minimum, the following persons:

- children born in and out of wedlock, adopted children or step-children;
- lawfully wedded partner or unwedded partner; and
- parents (including step-mother, step-father, adopter);
- full or half or adopted sisters and brothers.

Adapted from the ICRC Advisory Service on International Humanitarian Law definition²⁵

Psychological support can play a vital role in helping families cope with common reactions, such as intense sadness, uncertainty, guilt, feelings of isolation, anger, mental exhaustion, confusion and anxiety. These reactions may be exacerbated during family gatherings, when the families of missing persons are confronted with their feelings, triggering painful memories.

MENTAL HEALTH AND PSYCHOSOCIAL NEEDS

The families of missing persons face the same difficulties as other people affected by armed conflict and other situations of violence, including the loss of their homes or income. In addition, they often also face specific psychological and psychosocial challenges that may cause distress and disrupt their ability to function and cope with daily life.

Coping with ambiguous loss

The programmes run by the ICRC in various countries provide support to many families dealing with ambiguous loss. Ambiguous loss theory, as defined by Pauline Boss,²⁶ is based on the premise that the uncertainty associated with not knowing the whereabouts of a loved one (or whether they are dead or alive), is generally extremely distressing for individuals, couples and families. Unlike death, ambiguous loss offers no certainty, as the person may still be alive somewhere; the fact that no remains have been recovered means that the family cannot hold a burial ceremony and move forward with the grieving process.

Family members suffering from ambiguous loss may experience symptoms of depression, anxiety and somatization, as well as relational conflicts. Prolonged ambiguity can paralyse people; decisions are put on hold, coping strategies stall and the grieving process is suspended as families remain trapped in a confusing limbo. People may feel unable to resume their familial and marital roles, rules and rituals, as they do not know whether the missing family member will ever return.²⁷

²⁵ *Ibid.*

²⁶ P. Boss, *Ambiguous Loss: Learning to Live with Unresolved Grief*, Harvard University Press, Cambridge, MA, 1999

²⁷ P. Boss, “Ambiguous loss in families of the missing”, *The Lancet*, Vol. 360 (Suppl. 1), December 2002, s39

Emotional and social isolation

The families of missing persons often feel emotionally isolated. They may believe that no-one else understands their suffering and, consequently, refuse to reach out for help. Some community members may lose patience with their lack of closure, while others may actively stigmatize these families on the basis of assumptions about the fate of the missing person.

Disappearances can become an extremely sensitive issue if people vanish in a context of violent tensions or armed conflict between two or more groups. In such cases, the families of missing persons may be suspected of having links to “rebel” groups. Members of their community might fear becoming tainted by association, and may decide to keep their distance. This can stigmatize the families and isolate them further.

The struggle against forgetting, the search for meaning and the need for recognition

In an atmosphere of silence and uncertainty, people actively struggle to keep the memory of their missing relatives alive both within the family and in the wider community. The absence of a gravestone or other means of commemorating their loved ones makes that task even more difficult; the ambiguous status conferred on missing persons deprives families of the customary markers of life and death. As a result, their distress remains unacknowledged.

Families may seek to keep the memory of missing persons alive by searching persistently for answers, fighting for formal recognition of the person’s status, and by talking about them. However, this approach can become maladaptive if it includes obsessive thoughts and compulsive behaviours that significantly affect a person’s day-to-day functioning and their ability to interact and work with others.

Finding a means to address and channel families’ need to remember their missing relatives and in some way acknowledge their status as “missing persons” can reduce suffering. Memorials and commemorative events, monuments or burial ceremonies provide a powerful outlet for families to voice unexpressed suffering, give meaning to their experience and connect with others. Family members may require specialized psychological and psychosocial support during the process of memorialization, as a number of difficulties may arise during and after this process.

Mental health difficulties

On the whole, relatives of missing persons do not usually experience severe mental health problems, although many do need psychological support to recover a modicum of normality and improve their individual and social functioning. However, ambiguous loss is not necessarily a concept that is well known in every corner of the world, and it can be difficult to find care providers who understand the issues that the families of missing persons face.

A small proportion of family members may present with severe psychological problems and mental health disorders. These may include obsessive thoughts and speech, as well as repetitive and rigid patterns of behaviour. They may become confused, as the emotional intensity of the situation can distort perceptions and lead people to believe that they have caught a glimpse of their missing relative. In extreme cases, life seems to come to a standstill. People may be unable to move on as they believe that their missing relatives might return at any moment. Family members may also experience excessively intense or prolonged states of anxiety, depression, isolation or withdrawal that disrupt their functioning and ability to cope, leading to further distress.

Severe complications may arise if family members witnessed the events leading up to the disappearance of their loved ones, and if their lives were also threatened. When a disappearance is compounded by another horrendous event (such as shelling, bombing, a massacre, etc.), it can be even more challenging to deal with the possible loss or disappearance of a loved one. Likewise, if a family has to deal with the loss or disappearance of more than one relative, it can increase their suffering exponentially.

These severe mental health difficulties may persist, unaddressed, for long periods of time. Family members often continue their search for the missing person or focus on consoling others while neglecting their own needs. Without outside intervention, it can be difficult to break patterns that prevent families from seeking help. Training local specialists and establishing an appropriate referral network of quality local support services requires an in-depth understanding of the mental health difficulties experienced by relatives of missing persons.

Support during the process of recovering and identifying human remains

Families often require long-term support during the long and difficult process of investigating disappearances. The relatives of missing persons will undoubtedly experience difficult moments during the process of recovering and identifying human remains that could potentially belong to their loved ones. They may have to face the bleak fact that either their loved one is dead or the remains could not be identified.

During the process of recovering and identifying remains, painful memories may resurface and cause intense and unexpected emotional reactions, including anger, frustration, mistrust, fear, denial and despair. Family members may also experience feelings of confusion and disappointment. Obtaining conclusive proof of death is a slow and laborious process, and does not always provide families with the answers they seek. During this time, family members will need more intensive mental health and psychosocial support, particularly if they are asked to provide ante-mortem data and blood/saliva samples for DNA analysis; are informed of their loved one's death; are present when the remains are recovered; and/or are asked to identify or claim the remains and personal belongings of their loved ones.²⁸

If a bond of trust is not established between forensic practitioners and the families of missing persons at the start of the process, these families are unlikely to have faith in the outcome of the investigation. Thus, practitioners often need technical support from mental health professionals when they interview, share information and work with the families of missing persons, in order to avoid causing further distress.

THE MENTAL HEALTH AND PSYCHOSOCIAL RESPONSE

A multidisciplinary approach is required to address the diverse needs that arise in the wake of a disappearance. A range of measures must be implemented, including steps to help families find answers about what happened to their loved ones, financial, legal, administrative, psychological and psychosocial support, and help to get recognition and justice.

The ICRC seeks to include all of these components in its approach. The main aim of what it calls “accompaniment” is to strengthen the ability of individuals and families to cope

²⁸ ICRC, *Missing People, DNA Analysis and Identification of Human Remains: A Guide to Best Practice in Armed Conflicts and Other Situations of Armed Violence*, 2nd ed., ICRC, Geneva, 2009

with the difficulties stemming from the disappearance of one or more relatives and to gradually recover their psychological and psychosocial well-being. This may include learning to live with uncertainty. This can be achieved by drawing on the families' own resources and those of the broader community – at both local and national level – and by creating a support network. The implementation framework is described in *Accompanying the Families of Missing Persons: A Practical Handbook*,²⁹ which draws on the ICRC's experience of supporting families of missing persons in a range of settings.

“Accompaniment” is a multidisciplinary response that involves “walking beside someone”, by forming empathic relationships and mutual support networks with local actors (“accompaniers”) who are trained to provide support whenever it is needed.

“Accompaniers” are trained and supported by a multidisciplinary team. They are taught to understand and address the wide range of needs of the families of missing persons, and to provide a bridge to local services. The key to an effective accompaniment programme is the quality of the relationship established with the family. If accompaniers are able to show empathy and win the family's trust, family members will feel that they are understood and supported, and will be comfortable participating in group sessions and receiving home visits. The ICRC has trained accompaniers from a wide range of backgrounds, including professionals from many different disciplines, volunteers from National Red Cross and Red Crescent Societies and non-governmental organizations, people whose relatives are also missing, and members of the community. It is more important that accompaniers are selected on the basis of their ability to understand, empathize with and provide support to the families of missing persons, rather than any particular qualifications. Ideally, they should also be people whom community members (and the families of missing persons in particular) view as best suited to the task.

Although accompaniers do not need to be specialists, they do require proper training, practical tools and supervision in order to effectively provide short- and long-term support. Furthermore, it is important to build and strengthen relationships between accompaniers, as they constitute the support network for these families.

Accompaniers may be trained to provide additional care before, during and after specific events such as memorials and remembrance ceremonies and during the process of recovering and identifying human remains. Family members may react very differently when faced with the possibility that their loved ones might be dead, or if that fear is confirmed. Family members may need more intensive support to cope with the difficult memories elicited during the recovery and identification process, which may include an ante-mortem interview and the actual recovery, identification and/or handover of the remains. Accompaniers may need to prepare family members and support them through every step of this difficult process. By ensuring that they are well-informed and understand what is happening, accompaniers can help to reduce family members' distress during this process. It may be useful for families to share their experiences with a supportive social network (e.g. other people whose relatives have been reported missing, members of their own family, friends, neighbours, or other members of their community). To improve the quality of support that families receive at specific moments in the process,³⁰ sensitization and training might be

²⁹ ICRC, *Accompanying the Families of Missing Persons: A Practical Handbook*, ICRC, Geneva, 2013

³⁰ For further information, see ICRC, *Accompanying the Families of Missing Persons: A Practical Handbook*, ICRC, 2013, pp. 123–147.

offered to health staff, forensic experts, professionals from government offices and/or members of local associations.

Accompaniers working under supervision should, ideally, be able to handle the majority of cases. If family members require specialist mental health support, they can contact accompaniers who are also trained psychologists, MHPSS field officers/local psychologists or experienced accompaniers who have been trained to provide psychological support. An effective referral network is also necessary to provide external support, if required. Identifying motivated mental health care providers and building their capacity to support families helps to ensure that accompaniers are able to provide appropriate assistance without causing further harm and families can get the psychological support they need through local resources.

Investing in well-equipped and competent accompaniers facilitates access to psychological and psychosocial support and the development of good quality, non-harmful programmes that are designed, implemented and supervised by mental health professionals. As accompaniment involves a multidisciplinary response, MHPSS activities are implemented alongside protection, legal, economic security and other support activities.

NEEDS ASSESSMENT

The families of missing persons have specific needs, which the ICRC must assess before any action is taken. As it is often not possible for a specialist from every field to carry out an assessment, the ICRC's Protection Division has developed a multidisciplinary assessment model that can be used by non-specialists to assess the needs of the families of missing persons. Although, in an ideal situation, an MHPSS field delegate located in the country would support the assessment, support may also be provided by a trained local psychologist or – remotely – by MHPSS advisers.

The needs assessment is used to provide field teams with an in-depth understanding of the situation, to identify and raise awareness of the problems that the families face and to plan a multidisciplinary response. Information is collected on families' specific difficulties, needs and expectations, with a view to determining existing resources, means and coping mechanisms. The collated data is used to show how the different aspects of the families' lives (including their economic situation, their quest for information, their legal, psychological and psychosocial needs, and their desire for justice and recognition) relate to each other, to demonstrate the impact of vulnerability and to highlight the need for a cross-cutting response.

When preparing the needs assessment, it is crucial to involve local staff in order to ensure their ownership of the process. This will facilitate the effective implementation of a potential accompaniment programme, as the field team will already have gained practical knowledge and experience of interacting with the families. They will understand their needs, be able to develop a close connection and win their trust, thus creating a solid basis for implementing the programme.

It is highly recommended that a mental health professional – a MHPSS delegate or local psychologist – is present during the assessment, particularly to assist with training and preparing the interviewers. They can provide advice and supervise the psychological and psychosocial part of the assessment, which includes helping the team to adapt mental health questions to the cultural context. Technical expertise is also required to ensure that the assessment questions are translated into the local language. Furthermore, they can provide support to interviewers and families if they experience psychological difficulties during the interview process.

PROGRAMME DESIGN AND IMPLEMENTATION

The needs identified during the assessment are analysed and prioritized. Then, specific objectives and related strategies are defined, including the human resources requirements and the programme time frame.

In cases where MHPSS needs are identified as a high priority, a MHPSS delegate should assist, for a **minimum of 12 months**, in the design and implementation of the programme. If MHPSS needs are less urgent, a delegate might be involved for a shorter period of time (approximately 3–6 months).

The delegate will help to plan a programme that draws on local resources to address needs, and to define the activities to be performed by the ICRC or other actors. As in the case of the needs assessment, a participatory approach that includes families, communities and local actors will enhance ownership of the programme and help to adapt it to the local setting.

MHPSS programmes cover both mental health and psychosocial activities. Psychosocial activities benefit the families and their communities, while mental health activities are aimed at family members who require more specialized psychological support.

TARGET GROUPS

1. Direct: The families of missing persons

Families are targeted as a unit because the uncertainty of not knowing the fate or whereabouts of a relative can have a direct or indirect impact on all family members. Common problems include disagreements over the fate of the missing person, different coping mechanisms, communication problems between family members and challenges associated with a change of role. In many sociocultural contexts, families include an extended network of people who live under the same roof or have a close relationship to one another.

Individual family members may require specialist psychological support. They may experience distressing uncertainty, guilt, anger and lack of interest in other aspects of their lives. They may blame themselves and vacillate between hope and despair.

2. Indirect: The community

Missing persons are part of a community (ethnic, religious, political, etc.) and their disappearance will have an impact on the groups to which they belong. MHPSS interventions target these groups in order to address problems such as stigma, the absence of rituals or social isolation, and to foster social support networks. They also target service providers in the community through sensitization and training activities.

SPECIFIC OBJECTIVES

What the MHPSS part of an accompaniment programme aims to provide:

MHPSS support for the families of missing persons

From a total of XX families of missing persons in [specify], XX families in location(s) XX will have their psychological and psychosocial needs addressed by local service providers. This will be done through the work of the ICRC [specify the type/content of MHPSS interventions].

What the overall accompaniment programme aims to provide:

Multidisciplinary support for the families of missing persons

XXX families [specify number] in XXX [specify district, region, country] have improved their capacity to deal with psychosocial and psychological, socio-economic, legal, administrative and other issues with the help of a network of accompaniers [specify as relevant – families themselves, organizations including the ICRC and the National Society, governmental and non-governmental service providers], during XXX group sessions [specify number] and – if indicated – XXX individual sessions [specify number].

The network of accompaniers aims to become self-sustaining, through XXX training workshops [specify number], support and coaching by the ICRC and XXX local experts [specify number] of XXX local resources (accompaniers) [specify number] during the period of XXX [specify time].

METHODS

Group-based support for the families of missing persons

Group-based activities are a key element of accompaniment programmes. They bring the families of missing persons together, create a supportive environment, and promote peer support, feedback and reciprocal care.

The order of these activities and the number of sessions provided as part of the accompaniment programme cycle depends on the needs identified and the specific situation. A sample set of activities, drawn from a number of existing accompaniment programmes, is set out below.

ACTIVITY	PURPOSE	METHODOLOGY	EXPECTED OUTCOMES
Support groups	To provide family members with basic psychological and psychosocial support through shared experiences and social interaction.	Groups facilitated by an accompanier and/or a mental health practitioner. An average of 6 to 10 sessions at regular intervals.	Family members: <ul style="list-style-type: none"> • strengthen their support network; • reduce their psychological distress; • improve their daily functioning; and • enhance their knowledge and ability to apply new or existing positive coping mechanisms. Family members with more acute mental health needs receive appropriate referrals.
Visits to existing support groups	To motivate and increase the self-confidence of family members who are apprehensive about participating in a support group.	Family members are invited to attend existing support groups facilitated by an accompanier and/or mental health practitioner.	Family members have the necessary information about support groups and feel more comfortable participating in such groups.

ACTIVITY	PURPOSE	METHODOLOGY	EXPECTED OUTCOMES
Information sessions	To provide useful information on relevant topics (e.g. common MHPSS issues, the services available).	<p>Sessions are facilitated by an accompanier and/or mental health practitioner and/or other experts.</p> <p>Sessions are tailored to the target group – general information is provided to a large group of people in a public place while specific information is given to a smaller, more select group (e.g. the mothers or siblings of missing persons).</p>	<p>Family members have sufficient knowledge of topics of concern.</p> <p>Family members know what services are available and how to access them.</p> <p>Appropriate referrals to specialized services are made when necessary.</p>
Commemorative activities	To provide an opportunity for family members to remember their loved one in a positive way, share their pain with those in their social setting and, together with others in the community, pay public tribute to their relatives.	<p>Family members participate in planning the ceremony.</p> <p>Relevant actors are invited to participate, e.g. traditional healers, community leaders, political party officials and government officials at local level.</p> <p>The event is overseen by an accompanier and/or mental health practitioner.</p>	<p>Family members are able to maintain positive memories of their loved ones.</p> <p>Communities and/or local/national authorities acknowledge the families of missing persons and reduce marginalization.</p>
Group sensitization sessions	To provide information and sensitize specific groups about the MHPSS needs and concerns of the families of missing persons.	<p>Activities are tailored to the audience and specific issues of concern. Target groups include family members, traditional healers, community leaders, political party officials and government officials at local level.</p> <p>Sessions are facilitated by an accompanier and/or mental health practitioner.</p>	<p>Communities and/or local/national authorities understand the specific needs of families of missing persons and reduce marginalization.</p> <p>Communities and/or local/national authorities become part of an enhanced support network for families of missing persons.</p>
International Day of the Disappeared	To publicly acknowledge the fate of missing persons and support the social reintegration of their families.	Relevant events are organized by an accompanier and/or mental health practitioner. Target groups include family members, traditional healers, community leaders, political party officials and government officials at local level.	<p>Family members are able to maintain positive memories of their loved ones.</p> <p>Family members are able to resume or improve their daily functioning by helping others.</p> <p>Communities and/or local/national authorities acknowledge the fate of the missing persons and reduce their sense of isolation.</p>

Individual and family-based support

Many programmes offer individual accompaniment, including home visits, individual and/or family consultations and referrals to other service providers. If people refuse to participate in group sessions but express certain needs and wish to benefit from personal accompaniment, individual consultations or home visits may be provided.

In programmes that support families during the recovery and identification of remains, individual and family-based support might be necessary at the various stages of the process.

The table below describes the circumstances in which this type of support is offered and how some of these elements are applied in the context of a given programme:

ACTIVITY	PURPOSE	METHODOLOGY	EXPECTED OUTCOMES
Home visits	<p>To encourage participation in the accompaniment programmes and provide psychological and psychosocial support to individuals and/or families who:</p> <ul style="list-style-type: none"> • are psychologically affected • are geographically isolated • have health problems that reduce their mobility • have little motivation or display passive behaviour • need to be monitored over time (require follow-up). 	<p>An accompanier and/or mental health practitioner visits the individual/family at home.</p> <p>The frequency and level of support depends on the family's needs: if home visits replace support group sessions (e.g. due to geographical isolation) the number of sessions is the same as for support group sessions, i.e. 6 to 10 sessions. If home visits are provided in addition to the support group as a follow-up measure (due to the family's psychological needs), an average of 3 to 5 sessions is provided.</p>	<p>Family members:</p> <ul style="list-style-type: none"> • are able to access support services; • are motivated to participate in accompaniment programmes; • reduce their level of psychological distress; • improve their daily functioning; and • enhance their knowledge and ability to apply new or existing positive coping mechanisms. <p>Other needs are identified and the appropriate referrals made.</p>
Office consultations	<p>To provide psychological and psychosocial support to individuals and/or families with specific needs and challenges that cannot be addressed during home visits or group sessions.</p>	<p>An accompanier and/or mental health practitioner provides individual and/or family support at their office.</p> <p>The frequency and level of the support depends on the needs of the family. If office visits replace support group sessions (e.g. due to geographical isolation) the number of sessions remains the same as that of support group sessions, i.e. 6 to 10 sessions. If office visits are provided in addition to support group sessions as a follow-up measure (due to the family's psychological needs), an average of 3 to 5 sessions is provided.</p>	<p>Individuals with challenges that cannot be addressed during group sessions or home visits receive assistance.</p> <p>Open access and referral to other service providers is encouraged.</p> <p>Individuals are motivated to take action.</p>
Referrals	<p>To provide support to individuals and/or families whose needs cannot be met using the resources of the accompaniment network, by referring them to other service providers (e.g. government institutions, other NGOs, funds, etc.).</p>	<p>An accompanier, mental health practitioner or other relevant practitioner refers individuals and/or families with specialized needs, at any stage of the accompaniment cycle.</p>	<p>Specialized service providers are mobilized to assist family members.</p> <p>Family members' specific needs are addressed.</p> <p>Family members use the available services and are motivated to take care of themselves and each other.</p>

MONITORING AND EVALUATION

Programmes designed to support the families of missing persons use the accompaniment framework. By collecting and reviewing feedback, steps are taken to ensure that strategies and activities are context-specific and culturally appropriate. Given that accompaniment combines various forms of support activities, regular monitoring ensures improved multidisciplinary coordination. The ICRC's comprehensive MHPSS data collection tool provides a consolidated platform for data collection and analysis.

All indicators are defined prior to the start of the programme and a time frame is established. Examples of the output and outcome indicators used to measure the effectiveness of interventions are listed below:

INDICATOR	REASON FOR USE
Output	
Number of accompaniers trained to provide MHPSS	<ul style="list-style-type: none"> Provides information on the availability of MHPSS services (accompaniers) to support the families of missing persons
Number of trained accompaniers who are supervised	<ul style="list-style-type: none"> Provides information on the quality of follow-up and monitoring measures Helps to plan human and other resources (refresher training and level of support provided by a supervisor/mental health professional)
Number of family members with MHPSS needs who access MHPSS services	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Serves as a basis to calculate MHPSS services coverage Helps to plan human and other resources
Number of family members with MHPSS needs receiving individual, group or family MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs for particular services Monitors use of MHPSS services Serves as a basis to calculate MHPSS services coverage Helps to plan human and other resources
Number of family members referred to specialized mental health services / Number of family members with MHPSS needs	<ul style="list-style-type: none"> Provides information on MHPSS needs that meet the criteria for referral Provides information on the feasibility, appropriateness and effectiveness of the continuum of care Provides information on the ability of accompaniers to identify cases that require referral and to refer those people
Outcome	
Number of family members who display reduced distress / Number of family members receiving MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services
Number of family members who display improved functioning / Number of family members receiving MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services
Number of family members who display improved coping / Number of family members receiving MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services

As accompaniment uses a multidisciplinary approach, indicators relating to other components (i.e. not MHPSS) are incorporated into the monitoring and evaluation process, depending on the needs of families in a given setting. Examples of output indicators that describe referral pathways to other forms of accompaniment include:

INDICATOR	REASON FOR USE
Output	
Number of family members referred to legal services	<ul style="list-style-type: none"> • Provides information on legal needs that meet the referral criteria • Provides information on the feasibility, appropriateness and effectiveness of the continuum of care • Provides information on the ability of accompaniers to identify cases that require referral and to refer those individuals
Number of family members referred to economic services	<ul style="list-style-type: none"> • Provides information on economic needs that meet the referral criteria • Provides information on the feasibility, appropriateness and effectiveness of the continuum of care • Provides information on the ability of accompaniers to identify cases that require referral and to refer those individuals
Number of family members referred to medical services	<ul style="list-style-type: none"> • Provides information on medical needs that meet the referral criteria • Provides information on the feasibility, appropriateness and effectiveness of the continuum of care • Provides information on the ability of accompaniers to identify cases that require referral and to refer those individuals
Number of family members referred to protection services	<ul style="list-style-type: none"> • Provides information on protection needs that meet the referral criteria • Provides information on the feasibility, appropriateness and effectiveness of the continuum of care • Provides information on the ability of accompaniers to identify cases that require referral and to refer those individuals

GLOSSARY OF TERMS USED IN MONITORING AND EVALUATING MHPSS PROGRAMMES FOR FAMILIES OF MISSING PERSONS

MHPSS needs: Categorized by levels of distress, functioning and coping, measured using standardized scales.

Family member: Relative of a missing person (detailed definition provided under Issues of Concern).

Distress: Levels of distress are measured using standardized scales.

Functioning: Levels of functioning are measured using standardized scales.

Coping: Coping mechanisms are measured using standardized scales.

Legal services: Services addressing legal needs.

MHPSS/MHPSS services: Support/services addressing mental health and psychosocial needs, provided as part of an MHPSS programme.

Specialized mental health services: Services addressing the needs of people with severe/complex mental health problems, including psychiatric disorders.

Economic services: Services addressing economic needs.

Medical services: Services addressing medical needs.

Referral: The specific needs of a family member are identified and the individual is then put in touch with an appropriate service to address his/her needs.

Trained to provide MHPSS: Levels of MHPSS training provided will vary depending on the needs of the victims, availability of local mental health practitioners, the gap between needs and the availability of MHPSS services, and the competences and availability of the accompaniers being trained. It may include a range of basic psychological support techniques and/or more in-depth psychotherapeutic techniques tailored to the needs of victims.

MAIN CHALLENGES FOR PROGRAMME IMPLEMENTATION

- **Multidisciplinary approach**

The multidisciplinary approach used in accompaniment programmes is both a source of strength and a major challenge. Effective accompaniment programmes are based on the outcome of the needs assessment, and ensure an appropriate response to those needs. To that end, it is crucial that field teams work together in a coordinated way to provide an integrated response.

- **Long-term support**

If they are to be effective, programmes to support the families of missing persons must adopt a long-term approach from the outset; the process of trying to find out what happened to missing relatives, and dealing with the aftermath of their disappearance, is inevitably long and slow.



3. VICTIMS OF VIOLENCE

ISSUES OF CONCERN

Violence³¹ devastates lives, breaks up families and communities and threatens development. It is estimated that approximately one fifth of the world's population is affected by some form of conflict, violence or insecurity.³² Violence, which is becoming widespread at both national and regional level, destroys social and economic progress. New types of conflicts are emerging: cross-border, urban and/or highly volatile. Although the number of international conflicts is falling, internal armed conflicts and long-lasting situations of violence are on the rise.

Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.

WHO definition³³

As the dynamics of violence and conflict become more complex, so does their impact on the population. More people are dying as a result of conflict, violence or insecurity,³⁴ while the psychological and social impact of conflict is becoming increasingly far-reaching. Armed conflicts and other situations of violence often result in a huge surge of internally displaced people and refugees, which puts enormous pressure on social services and, in some cases, can lead to a total collapse of basic infrastructure. Violence separates families and tears communities apart, undermining or destroying social support networks. In this climate of danger, uncertainty and loss, victims/survivors³⁵ of violence are likely to face long- and short-term mental health and psychosocial difficulties. At a time of extreme psychological distress, when people's basic ability to function on a daily basis has been diminished, a lack of quality mental health and psychosocial services means that the majority of victims are unable to access care. In cases where humanitarian assistance efforts are hampered by violence, access to care is even more difficult.

Victims of sexual violence are a vulnerable group that requires special support during armed conflict and other situations of violence. Sexual violence becomes more prevalent when protection, security and justice systems are weakened. Indeed, it is often used as a strategic method of warfare. Sexual violence is a widespread and devastating problem, with wide-ranging consequences for the victims, their families and the communities affected. It is an act of violent domination rooted in a complex web of cultural prejudices, especially with regard to gender roles. Conflict-related sexual violence includes rape, sexual slavery, sexual exploitation, forced prostitution and any other form of sexual violence that is directly or indirectly linked to conflict.

³¹ For the purposes of this document, "victims of violence" includes victims of sexual violence and children affected by violence.

³² World Bank Group, *World Development Indicators 2016*, World Bank Group, Washington, D.C., 2016

³³ WHO, *World Report on Violence and Health: Summary*, WHO, Geneva, 2002, p. 4

³⁴ Institute of Strategic Studies (ISS), *The Armed Conflict Survey 2015*, ISS, 2015

³⁵ While the ICRC recommends using the term "victim" to describe individuals who have suffered acts of violence, and particularly acts of sexual violence in order to emphasize that it constitutes a grave breach of international law, there has been some criticism of the term as disempowering and implying weakness, powerlessness and passivity. Resilience literature advocates the term "survivor" to connote agency, enthusiasm and activeness when describing individuals who have suffered violence, as well as to prevent negative biases in the organizations and service providers that use such labels. These ICRC guidelines thus use the terms "victim" and "victim/survivor" to better illustrate the complex identities of those who have suffered violence and must deal with its consequences. For these reasons, both terms are used in this document.

The majority of conflict-related sexual violence victims are women and girls. Men and boys are also targeted and are particularly vulnerable when in detention or when forcibly recruited by armed forces and/or groups. It is not unusual that victims of sexual violence are revictimised, being raped multiple times during their life by different perpetrators and groups of perpetrators.

Sexual violence: Acts of a sexual nature imposed by force, threat of force or coercion owing to the threat of violence, duress, detention, psychological oppression or abuse of power, which may be perpetrated against women, men, girls or boys. Sexual violence can include any of the following acts: rape, sexual slavery, forced prostitution, forced pregnancy, forced sterilization, or any other form of sexual violence of comparable gravity. Sexual violence is not limited to physical violence and does not have to include physical contact. It can encompass anal and vaginal rape; forced nudity; forced masturbation; forced raping of others; being forced to witness the rape of others, including family, friends or co-detainees; use of instruments on genitals; trauma, for example through beatings with sticks, wire, etc.; and verbal sexual threats.

*ICRC definition*³⁶

Even outside of crisis situations, sexual violence often goes unreported for a number of reasons: victims may fear retaliation or think that no-one will believe them; or they may lack support or have lost faith in the public services available. Many victims of sexual violence fear being ostracized or stigmatized; they may even fear being harmed or killed by their family or community if they disclose what happened to them or seek help. Often, perpetrators of sexual violence are known to the victim – they may be the breadwinner in the family or provide financial remuneration for sexual acts. In such cases, the victim may feel trapped and hopeless, leading to further psychological and psychosocial harm.

These problems are exacerbated in conflict settings, thereby increasing the likelihood that incidents of sexual violence will go unreported and unaddressed. In cases where care is available, victims face an excruciating choice: if they seek treatment, they may have to disclose information and potentially face rejection and stigma; if they tell no-one, they will have to carry their burden of pain, grief and shame alone. This may harm their health and well-being in the short and long term.

Children are another vulnerable group that requires special consideration, particularly children who have been separated from their primary caregivers. Without the protection and care of their families at a time when they need it the most, they are often more vulnerable to hunger, disease, violence, military recruitment, exploitation and sexual assault.

³⁶ Based on the definition given in the *Rome Statute of the International Criminal Court* and the Court's *Elements of Crimes*.

A separated child is a child separated from both parents, or from his/her previous legal or customary caregiver, but not necessarily from other relatives.

A separated child, thus, might be accompanied by other adult family members.

An unaccompanied child, also called an unaccompanied minor, is a child who has been separated from both parents and other relatives and is not being cared for by an adult who, by law or custom, is responsible for doing so.

Definition adapted from the Inter-Agency Guiding Principles on Unaccompanied and Separated Children³⁷

A child associated with an armed force or armed group refers to any person below 18 years of age who is or has been recruited or used by an armed force or armed group in any capacity, including but not limited to children, boys and girls, used as fighters, cooks, porters, messengers, spies or for sexual purposes. It does not only refer to a child who is taking or has taken a direct part in hostilities.

Definition adapted from The Paris Principles³⁸

Victims of violence, including victims of sexual violence and children, may find it very difficult to obtain assistance. When assistance is provided, the caregivers' prejudices or lack of training may make victims feel guilty, re-victimized or stigmatized. Fear and shame lead to silence, making it difficult to identify people in need of support.

MENTAL HEALTH AND PSYCHOSOCIAL NEEDS

Victims of violence in conflict situations may be simultaneously exposed to many different types of violence: the violent deaths of family members or friends, forced exile or displacement and the loss of everything dear or familiar, including their homes, possessions, customs and traditions. The cumulative impact of these experiences of violence on interpersonal relationships can be disabling and chronic. Victims may be unable to fulfil their familial responsibilities, such as taking care of the household, looking after children or going out to work. Violence also has a collective impact on the psychosocial well-being of communities by weakening social cohesion and undermining coping mechanisms that could help victims recover. Thus, the psychological and psychosocial consequences of violence are very closely correlated and impossible to untangle.

Victims of violence experience a wide range of mental health and psychosocial problems. However, common psychosomatic symptoms include headaches, backache and abdominal pain, resulting in repeated, but ultimately futile, visits to health practitioners. Victims also frequently suffer from depression, anxiety and trauma-related symptoms, such as feeling emotionally numb, withdrawing from other people and reliving distressing experiences. They may develop unhealthy coping mechanisms, including

³⁷ ICRC, IRC, Save the Children, UNICEF, UNHCR and World Vision, *Inter-Agency Guiding Principles on Unaccompanied and Separated Children*, ICRC, Geneva, 2004: https://www.unicef.org/protection/IAG_UASCs.pdf

³⁸ UNICEF, *The Paris Principles: Principles and Guidelines on Children Associated with Armed Forces or Armed Groups*, 2007: <https://www.unicef.org/emerg/files/ParisPrinciples310107English.pdf>

self-harm, substance abuse and/or aggressive behaviour, which only cause further harm. In chronic cases, these symptoms often lead to significant levels of dysfunction and disability. The impact of the violence on the victim depends on a range of factors, including the victim's personal history, their relationship with the perpetrator(s) and whether the victim has a social support network.

Victims of sexual violence in particular suffer a very intimate form of violation. They may react very differently, but most victims find that the experience destroys their sense of personal safety and threatens their assumptions and beliefs about themselves and the world around them. The aftermath of an attack can be as punitive and painful as the incident itself: there is evidence that victims of rape exhibit high levels of psychological distress in the first week following the rape. Their distress peaks at three weeks post-rape and remains high for up to two more months, before finally abating.³⁹ In some cases, symptoms may develop into a trauma-related disorder and/or eventually lead to permanent behavioural or personality changes. Family and community members may humiliate, blame, reject or stigmatize victims, who often have to battle overwhelming feelings of shame, self-blame and fear. Whether or not victims speak about their experience, they are often left feeling isolated and vulnerable to further ill treatment.

Children affected by violence, especially those separated from their families and/or associated with armed forces, require specific care. It is more likely that children's psychological difficulties will manifest themselves as psychosomatic symptoms. Children may experience depression, anxiety, fear, anger and sleeping problems (e.g. insomnia, nightmares, bedwetting, sleepwalking and excessive sleep). They may constantly relive their traumatic experiences, remembering what they saw or were forced to do. As a result, they may suffer trauma-related symptoms – flashbacks, avoidance behaviours and hypervigilance. In the long term, children may continue to fear being taken away or may attempt to escape even when they are safe.

Children who have participated in hostilities as members of an armed group experience psychological difficulties when they are reintegrated into society and need to readapt to civilian life. Their experience is likely to have a direct impact on their behaviour and their relationships with others, including family members, peers and communities. Moreover, in the case of children who were driven to join an armed group by lack of work, violence at home, lack of a caregiver or a desire for revenge, their reintegration may prove extremely difficult, as they return to the same environment they wanted to leave behind.

When these children are reunited with their families, it can be difficult to reintegrate them into society. Family members and communities may dread the return of someone they consider as more of a perpetrator than a victim, especially if the child was forced to commit atrocities and violence during their separation. Thus, the child may face stigma or even outright rejection. Children may also feel misunderstood and isolated if their community does not recognize certain skills they acquired and for which they were commended while part of an armed group – for instance, their leadership and fighting abilities. It is especially important for communities and relatives to help children returning from an armed group to reintegrate into normal life. Reunited families have to learn new ways of relating to one another and need to create a new family dynamic. Children are more likely to suffer mental health and psychosocial problems after a prolonged separation, particularly if they have been reunited with distant relatives or when the family is in very difficult financial circumstances.

When responding to the needs of children, protecting their well-being and interests must be at the centre of all activities.

³⁹ R. Campbell, "Mental health services for rape survivors: Current issues in therapeutic practice", *Violence Against Women Online Resources*, 2001, pp. 1–9

THE MENTAL HEALTH AND PSYCHOSOCIAL RESPONSE

The ICRC strives to respond to the suffering and needs of people affected by armed conflict and violence, and to address both the causes and effects of such circumstances. Its activities are multidisciplinary and include taking preventative measures, providing victims/survivors with assistance (curative and follow-up) and protecting vulnerable individuals and groups.

An effective response requires a strong psychosocial framework, in order to make it easier and safer for victims to come forward. To that end, it is important for programme planning to take the sociocultural context of the violence into account, to facilitate community participation and to build trust between service providers and communities, all of which takes time.

The planned response needs to incorporate medical, psychological and psychosocial care. As outlined in the ICRC 2014–2018 Health Strategy, an integrated health response is required in order to deliver a continuum of care for victims of armed conflict and other situations of violence.

Although victims rarely talk openly about their experiences, they may seek treatment for physical symptoms (e.g. injuries, fatigue, headaches, urinary tract infections, and/or sexually transmitted infections). Thus, health facilities (i.e. health posts, health centres and hospitals) can play a key role in helping to identify victims of violence. Likewise, it is important to consider the role of religious and community leaders, who are often trusted members of the community. Given that victims of violence may turn to them for support and guidance, community leaders can also help to identify people who require support.

In order to effectively address their needs, it is crucial to create a safe environment for victims of violence. This implies adopting a “do no harm” approach that extends beyond clinical management. Victims need to be able to disclose the details of the violence they have suffered to service providers without risking further stigma. Health care activities, whether in health facilities or at the community level, must be discreet and target all people affected by violence, protecting the identity of specific victims (particularly victims of sexual violence) and ensuring complete confidentiality.

NEEDS ASSESSMENT

Assessing the psychological and psychosocial needs of victims of violence is a challenge that must be approached with care. It is difficult to identify victims, especially victims of sexual violence, in order to assess their needs, identify entry points and design an appropriate multidisciplinary programme. As victims are reluctant to reveal the details of their experience, an assessment needs to detect invisible and unspoken problems. Moreover, service providers are often unwilling to acknowledge that a sexual assault took place. This reluctance, together with the victim’s silence, makes it difficult to detect problems. It is therefore important that the needs assessment process creates a space that can overcome silence and reluctance; psychological and psychosocial considerations are pivotal in this regard.

Entry points are existing mechanisms of support that victims recognize, trust and are able to access. An effective response to victims' needs works by strengthening entry points so that victims can be identified and offered support and followed up in a way that is accessible, retains their trust, and does not perpetuate stigma.

Assessments must be conducted without forcing victims to disclose what happened to them. However, as traumatic memories may be triggered during the process, it is important to avoid further traumatizing victims when they are reliving horrific experiences. Mental health professionals are valuable during this process as they have the skills to provide psychoeducation (i.e. information about specific psychological reactions and positive coping strategies) and psychological support and, if necessary, can also refer victims. Moreover, victims may open up if they see that the interview and/or the group discussion is not simply an information-gathering exercise.

A survivor-centred needs assessment is a participatory process that takes into account victims' existing coping mechanisms, suggestions and expectations. Victims need to be asked where and to whom they turn for help. Questions posed include: *When you feel the need to talk about what you have experienced, is there anyone in the community that you talk to? If you are feeling physically unwell as a result of what happened to you, where do you go to seek help?* The answers to these questions provide information about possible "entry points" for an MHPSS response.

As part of the ICRC's comprehensive survivor-centred needs assessment, the following aspects are considered:

Victims: Identify and refer (if necessary) victims of violence; assess specific risk factors, vulnerable groups and their needs; identify the current health needs, concerns and strengths of victims and communities, including social support (rejection/inclusion) and their perception and experience of stigma.

Health facilities: Assess the potential of health facilities to care for victims at both primary and secondary care level, including health posts, health centres and hospitals, in cooperation with health professionals. For victims of sexual violence, include the type(s) and availability of medical treatment for adequate clinical management.⁴⁰

Stakeholders: Map key actors in the community and at health facilities involved in caring for victims of violence. Assess the effectiveness of existing services, including health, mental health and psychosocial services.

Community involvement: It is essential to involve key community actors, as victims of violence are often afraid to contact formal services. Identify both community resources and obstacles to meeting the needs of victims, including barriers to access. The assessment will also help to identify the attitudes and practices of key actors within the health, psychosocial, security, human rights and legal sectors (the ICRC health and protection teams do this together). Another important legal aspect to consider is the issuance of a medical certificate in line with existing legislative provisions.

⁴⁰ See WHO and UNHCR, *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons* (revised edition), WHO and UNHCR, Geneva, 2004: <http://whqlibdoc.who.int/publications/2004/924159263X.pdf?ua=1>

Methods used to collect this information include semi-structured (individual/small group) interviews with:

1. community members, grouped by gender (e.g. when focusing on sexual violence it is recommended that women and men are separated) and age;
2. informal service providers, including community leaders (e.g. religious leaders, traditional birth attendants, women's groups/associations);
3. health service providers (e.g. doctors, nurses, mental health professionals and midwives);
4. other relevant stakeholders.

When assessing the needs of victims/survivors of sexual violence through group or individual interviews conducted in a safe space, it is vital to ensure confidentiality and privacy. The topics for these groups and individual interviews need to be broad enough to provide opportunities for victims to talk about their experience of sexual violence without explicitly inviting them to do so (e.g. reproductive health, women's health or violence in general). This will ensure that the assessment process does not further dis-empower or stigmatize the victims/survivors.

Determining whether to hold group and/or individual interviews depends on local socio-cultural practices and beliefs. In some settings, it may be possible to interview women together in groups, while in others, a male leader will ask to be present – which may discourage women from speaking openly. Similarly, in certain situations, holding the interviews at the victim's home might guarantee privacy, while in others, people may not want to disclose what happened to them within earshot of their relatives. Socio-cultural factors also need to be taken into account when deciding on whether male or female assessors, translators, interviewers or group facilitators should be involved.

As sexual violence is severely underreported, its prevalence cannot be determined from the number of recorded cases alone. Mechanisms to actively identify victims need to be employed during the assessment process. This may include asking health providers about the number of patients presenting with symptoms or signs suggestive of sexual violence (e.g. unexplained injuries, sexually transmitted infections, urinary tract infections, psychological symptoms indicative of violence, etc.).

In order to collect a comprehensive range of information, it is recommended that a minimum of ten (individual or group) interview sessions is held in each location, over a **minimum period of three months**. Further information can be gathered from secondary sources, including reports produced by international organizations, NGOs, human rights organizations and reviews containing public information. When assessing the relevance and feasibility of integrating MHPSS care into health facilities, the ICRC uses the Checklist for Integrating Mental Health in Primary Health Care in Humanitarian Settings⁴¹ developed by the World Health Organization (WHO) and the Office of the United Nations High Commissioner for Refugees (UNHCR). This checklist is mainly used in focus group discussions with health workers.

Following the assessment, a comprehensive report outlining detailed recommendations for programme design, including the strategy, the time frame, and the financial and personnel resources required, is drafted. The cross-cutting nature of mental health and psychosocial needs means that a multifaceted analysis of the problem must be carried out at the outset, and the resulting recommendations need to be multidisciplinary in nature. When assessing the needs of victims of armed conflicts and violence, ICRC teams (e.g. health, economic security, water and habitat, and protection) conduct joint in-depth needs assessments.

⁴¹ WHO and UNHCR, Checklist for Integrating Mental Health in Primary Health Care in Humanitarian Settings, in *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Settings*, WHO and UNHCR, Geneva, 2012

PROGRAMME DESIGN AND IMPLEMENTATION

MHPSS programmes can be implemented during an emergency (short term) or during situations of chronic violence (medium or long term). In both scenarios, an MHPSS delegate must assess, design, implement and supervise the programme. Emergency programmes may last from **3 to 6 months**, while in chronic situations of violence it is recommended that a programme is implemented for at least **12 months**. In all programmes, MHPSS field officers/local psychologists need to be recruited as soon as the programme starts in order to build local ownership and capacities.

Due to the diversity of contexts and needs, there is no one-size-fits-all response for victims/survivors of violence; programmes are tailored to the entry points identified by victims, the cultural specificities and the health needs. The level of involvement and the level of support provided depend on the needs and resources ascertained during the needs assessment, as well as on the objectives and the expected programme outcomes. Entry points (i.e. existing mechanisms of support recognized, trusted and accessed by victims) are reinforced in order to step up the medical, psychological and psychosocial support for victims, while the type of entry point determines the characteristics of the programme and its activities:

1. If health facilities (i.e. health posts, health centres and hospitals) are considered the best entry point, the programme will focus on training health staff to provide medical and basic psychological care (psychotherapeutic training may be provided in specific situations) and, where possible, embedding a mental health practitioner in the facility. In both cases, it is necessary to set up an outreach team whose task is to develop a psychosocial support network.
2. If the best entry point is provided by community services (e.g. religious leaders, community leaders, grassroots organizations), the programme will focus on strengthening their provision of psychological and psychosocial support, while medical care will be addressed through referrals.



1. Integrating programmes for victims/survivors of violence (including sexual violence) into health facilities

There is international consensus that the delivery of mental health care in health facilities (e.g. health posts, health centres and hospitals) is key to providing a comprehensive service. MHPSS is best delivered within a pyramid of care where primary health care works as a bridge between informal community care and self-care on the one hand, and specialized mental health facilities and services on the other.

The Declaration of Alma-Ata, adopted in 1978, was the first international declaration to underline the importance of primary health care and played a fundamental part in laying the foundations for protecting and promoting health throughout the world.⁴² In its first principle, the Declaration reaffirms the WHO's definition of health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity".⁴³ The Declaration further states that primary health care is about providing "essential health care" that is based on people's needs and is universally accessible to individuals and families in the community, thus provided as close as possible to where people live and work.

Both the WHO⁴⁴ and the IASC⁴⁵ recommend integrating basic MHPSS services into primary health care facilities in order to narrow the mental health gap, i.e. to improve access to care for people with common mental health disorders. As well ensuring better access to MHPSS care, this approach also obviates the stigma attached to being treated at a psychiatric facility. Integrated MHPSS services facilitate early identification and treatment in a supportive environment, with effective follow-up.

In order to best respond to victims' MHPSS needs, the ICRC focuses on strengthening primary health care facilities, which serve as key entry points for providing mental health care. This approach includes emphasizing the timely use of post-rape kits, which contain essential medications and equipment to treat rape victims appropriately,⁴⁶ and making sure that health staff understand that patient follow-up is key to ensuring compliance with treatment. Health staff at these facilities (e.g. doctors, nurses and other generalist clinicians who represent the first line of treatment) are trained to identify victims of violence by asking screening questions and to assist them by providing basic psychological support. The standard approach includes training, coaching and close follow-up, in order to enable health staff to provide MHPSS support in the form of individual consultations and, if necessary, to refer victims to a mental health practitioner embedded in the health facility or to specialized mental health services. In certain situations, health staff may themselves be trained to provide psychotherapeutic support. However, due to the high workload and time pressures that staff already face, this approach is not as common.

When assisting victims of violence, particularly victims of sexual violence, in health facilities, it is essential to ensure confidentiality and privacy. This approach involves handling them with sensitivity and registering their cases with discretion. It is also important to avoid attaching labels to the services provided that might further stigmatize

⁴² Declaration of Alma-Ata, adopted at the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978

⁴³ Constitution of the World Health Organization, adopted in 22 July 1946

⁴⁴ WHO & World Organization of Family Doctors (Wonca), *Integrating Mental Health into Primary Care: A Global Perspective*, Singapore, 2008; WHO, *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings* (version 2.0), WHO, Geneva, 2016

⁴⁵ IASC, *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, IASC, Geneva, 2007

⁴⁶ For more information, see WHO and UNHCR, *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons* (revised edition), WHO and UNHCR, Geneva, 2004: <http://whqlibdoc.who.int/publications/2004/924159263X.pdf?ua=1>

or harm victims (e.g. by avoiding terms such as “rape clinic” or “sexual violence centre”). Ideally, psychological support should be incorporated into the framework of existing services. Psychological support can be provided either by training staff already working in these services, or by employing trained counsellors or psychologists to provide support services to all victims of violence and to prevent stigma.

In acute crises where primary health care facilities have stopped functioning, the ICRC deploys mobile health units to provide emergency medical care. It may be possible to temporarily incorporate MHPSS activities into the services provided by mobile health units, until the permanent health facilities reopen.

2. Integrating programmes for victims/survivors of violence (including sexual violence) into community services

The capacities of local community actors (identified as suitable entry points for providing assistance) are developed using a participatory approach. These actors, including community leaders or heads of women’s groups, are empowered to provide appropriate and effective support to victims of violence. The training provided allows them to incorporate psychological support into their existing activities. In addition, existing mental health service providers are mapped and community actors are trained to identify victims who require referral to more specialized services.

Trained community actors can run support groups that address mental health and psychosocial problems. Those support groups can help individuals who refuse to seek help or decide to discontinue treatment because of barriers to access. They can also be very effective in cultures that value community relations and social cohesion.

Information and sensitization

Victims must often navigate an institutional labyrinth to access services, which can be a confusing and demoralizing experience. The ICRC can train and empower key community members to serve as the first point of contact for victims of violence. For victims of sexual violence in particular, outreach teams can provide information and support before, during and after medical treatment. Outreach work serves as a safety net to facilitate access to care in situations where the health system cannot cope with demand or would lead to stigma.

Outreach activities include broad information and sensitization campaigns. Outreach teams provide information on the availability and location of services, motivate people to seek support, and follow up on victims at the community level. They also teach people to recognize the signs of psychological distress, the consequences of violence and the negative impact of stigma. The aim of these activities is to encourage victims to seek help and to reduce stigma. Moreover, outreach activities improve the general functioning of health facilities by creating a real interaction with the community.

In order to ensure that victims of violence have access to comprehensive care, it is crucial to build and maintain a well-functioning multidisciplinary referral system that properly respects patient confidentiality. An effective system includes a range of services, such as clinical/medical management, physical safety and shelter, legal and social services and psychological support. It may also offer links to services that promote further education and economic empowerment. All of these elements can contribute to recovery. Victims should not be asked the same questions by different service providers. It is therefore essential for all service providers to coordinate and share information, while maintaining confidentiality and working to protect victims and prevent further harm.

Specific considerations for children

Family members are often separated from each other during armed conflicts and other situations of violence. Part of the ICRC work is to reunite families. This process is often idealized as a quick return to “normality”. However, depending on what occurred during the period of separation, both adults and children may struggle with psychological difficulties that have an impact on their interaction with members of their family or community during and/or after the process of family reunification.

The ICRC has Restoring Family Links (RFL) teams to reunite separated families. The work of some of these teams includes MHPSS: the teams are taught to recognize the MHPSS needs of children and their families so that they avoid causing further harm during the family reunification process. Mental health professionals assist in building the capacity of RFL field teams to assess psychological and psychosocial needs, provide basic psychological support, identify children with more severe mental health needs and refer them to specialized service providers. After a family has been reunited, MHPSS issues are monitored and, if necessary, addressed during family visits.

In countries where MHPSS programmes (or other mental health services) run by trained counsellors are available, children with psychological needs can be referred. Where no MHPSS system exists, it is even more important to build the capacity of RFL teams to provide basic psychological support. If RFL teams are trained to understand the potential psychological and psychosocial difficulties that children and their families may experience, the family reunification process is likely to be more successful. While children are waiting for their family to be found, they are ideally placed in family-based alternative care rather than a residential institution. This is in the children’s best interests, as properly selected temporary host families provide an opportunity for children to interact within a family structure and a community. RFL teams are also trained to support these host families while they accompany children during this waiting period.

TARGET GROUPS

1. Direct: victims of violence (including victims of sexual violence and children)

Efforts are made to identify particularly vulnerable groups or individuals according to: gender; disability (physical or mental); age (paying specific attention to children separated from their families, children associated with armed groups, children born of rape, and the elderly); any other marginalized social group within the community; or victims of certain types of violent event (e.g. sexual violence).

2. Indirect: families of victims, health staff, key community actors, RFL field teams and community members in general.

SPECIFIC OBJECTIVES

The programme aims to provide MHPSS support to:

Victims of violence (including sexual violence) in health facilities

Patients in health facilities supported by the ICRC [SPECIFY, *type(s) / name of the facility (/ies) and/or location(s), etc.*] who are suffering from mental health problems and/or the psychosocial consequences of violence are properly diagnosed and treated, in line with national/international standards.

Victims of violence (including sexual violence) at community level

Victims of violence in [SPECIFY *type(s) of violence, e.g. urban, and location(s)*] have their psychological and psychosocial needs met by trained community actors.

Child victims of violence who need to be reunited with their families

Children separated from their families in/as a result of [SPECIFY, *e.g. location(s), reason(s) of the separation, etc.*] and/or their families and/or their foster families benefit from MHPSS support to address the psychological and psychosocial aspects of being reunited and to facilitate that process.

These objectives can be achieved by building the capacity of health staff and key community actors and providing group and individual support to victims/survivors.

METHODS

Capacity-building for health staff and/or key community actors to provide basic (individual or group) psychological support:

ACTIVITY	PURPOSE	METHODOLOGY	EXPECTED OUTCOMES
Advocacy	To embed mental health practitioners within the health facility.	Discuss with relevant local health authorities, including the management staff at the health facility, the importance of incorporating MHPSS into their services and employing on-site mental health practitioners.	Health authorities and the management staff at the health facility incorporate MHPSS into their services. The health facility includes mental health practitioners in its workforce.
Training local mental health practitioners	To teach and/or improve practitioners' skills to provide MHPSS to victims of violence, paying specific attention to victims of sexual violence and children.	Workshops with local mental health practitioners on the psychological needs of victims of violence and psychotherapeutic techniques used to address them. Workshops are conducted by ICRC MHPSS delegates. Workshops take place every week or two weeks, over 3 to 6 months (i.e. a period of time that allows the necessary content to be covered). Workshops include theoretical presentations, as well as group activities, role play, videos and case discussions.	Local psychologists or counsellors provide quality MHPSS support to victims of violence, including: identifying and treating symptoms of psychological distress; understanding the impact of distress on daily functioning; identifying current coping strategies and exploring positive coping strategies; fostering individual resources and social support networks. MHPSS data collection methods are used and, where possible, incorporated into the data collection tools used in the health facility. Other available services (e.g. mental health, economic, legal and social services) are mapped and, if possible, a referral system is established.
Training health staff	To establish and/or improve the skills of health staff to provide basic psychological support to victims of violence, paying specific attention to victims of sexual violence and children.	Workshops for health staff on basic psychological support. Topics include: listening skills, communication skills, how to collect information on the victim in a sensitive manner, how to spot psychological problems, prioritize needs, identify individual and social resources, and where to refer the victim for further care. If necessary, health staff may be given more in-depth psychotherapeutic training. Workshops for health staff on providing basic psychological support to victims of sexual violence, including the use of post-rape kits, and the importance of follow-up to ensure adherence to treatment. The schedule of workshops should be aligned with staff working hours (e.g. one hour per day over a period that is long enough to cover the course material, i.e. 1 to 3 months of regular training sessions). Workshops are conducted by mental health professionals (i.e. MHPSS delegates or local psychologists). Workshops include theoretical presentations, group activities, role play, videos and discussions.	Health staff have sufficient knowledge and skills to provide basic psychological support. Health staff have the capacity to provide solution-oriented counselling, including a "golden session" (because victims in violent situations are unlikely to come for follow-up, the first session may be the only one they will receive). Health staff have the knowledge and skills to provide basic psychological support to victims of sexual violence, including the follow-up of patients taking post-rape medication. Health staff are involved in mapping other related services, and establishing a referral/follow-up system. Health staff are able to identify those with more severe psychological needs or other requirements, and make appropriate referrals (where services are available).

ACTIVITY	PURPOSE	METHODOLOGY	EXPECTED OUTCOMES
Training key community actors	To establish and/or improve the skills of community actors to provide basic psychological or psychotherapeutic support to victims of violence, paying specific attention to victims of sexual violence and children.	<p>Workshops with key community actors on basic psychological support. Topics include: listening skills, communication skills, how to collect information on the victim in a sensitive manner, how to spot psychological problems, prioritize needs, identify individual and social resources, and where to refer the victim for further care.</p> <p>Workshops with key community actors to provide knowledge and skills in psychotherapeutic support: psychotherapeutic techniques to address moderate psychological and psychosocial needs.</p> <p>Workshops with key community actors on providing specific psychological support to victims of sexual violence.</p> <p>Workshops on working with children, issues relating to family separation, the family reunification process and important MHPSS considerations.</p> <p>Workshops take place every week or two weeks over several months (the period of time varies, in order to ensure that all the course content is covered).</p> <p>Workshops are run by mental health professionals (i.e. MHPSS delegates or local psychologists).</p> <p>Workshops include theoretical presentations, group activities, role play, videos and discussions.</p>	<p>Key community actors have sufficient knowledge and skills to provide basic or in-depth psychological support to victims of violence (including sexual violence).</p> <p>Key community actors have the capacity to provide solution-oriented counselling, including a “golden session” (because victims in violent situations are unlikely to come for follow-up, the first session may be the only one they receive).</p> <p>Key actors have knowledge and skills relating to the following MHPSS issues: working with children, family separation, and the family reunification process.</p> <p>Key community actors are involved in mapping related services and establishing a referral/follow-up system.</p> <p>Key community actors are able to identify those with more severe psychological needs or other requirements (including medical needs), and arrange appropriate referrals.</p>
Training outreach teams	To develop a psychosocial support network in communities by establishing outreach strategies.	<p>Workshops with key community actors – taking place over a short period of time (2 to 4 weeks).</p> <p>Workshops are conducted by mental health professionals (i.e. MHPSS delegates or local psychologists).</p> <p>Workshops include theoretical presentations, group activities, role play, videos and discussions.</p>	<p>Outreach teams are able to provide information on the impact of violence on mental health, paying specific attention to sexual violence and vulnerable children.</p> <p>Outreach teams have the knowledge and skills to sensitize relevant groups on MHPSS, tailoring sessions to specific participants.</p> <p>Outreach teams have the knowledge and skills to identify victims of violence during information and sensitization activities and make appropriate referrals.</p> <p>Outreach teams are able to help victims obtain MHPSS support by efficiently guiding them through the institutional care system.</p>

ACTIVITY	PURPOSE	METHODOLOGY	EXPECTED OUTCOMES
Supervision	Ongoing monitoring and support for health staff and/or key community actors to consolidate the knowledge and skills gained during training.	<p>Regular visits to health facilities and regular meetings/discussion with health staff and/or key community actors, as required.</p> <p>Occasional participation in psychological support sessions.</p> <p>Case discussions with health staff who provide basic psychological support to patients or with key community actors who provide either basic psychological support or more in-depth psychological care to victims.</p> <p>Accompany and observe outreach teams during information campaigns and sensitization activities. Provide feedback on content and relevance of activities, communication skills, etc.</p> <p>Review community perceptions about the outreach team's role in the community, e.g. assess trust-building capability of outreach teams through interviews with community members.</p>	<p>Ownership of the programme and sustainability of psychological and psychosocial support is ensured.</p> <p>Quality psychological and psychosocial support services are provided by trained health staff and/or key community actors.</p> <p>Trained health staff and/or key community actors have the knowledge and ability to use a solution-focused approach and to respond to all the victims' needs.</p> <p>Trained health staff and/or key community actors are able to identify cases of severe psychological distress and psychiatric conditions and to refer these patients (if specialized services are available).</p> <p>Outreach teams understand key messages and get the support necessary to effectively communicate this information.</p> <p>Appropriate data collection methods are used.</p> <p>Areas that require further support are identified and refresher training activities are provided.</p>

MHPSS support is provided to victims of violence by mental health practitioners, health staff or key community actors through:

ACTIVITY	DESCRIPTION OF ACTIVITY
Individual consultations	People with symptoms of psychological suffering are identified and treated by local mental health practitioners, trained health staff or trained key community actors . In case of severe psychological needs, patients are referred to specialized services. An individual consultation lasts 30 to 40 minutes on average. The follow-up process may be supported by outreach teams.
Home visits	If mental health practitioners (e.g. counsellors or local psychologists) and/or trained key community actors and/or outreach teams are available , home visits may be arranged for victims with specific psychological needs. The aim of these visits is to provide support, identify further needs, assess individual, family and community resources and follow up on cases involving patients who are unable to access individual and/or group support sessions or who are unwilling to do so because they fear stigma. In certain cases, the patients may be referred to specialized services.
Group support	Groups are run by local mental health practitioners and/or trained health staff and/or trained key community actors and/or outreach teams . Participants must agree to maintain confidentiality. These groups may be open (new participants can join at any point) or closed (open only to participants involved from the start). The content depends on the needs of the participants. On average, groups run for 5 to 10 sessions, with a maximum of 12 participants, and last approximately 1.5 hours per session.

Information and sensitization:

Group sessions or home visits provide information and sensitize people to MHPSS issues. Group sessions held in public places may provide an ideal opportunity to reach out to the community, while home visits may be most appropriate for people who are less mobile, including the elderly, people with physical disabilities and homemakers.

Information activities organized by outreach teams use the following methods:

ACTIVITY	DESCRIPTION	ACTION TAKEN BY OUTREACH TEAMS
Public information	<p>MHPSS information provided to communities in large groups.</p> <p>Events held in public places (for example, markets or public squares) or via the most accessible/available media.</p>	<p>Define key information to be disseminated, including: health promotion messages (e.g. to motivate victims of sexual violence to seek support); guidance on where and how to access services; and descriptions of common psychological symptoms of distress as a result of violence.</p> <p>Define key messages for victims of sexual violence such as: the impact of sexual violence (medical, psychological and psychosocial consequences at both the individual and community level); where and how to access services; the importance of seeking help as quickly as possible (within 72 hours);⁴⁷ the treatment protocol at the health facility; and the accessibility (ideally 24/7) and cost (free of charge) of services.</p> <p>Inform communities by broadcasting messages, distributing leaflets and posters, using social media outlets, and/or radio broadcasts, etc.</p>
Group information	<p>MHPSS information provided to specific groups (e.g. young people, women, men, teachers or community leaders).</p> <p>Average time per session is approximately 1 hour.</p>	<p>Tailored information is provided to specific groups during presentations and discussions (the aim is to inform groups about the psychological symptoms of distress, create a safe space for participants to discuss their own experiences, and inform them about available services).</p>
Family information	<p>MHPSS information provided to family members (e.g. close relatives or extended family).</p> <p>Average time per session is approximately 1 hour per household.</p>	<p>Tailored information is provided to family members during home visits or at a convenient location (the aim is to provide information on psychological symptoms of distress, create a safe space for them to discuss their own experiences, and inform families about available services).</p>

Data collection tools are used to record the number of information activities implemented. Their effectiveness is monitored by recording the number of people who seek help as a result of MHPSS information activities.

Sensitization activities, implemented by outreach teams, are tailored in order to target specific issues.

ACTIVITY	DESCRIPTION	ACTION TAKEN BY OUTREACH TEAMS
Group sensitization	<p>MHPSS sensitization of mixed groups and/or specific groups (grouped by age, gender, religious affiliation, etc.).</p> <p>Events are held in public places within the community (e.g. youth centres, churches, mosques or schools).</p> <p>Average time per session is approximately 1 hour.</p>	<p>Inform community leaders and other key community members about the activity and, if necessary, obtain permission.</p> <p>Plan activities that engage the community, such as a theatre performance depicting a community member advising a person with psychological needs to go to a health facility, followed by a group discussion.</p> <p>Define the key messages that will be disseminated during the group sensitization activity.</p> <p>Use data collection tools to register participants, record their concerns and questions, and monitor changes in their perception of issues addressed during sensitization activities (e.g. stigma, health-seeking behaviour).</p>

⁴⁷ It is important to seek medical attention as soon as possible after a rape, so that the victim can be examined and evidence collected to support criminal prosecution. Medical treatment, including emergency contraception to reduce the risk of pregnancy and anti-retroviral medication, is most effective within 72 hours post-rape. For further information, see above note 46.

MONITORING AND EVALUATION

To support the monitoring process, various indicators can be used to assess the efficacy of MHPSS programmes aimed at victims of violence.

Since programmes to support victims of violence are implemented in health facilities and at the community level, indicators and data collection tools must be adapted accordingly. Regular monitoring improves multidisciplinary coordination of programmes that frequently combine several different kinds of support, such as medical care, psychological support, and information and sensitization activities.

Information about incidents of sexual violence is extremely sensitive and confidential. Divulging such information can have serious and potentially life-threatening consequences for the victims/survivors and those who help them. However, it is also important to collect data in order to understand broader trends and patterns relating to protection and prevention needs. Secure data collection protocols must put victims/survivors first and protect their identities. For example, data must remain anonymous and health providers must follow a strict code of confidentiality. The ICRC's comprehensive MHPSS data collection tool provides a consolidated platform for data collection and analysis.

All indicators are specified prior to the start of the programme and assigned a time frame. Some examples of the output and outcomes indicators employed to measure the effectiveness of interventions include:

Integrating programmes for victims/survivors of violence into health facilities

INDICATOR	REASON FOR USE
Output	
Number of health staff trained to provide MHPSS	<ul style="list-style-type: none"> Provides information on the availability of MHPSS services for victims of violence
Number of patients with MHPSS needs accessing MHPSS services	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Serves as a basis to calculate MHPSS services coverage Helps to plan human and other resources
Number of referrals made by health staff to specialized mental health services	<ul style="list-style-type: none"> Provides information on the extent of MHPSS needs that reach the referral criteria Provides information on the feasibility, appropriateness and effectiveness of the continuum of care Provides information on the ability of accompaniers to identify cases that require referral and to make referrals
Outcome	
Number of patients with MHPSS needs who show reduced distress / Number of patients receiving MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services
Number of patients with MHPSS needs who show improved functioning / Number of patients receiving MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services
Number of patients with MHPSS needs who show improved coping / Number of patients receiving MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services
Number of patients with MHPSS needs accessing MHPSS services due to information and sensitization sessions / Number of patients with MHPSS needs accessing MHPSS services	<ul style="list-style-type: none"> Monitors the effectiveness of MHPSS services, specifically of information and sensitization activities Provides information on the ability of outreach teams to identify cases that require referral and to make referrals Provides information on the extent of MHPSS needs reaching the referral criteria

Integrating programmes for victims/survivors of violence into community services

INDICATOR	REASON FOR USE
Output	
Number of key community actors trained to provide MHPSS	<ul style="list-style-type: none"> Provides information on the availability of MHPSS service providers for victims of violence
Number of referrals made by key community actors to specialized mental health services	<ul style="list-style-type: none"> Provides information on the extent of MHPSS needs reaching the referral criteria Provides information on the feasibility, appropriateness and effectiveness of the continuum of care Provides information on the ability of key community actors to identify cases that require referral and to make referrals
Outcome	
Number of victims of violence who show reduced distress / Number of victims of violence receiving MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services
Number of victims of violence who show improved functioning / Number of victims of violence receiving MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services
Number of victims of violence who show improved coping / Number of victims of violence receiving MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services

Specific considerations for victims of sexual violence

INDICATOR	REASON FOR USE
Output	
Number of health staff trained to provide MHPSS to victims of sexual violence	<ul style="list-style-type: none"> Provides information on the availability of MHPSS services for victims of sexual violence
Number of key community actors trained to provide MHPSS to victims of sexual violence	<ul style="list-style-type: none"> Provides information on the availability of MHPSS services for victims of sexual violence
Number of new sexual violence victims accessing services at the health facility	<ul style="list-style-type: none"> Provides information on the extent of sexual violence Provides information on the use of and access to health services Serves as a basis to calculate MHPSS services coverage Helps to plan human and other resources
Number of rape victims who consulted medical services within 72 hours	<ul style="list-style-type: none"> Provides information on access to health services for rape victims (i.e. help-seeking behaviour of victims/survivors) Provides information on the effectiveness of MHPSS services, specifically information and sensitization activities regarding accessing health services within 72 hours
Outcome	
Number of new sexual violence consultations in the health facility / Number of new consultations in the health facility (within a given time frame)	<ul style="list-style-type: none"> Monitors the number of victims of sexual violence accessing health services Provides information on access to health services (i.e. help-seeking behaviour of victims/survivors) Helps to plan human and other resources
Number of new rape victims who consulted health services within 72 hours / Number of rape victims who consulted health services (within a given time frame)	<ul style="list-style-type: none"> Provides information on access to health services for rape victims (i.e. help-seeking behaviour of victims/survivors) Provides information on the effectiveness of MHPSS services, specifically information and sensitization activities regarding accessing health services within 72 hours

Specific considerations for children

INDICATOR	REASON FOR USE
Output	
Number of RFL volunteers trained to provide basic psychological and psychosocial support to children during the reunification process	<ul style="list-style-type: none"> Provides information on the availability of MHPSS services for children in need of reunification
Number of child victims of violence with MHPSS needs accessing MHPSS services	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Serves as a basis to calculate MHPSS services coverage Helps to plan human and other resources
Outcome	
Number of child victims of violence who show reduced distress / Number of child victims of violence receiving MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services
Number of child victims of violence who show improved functioning / Number of child victims of violence receiving MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services
Number of child victims of violence who show improved coping / Number of child victims of violence receiving MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services

GLOSSARY OF TERMS USED IN MONITORING AND EVALUATING MHPSS PROGRAMMES FOR VICTIMS OF VIOLENCE

MHPSS needs: Categorized by levels of distress, functioning and coping, measured using standardized scales.

Rape victims: Victims of sexual violence who experienced penetration of the vagina or anus with any body part of another person or object, or oral penetration by a sex organ of another person, without the consent of the victim.

Distress: Levels of distress are measured using standardized scales.

Functioning: Levels of functioning are measured using standardized scales.

Coping: Coping mechanisms are measured using standardized scales.

MHPSS/MHPSS services: Support/services addressing mental health and psychosocial needs provided as part of the MHPSS programme.

Specialized mental health services: Services addressing the needs of people with severe/complex mental health problems, including psychiatric disorders.

Referral: The specific needs of a victim of violence are identified and the individual is then put in touch with an appropriate service to address his/her needs.

Trained to provide MHPSS: Levels of MHPSS training provided will vary depending on the needs of the victims, the availability of local mental health practitioners, the gap between needs and the availability of MHPSS services, and the competences and availability of the companions being trained. It may include a range of basic psychological support techniques and/or more in-depth psychotherapeutic techniques tailored to the needs of victims.

MAIN CHALLENGES FOR PROGRAMME IMPLEMENTATION

- **Workload of health staff**

Health staff who deal with victims of violence already have a heavy workload; while some may be eager to incorporate mental health activities into their daily work, others may be less motivated to do so or become overburdened. It can be a challenge to prevent this extra workload from jeopardizing the quality of services. Providing basic psychological support can also be challenging for health staff owing to language barriers, preconceptions about mental health issues, time pressures and personal aptitude. It is important that MHPSS services are tailored to the circumstances in order to strike a realistic balance between health staff's workload and patients' mental health needs.

- **Identifying victims of sexual violence**

Addressing and overcoming the silence associated with sexual violence is a major challenge. Victims face a difficult choice: seeking treatment means disclosing information and may lead to rejection and stigma; keeping quiet may significantly harm their health. The way to deal with this is to create an environment in which victims feel secure enough to speak out. This means not just creating a calm, private space where they can speak and be sure that what they say is kept confidential, but also ensuring that they are dealt with by supportive people from the outset.

Identifying male victims of sexual violence can be extremely complex. All over the world, the way societies view sexual violence against men can prevent the victims from accepting that they are victims, which leads to a long delay before they seek support. Sensitization and information activities may broach this issue, but it must be done in a culturally sensitive manner.

- **Providing an appropriate multidisciplinary response**

The needs of victims of violence (including sexual violence) go beyond MHPSS needs. To ensure all their needs are met, the response must be multidisciplinary. All the actors involved must work together, sharing relevant information while ensuring that sensitive information remains confidential.

- **Specific needs of children**

Dealing with cases of violence against children is particularly challenging, as it requires the agreement of their caregivers and the service providers. When there are no caregivers, service providers must make decisions based on the children's vital interests. To avoid perpetuating stigma, it is recommended that any MHPSS response involves all the children in the community, i.e. avoiding activities that only target specific groups of children, such as those associated with armed forces or children born of rape.



4. HELPERS

EMERGENCY CARE RESPONDERS
& KEY COMMUNITY ACTORS

ISSUES OF CONCERN

During armed conflict, other situations of violence and emergencies, it is primarily people from within affected communities who help others on a daily basis. These “helpers” are people facing the same difficulties as others in their community (they have lost relatives and friends, their homes have been destroyed, and they are living in a dangerous and unstable environment), yet they continue to provide help to others. Recognizing the double burden placed on these helpers, the ICRC focuses in particular on supporting those who channel their energy, efforts and knowledge into meeting the needs of their communities in the most challenging circumstances.⁴⁸

Helpers are people who hold a service-oriented front-line position. They are members of a community affected by armed conflict and violence and are people who others know, trust and approach for advice, relief and support. They have unique access to others in their community who are in need of assistance as well as important cultural insights that outsiders may not have. These individuals may be in either paid or voluntary positions.

Definition used in ICRC MHPSS programmes

In assisting others in situations of crisis, conflict and/or violence, helpers – across many different disciplines – often display a high level of motivation and concern for the welfare of others. Working in volatile and dangerous situations, with limited resources and in close proximity to the victims, helpers foster a sense of solidarity within communities that can help restore and stabilize the societal system.

While providing care and assistance to others can be incredibly rewarding, situations of ongoing violence and insecurity, disrupted social networks, long working hours and uncertainty about the effectiveness of their efforts, increase the likelihood of helpers experiencing distress. Helpers may experience insecurity and fear in their daily lives outside of work, making it particularly difficult to keep their personal and professional lives separate. While helpers are striving to meet the needs of others, their own basic needs (such as food and shelter) may not be met. This increases the burden placed on helpers and their families – striving to provide assistance to others, while struggling to meet their own needs at the same time. In addition, a difficult working environment, especially when combined with ineffective management, can significantly affect the well-being of helpers. They often do not get the recognition or rewards they deserve from their supervisors, which can negatively impact their morale and ultimately their performance.

Like everyone, helpers bring their own emotional vulnerabilities to crises. Personality styles, past or present mental health difficulties, existing coping strategies, and/or family dynamics may create blind spots that are exacerbated by the rigours of working in difficult circumstances. Some helpers may not take advantage of the usual sources of support, as they are too focused on the needs of others. These aspects, rather than ruling them out from assisting others, need to be understood and addressed in order

⁴⁸ In contrast to “helpers”, who are members of the affected community, ICRC staff receive support from the staff health team from the ICRC Department of Human Resources. This support is separate from operational MHPSS programmes in the field, which specifically focus on assisting individuals and communities affected by armed conflicts, other situations of violence and emergencies.

to support the effectiveness and endurance of helpers. It is important to identify these issues, evaluate their potential impact and take proactive steps to ensure helpers' long-term well-being and prevent burnout.

Helpers also require guidance and support to improve the way they help others in situations of crisis. In the midst of conflict and chaos people are in extreme turmoil and can exhibit intense emotional reactions, such as desperate crying, anger, nervousness or panic. These reactions are difficult to manage for those not trained to do so. At times helpers need to convey bad news or other difficult information, which not everyone is prepared to deliver. Certainly, all helpers have the basic skills to conduct their work with humanity and strive to protect the dignity of victims, but in situations of conflict, violence and emergencies this may not be enough. Although well intentioned, without appropriate training, helpers may unintentionally cause harm. They need extensive training and supervision to develop their basic psychological support skills. As helpers are already agents of change in their communities, with appropriate training, guidance and supervision they can have an even greater positive impact on the people they are helping.

Helpers may be:

emergency care responders whose role entails being first on the scene of a critical incident in their community and/or providing emergency assistance, e.g. ambulance personnel, first-aiders, emergency medical staff, community first responders; or,

key community actors who play an active role in their community in terms of providing services and/or care to others, e.g. community leaders, teachers, non-emergency medical staff and other volunteers.

The ICRC strives to support the mental health and psychosocial well-being of helpers (emergency care responders and key community actors), while recognizing that their commitment, motivation and willingness to help victims in their communities can also expose them to possible physical, psychological and psychosocial harm. Both emergency care responders and key community actors in affected communities are not only dealing personally with the consequences of conflict and violence, but are also exposed to the suffering of others on a regular basis.

While delivering an emergency response during crisis situations is difficult enough during peacetime, a climate of conflict and violence makes it even more challenging, and entails increased security risks for everyone involved. As the quantity, frequency and severity of critical incidents escalate, emergency care responders increasingly have to deal with people with immediate and acute MHPSS needs. They are often poorly prepared for their own emotional reactions to the pain and suffering of the people they are helping and may not know how to deal with people who are psychologically affected. Many emergency care responders provide physical assistance to people suffering from a sudden injury or illness and at the same time comfort and reassure both the casualties themselves and those present at the scene of the emergency. When the psychological needs of these casualties and bystanders are acute and severe, it can be overwhelming and may interfere with their ability to carry on with their work.

Unlike emergency care responders, key community actors are not necessarily used to working with people with MHPSS needs. However, during conflict, violence or emergencies, certain trusted actors may start being steadily exposed to the MHPSS needs of the people they serve. As key community actors are people from whom victims of

conflict and violence already seek some form of service or assistance, and even more so during crisis situations, they are well positioned to provide basic psychological and psychosocial support to specific groups of people, e.g. a local women's association leader has unique access to women in the community. However, without tailored training to provide this support, these helpers may feel ill-equipped and lack guidance on how to help, especially with complex issues like death and violence (especially sexual violence), as well as how to support children with specific needs.

It is becoming increasingly commonplace that helpers, as members of the affected communities, are the only ones who have access to people affected by conflict, violence and emergencies. In these cases, greater attention must be paid to these helpers, not only because their own psychological and psychosocial needs can become magnified but also because they are vital to efforts to provide MHPSS to their communities.

Within the International Red Cross and Red Crescent Movement, the National Red Cross and Red Crescent Societies play a particularly important role in programmes to help helpers, i.e. their paid staff or volunteers⁴⁹ who hold roles such as emergency care responders, particularly first-aiders. They are often the first to provide support when a disaster strikes and continue to do so after other actors have left. Given their dangerous and stressful working environment, they sometimes struggle to fully adhere to the Movement's Fundamental Principles of impartiality, neutrality and independence. The attitudes of their communities can have an uplifting or demotivating impact. For example, the helpers may be congratulated when they respond to the aftermath of an earthquake, but receive little or no recognition when supporting displaced communities or people from opposing groups. In addition, National Societies should consider how they are perceived locally, as a negative view can have a direct and sometimes dangerous impact on helpers who display or wear the Red Cross or red crescent emblem.

MENTAL HEALTH AND PSYCHOSOCIAL NEEDS

Helpers' psychological and psychosocial needs may be broadly similar to those of the people they are helping, but they are more likely to present with certain needs by virtue of their assistance work in very challenging circumstances.

Some of the concerns presented here are related to stress that goes beyond general daily stressors. Stress is a state of heightened arousal often described as a feeling of being overloaded, tense and worried. Stress is in itself a necessary and useful physiological and psychological reaction, which only becomes a problem when it lasts too long, is too intense and/or overwhelms a person's natural coping mechanisms. Stress reactions can be acute and/or cumulative.

Depending on the situation and their role, helpers may be at risk of being assaulted, find themselves within range of gunfire, or be the victims of bombings, kidnappings or other attacks. They are sometimes deliberately targeted, or may witness (or be forced to watch) awful acts such as execution and rape.⁵⁰ In addition, when involved in managing

⁴⁹ In accordance with the Movement's Fundamental Principle of voluntary service, volunteers or voluntary workers are people who offer their services for free or a small sum, on either a permanent or temporary basis.

⁵⁰ To address the issue of violence against patients, health care workers, facilities and vehicles, and with a view to ensuring safe access to, and delivery of, health care in armed conflict and other emergencies, the International Red Cross and Red Crescent Movement launched the Health Care in Danger initiative: healthcareindanger.org

dead bodies, they may not be prepared, well equipped or legally authorized to do so, or they may only gain access to bodies days after death (sometimes in very hot temperatures, leaving the corpses very deformed). Such scenes can be highly distressing. When helpers experience such horrific incidents, often they do not even receive basic support.

Acute stress reactions occur as a result of an event where a person is threatened with or witness to violence or death. These types of events are often referred to as critical incidents: a unique, sudden and unexpected event that affects a person's physical and/or psychological integrity, and robs them of time to prepare emotionally.

Experiencing acute stress reactions after a critical incident is a normal response to an abnormal situation. Reactions may include irritability, restlessness, sleeping and eating problems, fatigue, withdrawal from others and mutism. In addition to other reactions, such as decreased attention span and memory problems, trauma-related symptoms including flashbacks and avoidance behaviours can occur. As part of the recovery process some intense emotional reactions can occur, which may scare the individuals themselves and be hard for others to understand, such as fluctuating moods, exhilaration, guilt, anger, sadness, feelings of alienation, detachment, feeling out of control and emotional numbness. In addition, people exposed to a critical incident may present a heightened startle reflex (i.e. overreaction at a sudden noise or movement), withdraw from others, have difficulty expressing themselves, constantly talk about the event, argue with others or display exaggerated sinister humour.

Cumulative stress reactions are related to low-intensity but chronic stressors that pervade a person's life and "pile up" on top of one another. This is a gradual form of stress that affects people over time and can lead to burnout.

Burnout results from the prolonged stress of an overload of work that leads to physical and psychological exhaustion, as well as a lack of motivation and enthusiasm.

Some common sources of chronic stress for helpers include a chaotic work environment that requires quick decision-making and reactions, feeling overwhelmed by a high workload and unmet needs, stressed co-workers, or structural issues within the management. Additionally, helpers may encounter communication difficulties owing to personality and cultural differences, inadequate preparation and briefing, being asked to complete tasks outside their area of training and competence, or moral and ethical dilemmas. These factors are added to their feeling of isolation from a family or social support network, chronic sleep deprivation, and the absence of supervision and recognition. The negative effects of these everyday stressors build up and can lead to burnout. Higher stress levels are often better predicted by the presence of multiple chronic stressors than the occurrence of occasional, one-off critical incidents. In situations of armed conflict and violence, where individual and social resources are diminished, regulations and justice systems collapse and people are continually in danger, the effects of chronic stress can be even more devastating.

It is now widely documented that interacting with victims who have experienced traumatic events places helpers at a high risk of suffering from vicarious trauma and/or secondary trauma. Regularly hearing distressing stories or witnessing the traumatic events of others, and being faced with the realities of violence and suffering, can eventually affect the helpers themselves. They may present many of the same trauma-related stress reactions as the people they are helping.

Vicarious trauma is indirect exposure to traumatic events through first-hand accounts or narratives of the events from others who have suffered them. Over time this exposure results in a vicarious experience where the listeners themselves experience trauma-related reactions.

Secondary trauma involves direct experience of witnessing the traumatic event(s) of others. Although not a primary victim, the witness can become a secondary victim by becoming overwhelmed by what they see and hear in person. Depending on the nature and degree of their exposure, witnesses may also suffer primary trauma. Secondary trauma may also affect family members and close associates of trauma victims as a result of the closeness of the relationship.

Definition adapted from Help for the Helper: The Psychophysiology of Compassion Fatigue and Vicarious Trauma⁵¹

In addition to managing their own reactions to difficult situations, helpers face the burden of performing their designated tasks as well as simultaneously providing basic psychological support to the people they are assisting. As helpers are people who are in key positions to provide support for the psychological and psychosocial needs of communities affected by armed conflict and violence, it is essential to ensure that they are empowered to do so appropriately without becoming overburdened or overwhelmed.

Helpers exposed to the aforementioned risks require and deserve quality and comprehensive support to help themselves and better help others. A continuum of care must also be ensured, as some helpers may need assistance from specialized mental health services themselves or an understanding of when and how to use a referral system for the people they are helping.

THE MENTAL HEALTH AND PSYCHOSOCIAL RESPONSE

“Help the helpers” programmes use a number of strategies to support helpers’ well-being and empower them in their role, as well as improving the quality of the vital work they do.

These programmes are based on a twofold response:

1. Enabling helpers to care for themselves: Activities are culturally adapted and aimed at equipping helpers with tools that build on their inner resources to help them look after themselves more effectively and seek support when needed. In

⁵¹ Rothschild, B., *Help for the Helper: The Psychophysiology of Compassion Fatigue and Vicarious Trauma*, W.W. Norton and Company, New York, 2006

addition, the MHPSS programme strives to ensure managers do their utmost to reduce work stressors that may affect helpers.

2. Equipping helpers with MHPSS skills to better support the affected communities they are helping: The MHPSS response is not aimed at training helpers to offer curative mental health care, but instead at building on their specific capacities and resources to provide basic psychological support within the scope of their role and ensuring they know when and where to refer.

For programmes to achieve these two objectives, far more than one-off training workshops are required. The most effective strategy is to integrate psychological and psychosocial aspects into the core training helpers already receive for their current role (e.g. as part of first aid training). Moreover, ongoing training, supervision and follow-up are required. Equipping helpers with good basic psychological support skills can boost their self-confidence and better equip them to cope with stressful situations.

NEEDS ASSESSMENT

The first aim of the needs assessment is to ascertain the MHPSS needs of the helpers themselves. To this end, the first step is to identify helpers who are particularly vulnerable in their role due to their level of exposure to violence, distressing situations and/or emergency situations (i.e. emergency care responders), as well as helpers who are already being approached by victims or who are in a position to help specific groups that have been affected by violence (i.e. key community actors).⁵²

The needs assessment takes into consideration helpers' experiences, vulnerabilities and challenges, and the coping strategies that they currently use. The assessment also looks at structural and managerial difficulties that may have an impact on their well-being (e.g. schedule of work shifts, MHPSS knowledge and perceptions among managerial staff, and available MHPSS for helpers within their organization), and aims to identify risk factors and possible solutions to address them.

The second aim of the needs assessment is to identify the challenges helpers face in relation to the MHPSS needs of the people they serve. To this end, the discrepancies that exist between the MHPSS needs of the victims and the skills of the helpers who are responding to their needs are identified. This requires the assessment to be tailored to the specific group of helpers by looking at the duties of their role (e.g. teaching, nursing, providing first aid), the type of victims being assisted (e.g. children, patients, people with injuries) and their specific needs, and the level of the helpers' current MHPSS knowledge and skills (e.g. listening skills, identifying distress, etc.).

When the ICRC conducts a needs assessment within a National Red Cross or Red Crescent Society, the assessor (an MHPSS delegate) coordinates with ICRC first aid and cooperation delegates in the field,⁵³ whose roles involve working closely with the National Societies. This ensures that the ICRC works through an already established coordination set-up, facilitating the National Societies' active participation in the assessment and ownership of any programme to be rolled out.

⁵² An example of this group of helpers is the National Red Cross and Red Crescent Society Restoring Family Links volunteers, who help separated children.

⁵³ The ICRC often works alongside National Red Cross and Red Crescent Societies in the field. Cooperation delegates ensure that, in difficult situations, the ICRC, the Federation and National Societies all work together closely and towards the same goals. Similarly, first aid delegates work closely with National Societies to ensure that casualties during emergencies receive timely, impartial and effective immediate assistance in areas of armed conflict or other violence.

A comprehensive needs assessment takes **1 to 3 months** and is conducted by an MHPSS delegate. The length of assessment depends on the number of target groups and the severity of both the helpers' and victims' MHPSS-related needs.

PROGRAMME DESIGN AND IMPLEMENTATION

The needs identified during the assessment are analysed and prioritized. Specific objectives and related strategies are set out accordingly, as are human resources and the programme time frame.

An MHPSS delegate is deployed for **6 to 12 months**, depending on local capacities, to assess the needs as well as to develop, adapt and implement the programme. The programme is usually more effective when the same person who conducted the assessment also implements the programme. This allows them to build on and strengthen the proximity to specific helpers (i.e. the target group) already generated during the assessment.

The first priority of the programme is to ensure that helpers themselves receive psychological and psychosocial support. For example, this can be done by selecting adept helpers with a caring disposition and providing them with training and support in order to set up and facilitate a peer support system. A referral system for helpers who require specialized mental health services is created and implemented.

The second aim of the programme is to ensure that helpers have tools to help them better assist affected communities in their current role. This is done through training sessions that address the discrepancy between the MHPSS needs of the victims and the skills of the helpers, as well as providing ongoing supervision of the implementation of these basic psychological support skills.

The ICRC has an established first aid response, which covers both physical first aid and **basic psychological and psychosocial support**, i.e. support provided to people with MHPSS needs through basic MHPSS techniques.

The ICRC's MHPSS response involves providing basic psychological and psychosocial support as part of an in-depth response to MHPSS needs that requires extensive training, supervision and follow-up.

TARGET GROUPS

1. **Direct:** Helpers, i.e. emergency care responders and key community actors who are part of the affected community and acting in a service-oriented front-line position.
2. **Indirect:** Victims of armed conflict and other situations of violence who are helped by helpers.

SPECIFIC OBJECTIVES

The programme will aim to deliver:

MHPSS care for helpers

Helpers [SPECIFY, *e.g. NS volunteers/first aiders/caregivers, etc.*] improve their well-being and ability to provide quality basic psychological and psychosocial support to victims.

This objective is achieved by establishing a structural support system that provides effective psychological and psychosocial support to helpers, in order to prevent or enable them to recover, and by strengthening the helpers' ability to better support victims of violence within the scope of their role.

METHODS

Helping the helpers

ACTIVITY	PURPOSE	METHODOLOGY	EXPECTED OUTCOMES
Structural support	To establish a sustainable, quality stress management system embedded in the helpers' organization (e.g. National Societies, ambulance services or schools in violent settings).	<p>Advocate to senior management through sensitization activities (e.g. group discussions with management and helpers to facilitate experience-sharing; presentation of helpers' real case stories about critical incidents; workshops about the psychological and psychosocial risk factors associated with the helpers' work).</p> <p>Sensitization activities include recommendations on rest and recovery, adequate breaks for staff working under stressful conditions, clear job descriptions, clear communication between management and staff, and defusing after critical incidents.</p> <p>Sensitization sessions are conducted by mental health professionals (i.e. MHPSS delegates, local psychologists).</p>	<p>Senior management understands the importance of focusing on psychological preparation and recovery of helpers after critical incidents.</p> <p>Senior management embeds psychological and psychosocial support into the core activities of the specific group of helpers.</p> <p>Senior management designates a focal point for stress management.</p> <p>Senior management is committed to minimizing risk factors by promoting appropriate work schedules and resources.</p> <p>Senior management recognizes helpers' work internally and in a public forum.</p>
Training helpers to help themselves	Ensure helpers have knowledge of stress management tools and how to prevent and address negative MHPSS consequences of critical incidents at both individual and group level.	<p>Workshops with helpers to share and discuss knowledge about MHPSS issues, such as MHPSS consequences of exposure to violence, challenges faced in their role, stress, normalization of reactions, self-coping mechanisms.</p> <p>Workshops are conducted by mental health professionals (i.e. MHPSS delegates, local psychologists).</p> <p>Workshops include MHPSS theoretical presentations alongside group activities, role play, videos and discussions.</p>	<p>Helpers have sufficient MHPSS knowledge to understand and better cope with the challenges of their role.</p> <p>Helpers understand and feel comfortable using self-care techniques and accessing MHPSS services.</p>

ACTIVITY	PURPOSE	METHODOLOGY	EXPECTED OUTCOMES
Training helpers as peer support facilitators	Ensure helpers have knowledge and skills to provide quality basic psychological and/or psychosocial support to other helpers.	<p>Workshops with selected peer support facilitators (who are from the target group of helpers) to improve knowledge and skills of providing basic psychological support, including strengthening self-coping mechanisms, conducting defusing sessions after critical incidents, and providing referrals.</p> <p>Workshops with selected peer support facilitators to improve knowledge and skills of providing psychosocial support, including strengthening social support networks, addressing the impact of their work on family and relationships, and discussing other needs e.g. financial issues and living conditions.</p>	<p>Peer support facilitators provide effective basic psychological support for individuals and groups.</p> <p>Peer support facilitators identify helpers with more severe psychological needs and refer them appropriately.</p> <p>Procedures are established to deliver emergency MHPSS to helpers in cases of critical incidents, e.g. defusing sessions with trained facilitators directly after the helpers' involvement in the incident.</p> <p>Peer support facilitators provide effective psychosocial support to other helpers.</p>
Supervision	Ongoing monitoring of and guidance for the structural support system, and MHPSS prevention and recovery support for helpers.	<p>Regular meetings/discussions with senior management.</p> <p>Regular meetings/discussion with helpers.</p> <p>Regular meetings/discussion with peer support facilitators.</p> <p>Occasional participation in sessions where the provision of peer support is taking place.</p>	<p>Quality psychological and psychosocial support services are provided.</p> <p>Severe psychological cases are identified and appropriately referred (where specialized services are available).</p> <p>Other needs are identified and appropriate referrals are made to other services (where available).</p> <p>MHPSS services are embedded in the organization in a sustainable way.</p> <p>Appropriate data collection methods are used.</p>

Helping the helpers support victims of armed conflict and other situations of violence

ACTIVITY	PURPOSE	METHODOLOGY	EXPECTED OUTCOMES
Training helpers to help others	To establish and/or improve the skills of helpers to provide basic psychological and psychosocial support within the scope of their role.	<p>Discussion groups with helpers to define the type of MHPSS skills and activities that can be incorporated into their current daily work (e.g. for teachers, it is important to understand teaching schedules and students' demographics and corresponding needs in order to decide on suitable MHPSS activities to include in training).</p> <p>Workshops with helpers (adapted to helpers' current daily activities) on topics such as listening skills, communication skills, identifying psychological problems, normalization of reactions, prioritizing needs, identifying individual and social resources, and where to refer for further care. (MHPSS workshops with first-aiders are embedded in their first aid training.)</p> <p>When training helpers the schedule of workshops should be appropriately aligned with their working hours (e.g. one hour per day over a period of time that allows the necessary content to be covered, i.e. 1 to 3 months of regular training).</p> <p>Workshops are conducted by mental health professionals (i.e. MHPSS delegates, local psychologists).</p> <p>Workshops include MHPSS theoretical presentations alongside group activities, role play, videos and discussions.</p>	<p>Helpers have sufficient MHPSS knowledge and skills to provide basic psychological and/or psychosocial support to victims within their role.</p> <p>Helpers are able to identify those with more severe psychological needs and other needs and make appropriate referrals.</p> <p>First aid training activities include techniques and practices of providing basic psychological support.</p>
Supervision	Ongoing monitoring and support of the capability of helpers to provide basic psychological and psychosocial support within the scope of their role.	<p>Regular meetings/discussion with helpers.</p> <p>Participation in the helpers' daily activities where the provision of basic psychological and/or psychosocial support is taking place.</p>	<p>Quality basic psychological and psychosocial support services are provided to victims.</p> <p>Severe psychological cases are identified and appropriately referred (where specialized services are available).</p> <p>Other needs are identified and appropriate referrals are made to other services (where available).</p> <p>MHPSS skills are embedded in the current activities of the helpers in a sustainable way.</p> <p>Appropriate data collection methods are used.</p>

MONITORING AND EVALUATION

To support the monitoring process, the ICRC has identified a number of indicators that can be used to assess the efficacy of programmes that help the helpers, and help the helpers support victims of armed conflict and other situations of violence. Both these components need to be monitored. The ICRC's comprehensive MHPSS data collection tool provides a consolidated platform for data collection and analysis.

All indicators are specified prior to the start of the programme and given a time frame. Some examples of the output and outcomes indicators employed to measure the effectiveness of interventions include:

INDICATOR	REASON FOR USE
Output	
Number of helpers who participated in peer support groups	<ul style="list-style-type: none"> Provides information on the availability of MHPSS services for helpers
Number of helpers trained to provide basic MHPSS within the scope of their role	<ul style="list-style-type: none"> Provides information on the availability of MHPSS services (trained helpers) for victims of conflict, violence and emergencies Provides information on the ability of helpers to identify MHPSS needs and appropriately support victims of conflict, violence and emergencies
Number of referrals made by helpers to specialized mental health services	<ul style="list-style-type: none"> Provides information on the extent of MHPSS needs that reach the referral criteria Provides information on the feasibility, appropriateness and effectiveness of the continuum of care Provides information on the ability of helpers to appropriately identify cases that require referral and to make referrals
Outcome	
Number of helpers who show reduced distress / Number of helpers provided with MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services
Number of helpers who show improved functioning / Number of helpers provided with MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services
Number of helpers who show improved coping / Number of helpers provided with MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services
Number of helpers providing quality basic MHPSS to others within the scope of their role / Number of helpers trained to provide basic MHPSS within the scope of their role	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services Provides information on the ability of trained helpers to support victims of conflict, violence and emergencies

GLOSSARY OF TERMS USED IN MONITORING AND EVALUATING MHPSS PROGRAMMES FOR HELPERS

MHPSS needs: Categorized by levels of distress, functioning and coping, measured using standardized scales.

MHPSS/MHPSS services: Support/services addressing mental health and psychosocial needs provided as part of the MHPSS programme.

Specialized mental health services: Services addressing the needs of people with severe/complex mental health problems including psychiatric disorders.

Distress: Levels of distress are measured using standardized scales.

Functioning: Levels of functioning are measured using standardized scales.

Coping: Coping mechanisms are measured using standardized scales.

Referral: The specific needs of a helper are identified and the individual is then put in touch with an appropriate service to address his/her needs.

Trained to provide basic MHPSS: Levels of MHPSS training provided will vary depending on the needs of the victims, the gap between needs and MHPSS services, and the competences and availability of the helpers being trained. As this training is aimed at enhancing the helper's current role it includes a range of basic psychological support techniques tailored to the needs of victims.

MAIN CHALLENGES FOR PROGRAMME IMPLEMENTATION

- Establishing a structural support system can be challenging, as it requires the incorporation of both preparatory and response measures into the structure of helpers' organizations in order to minimize and address the helpers' MHPSS needs. It often also entails changing attitudes about making the well-being of the helpers themselves a priority, which might challenge the management's views and wishes, in light of resource pressures and cultural norms.
- While challenging, it is also essential to bring about a resilience-focused and context-appropriate approach to supporting helpers' mental health and psychosocial needs. This means not only identifying local resources (e.g. social support systems, quality mental health services, access to services) but also understanding how such resources should shape the programme.
- To be effective, interventions aimed at helping the helpers to better help others have to be culturally adapted and relevant to the situation, the needs of the people who helpers are helping, and the role of the helpers. This means there is no "one-size-fits-all" model for the level and type of basic psychological support training each group of helpers will be trained to integrate into their role; each programme is unique.



5. HOSPITALIZED WEAPON- WOUNDED PATIENTS AND PEOPLE WITH PHYSICAL DISABILITIES

ISSUES OF CONCERN

Armed conflicts and other situations of violence cause injuries among civilians as well as those directly participating in the hostilities, and increase the vulnerability of people with an existing physical disability. The medical management of victims during these times is different from that practised in peacetime. Security constraints affect the entire health system, supplies are interrupted, hospitals are often attacked and staff flee, fearing for their safety.⁵⁴ A mass exodus of health care personnel leaves health facilities critically understaffed. Health staff trained to practise in multidisciplinary teams often find themselves bearing the entire medical workload alone, dealing with subspecialties with which they have, at best, only a passing acquaintance.

Hospitalized weapon-wounded patients are people who receive surgery and acute hospital treatment after being injured by a weapon.

As a result of conflict and violence the number of people who are sick or wounded and/or develop physical disabilities increases dramatically. Due to the violent nature of their injuries or the worsening of their physical condition during conflict, these people are physically and psychologically vulnerable. Most wounds affect the extremities; the extent of tissue destruction and contamination that occurs is nothing like the wounds seen during everyday trauma practice. Alongside these physical challenges, psychological difficulties are aggravated by factors exacerbated during conflict, such as separation of families, death of loved ones, loss of livelihood and displacement.

People with physical disabilities can be direct or indirect victims of conflict. Direct victims are those who have, for example, amputated limb(s), limb fractures, spinal cord injuries or burns as a result of the conflict. Indirect victims are those with disabilities due to restricted medical care related to the conflict or post-conflict situation, such as people with acute or chronic conditions (e.g. diabetes, stroke) or congenital deformities (e.g. children with club foot or cerebral palsy).

Health staff are faced with the huge challenge of providing services in a setting that is severely disrupted by the conflict, meeting the demands of a high workload while at the same time coping with the personal impact of conflict and violence.⁵⁵ This, together with a lack of trained mental health practitioners, may create and perpetuate a lack of quality relational care towards patients, which negatively impacts their well-being and recovery. The likelihood that the available health staff have some MHPSS knowledge and skills is low, at a time when the psychological and psychosocial needs of patients

⁵⁴ To address the issue of violence against patients, health care workers, facilities and vehicles, and with a view to ensuring safe access to, and delivery of, health care in armed conflict and other emergencies, the International Red Cross and Red Crescent Movement launched the Health Care in Danger initiative: healthcareindanger.org

⁵⁵ ICRC staff receive support from the staff health team from the ICRC Department of Human Resources. This support is separate from operational MHPSS programmes in the field, which specifically focus on assisting individuals and communities affected by armed conflicts, other situations of violence and emergencies.

are very high. Dealing with the psychological impact of a life-changing diagnosis and the strong emotions that come with it, such as fear, anger, sadness and denial, on top of the violent event that caused the injury, requires understanding and supportive care.

Experiencing stress over a prolonged period of time alters an individual's production of hormones, which in turn impacts their physiological processes and is associated with mental health problems. Just as distress impairs general healing processes, so a healthy mental health status promotes physical healing.

The treatment that patients receive during difficult times when they are at their most vulnerable affects their mental health in the short and long term. Many people experience physical, psychological and/or social difficulties at four critical phases in the aftermath of the incident: (1) reactions associated with the physical trauma; (2) reactions to medical procedures; (3) reactions to changes in one's physical condition and to the disability; and (4) reactions and readjustments to one's social and family environment.⁵⁶ These reactions may appear immediately or after some time, depending on the patient's individual and social resources. They need to be addressed accordingly, as part of a comprehensive mental health and psychosocial response.

The ICRC strives to assist people in such situations by providing mental health and psychosocial support integrated into hospital care and physical rehabilitation services – with good links to pre-hospital care and primary health care – in order to ensure a continuum of patient care.

MENTAL HEALTH AND PSYCHOSOCIAL NEEDS

Treatment for hospitalized weapon-wounded patients and people with physical disabilities usually focuses on physical aspects (such as the severity of injury, trauma models of care and clinical management). However, psychological aspects play an integral part in a patient's recovery following a traumatic physical injury.

Seriously injured patients run a high risk of developing psychological trauma-related symptoms such as shock, anxiety, anger, depression, despair, difficulties concentrating, insomnia, feelings of helplessness, numbness, a sense of constant danger, altered appetite and weight, frightening memories and reliving experiences (flashbacks). These symptoms may be exacerbated by factors such as personality type, pre-existing mental health conditions and substance abuse, as well as the nature of the event in which the person was injured and their social circumstances. Personality changes and cognitive impairments may occur following traumatic head injuries. Psychological symptoms can magnify the experience of pain and cause it to persist long after the physical injury has subsided.

People with new physical disabilities have to deal with specific challenges, such as coping with life transitions and experiencing their disability across their life span. At the same time, they have to adjust to changes in their family and social role (e.g. divorce, poor relationship prospects, unemployment), and face stigma and negative attitudes towards them from others. Their experience can be compared to that of a grief process involving shock, denial, anger, depression, adjustment and acceptance. Although these reactions can be anticipated, they can occur in any order and intensity.

⁵⁶ R. Singh *et al.* "Depression and anxiety symptoms after lower limb amputation: the rise and fall", *Clinical Rehabilitation*, Vol. 23, Issue 3, 2009, pp. 281–286

Complications arise when the person has trouble resolving one of these reactions and becomes “stuck”, hindering progress towards adjustment and acceptance.

Although the psychological reactions and symptoms described above are widely present in people with physical disabilities, they cannot be assumed in every case. Different types of injuries and disabilities will lead to different psychological symptoms. Reactions will also present differently depending on gender, age, family role (e.g. breadwinner, homemaker), occupation, and individual and social coping mechanisms.

Patients’ needs vary during the different stages of treatment and rehabilitation. While patients are hospitalized they have to cope with the psychological effects of the event that caused their injury, their pain, medical and pre-operative apprehensions and an unfamiliar hospital environment, possibly without contact with, or knowledge of the well-being of, their loved ones. Patients commonly experience fear of potentially life-threatening or life-changing physiological conditions, anxiety related to medical procedures (e.g. not awakening from anaesthesia, surgery-related stress), and fear of death. They are anxious about receiving bad news, such as that of an amputation, and may be reluctant to consent to a necessary medical procedure. In some situations patients may experience acute distress and require stabilization and specialized mental health support.

In the post-operative phase, patients face surgery-related pain, possible surgical complications, depression, anger, and fear of the challenges of prolonged recovery and long-lasting disability. Symptoms of anxiety and depression may lead to problems with adherence to treatment, from following dietary and hygiene plans to more complex post-operative care practices such as medication intake and wound-cleaning.

During the rehabilitation process, depending on their specific situation, people with physical disabilities may have to progressively reduce their reliance on medical, hospital and/or rehabilitation services, cope with the difficulties of using mobility devices, and accept their dependence on others for personal care and hygiene as well as their increased vulnerability in the face of danger. Some of the main challenges surround accepting and adjusting to a different body image and the limitations on their daily mobility.

Finally, chronic pain and phantom limb pain are common after limb amputation and severely affect quality of life. Patients who have a complex medical history, including multiple surgeries, chronic infections and complicated wounds, are likely to experience chronic pain. Phantom limb pain is the term given to any sensory phenomenon that is felt in an absent limb or portion of the limb. Most amputees experience phantom sensations at some point in their lives and for some this continues throughout their life.

THE MENTAL HEALTH AND PSYCHOSOCIAL RESPONSE

The ICRC aims to incorporate MHPSS activities in its integrated care programmes for hospitalized weapon-wounded patients and people with physical disabilities. Hospital and physical rehabilitation teams need to gain a comprehensive understanding of patients’ psychological difficulties during both treatment and rehabilitation.

MHPSS care can be provided either by health staff who are appropriately trained and supported, or by a mental health practitioner who works alongside them. Mental health practitioners also need to gain an understanding of the physical difficulties associated with disabilities, injuries and medical treatment and/or rehabilitation procedures. To provide patients with comprehensive care, it is therefore crucial that MHPSS, hospital and physical rehabilitation teams collaborate at every step of service provision. As part of the ICRC's efforts to ensure a continuum of care, patients are supported throughout their hospitalization and rehabilitation, with MHPSS integrated at both stages.

Since the needs of patients vary during the different stages of treatment and rehabilitation, the MHPSS response is adapted accordingly. Programmes implemented in hospital settings mainly aim to support patients to cope better with reactions associated with the physical trauma and with medical procedures. Psychological and psychosocial support at this stage helps hospitalized patients to accept and adhere to medical treatment, thereby facilitating their physical recovery. Programmes implemented in physical rehabilitation facilities mainly aim to help patients to cope better with reactions to changes in their physical condition (i.e. related to their disability), and with the readjustment to their social and family environment. Psychological and psychosocial support at this stage helps people with physical disabilities to overcome the trauma of their experience and promote independence, social well-being and self-reliance.

NEEDS ASSESSMENT

When conducting a needs assessment of hospitalized weapon-wounded patients and people with physical disabilities, the ICRC holds one-to-one interviews and group discussions with the health staff who work with these patients (e.g. general doctors, surgeons, nurses, orthopaedists and physiotherapists). The aim is to understand current care practices, the MHPSS services available and the extent to which MHPSS is already provided by health staff. It is also important to assess staff's MHPSS knowledge and their understanding about patients' MHPSS needs. Following this, individual interviews with hospitalized patients and people with physical disabilities are conducted in order to gain an in-depth understanding of their specific MHPSS needs and their experience of the health services.

The assessment determines the gap between the extent of the patients' MHPSS needs and the MHPSS services already available (this includes professional mental health services as well as the level of basic psychological and/or psychosocial support being provided by health staff as part of their role). When the MHPSS services available are insufficient to meet the patients' needs, the possibility of allocating a full-time local mental health practitioner is assessed. In some countries this is not feasible due to a lack of skilled practitioners and/or security and financial constraints in health facilities.

Consequently, the capacity of the health staff to provide MHPSS themselves is assessed: their level of knowledge and skills, their willingness to receive MHPSS training, their workload and available time. As hospitals and physical rehabilitation services are overwhelmed during armed conflict and other violence, the availability of staff to undergo training and provide MHPSS may be limited. Therefore, when patients' MHPSS needs are severe, the support provided by health staff may not be sufficient and it is necessary to explore other possible providers of MHPSS. This involves identifying other (non-specialized) community actors who could be trained to provide counselling.

Psychosocial aspects are also assessed, including an analysis of the local culture, which may have positive practices that encourage patients' resilience, or negative ones (such as stigma), which need to be identified and addressed. It is important to assess the patients' social network (e.g. family, caregivers, friends and colleagues) when identifying the support available during hospitalization, as well as the potential challenges

to their social reintegration. A comprehensive needs assessment is conducted by an MHPSS delegate and takes **1 to 3 months**. The length of time depends on the number of health facilities and the severity of the conflict-related needs.

PROGRAMME DESIGN AND IMPLEMENTATION

Upon completion of the assessment, specific MHPSS recommendations are implemented at both hospital and physical rehabilitation facilities.

To ensure high-quality MHPSS care, the ICRC deploys an MHPSS delegate to oversee the programme design and implementation. It is highly recommended to have a delegate in place for **12 months** to ensure continuity and sustainability, as the capacity-building of health staff and/or local psychologists/counsellors at both hospital and physical rehabilitation facilities requires ongoing and in-depth training, supervision and support.

TARGET GROUPS

1. **Direct:** Hospitalized weapon-wounded patients and people with physical disabilities in need of physical rehabilitation.
2. **Indirect:** Health staff and patients' families/carers.

SPECIFIC OBJECTIVES

The programme aims to deliver:

MHPSS care for hospitalized weapon-wounded patients and people with physical disabilities

Hospitalized weapon-wounded patients and people with physical disabilities in facilities supported by the ICRC [SPECIFY, *e.g. type(s) / name of the facility(ies) and/or location(s), etc.*] benefit from mental health and psychosocial support adapted to their psychological and physical recovery/rehabilitation needs.

This objective is achieved through capacity-building of hospital and physical rehabilitation teams and/or local psychologists and/or counsellors to provide MHPSS.

METHODS

Building the capacity of hospital and physical rehabilitation staff to provide MHPSS to hospitalized weapon-wounded patients and people with physical disabilities

ACTIVITY	PURPOSE	METHODOLOGY	EXPECTED OUTCOMES
Advocacy	To integrate a quality MHPSS system for patients into the hospital and/or physical rehabilitation facility.	Talk to relevant local health authorities (including management staff at the hospital and/or physical rehabilitation facility) about the importance of incorporating MHPSS into their services.	<p>The relevant health authorities and management staff at the hospital and/or physical rehabilitation facility incorporate MHPSS into their services.</p> <p>The hospital and/or physical rehabilitation facility includes mental health practitioners in their workforce.</p>
Training of hospital and/or physical rehabilitation staff	To acquire and/or improve skills in providing mental health support (basic psychological support) to hospitalized weapon-wounded patients and people with physical disabilities.	<p>Workshops on topics such as: listening skills, sensitively collecting information on the patient and their situation, identifying psychological problems, prioritizing needs, identifying individual and social resources, and referring for further care.</p> <p>The schedule of workshops should be appropriately aligned with staff's working hours (e.g. one hour per day over a period of time that allows the necessary content to be covered, i.e. 1 to 3 months of regular training).</p> <p>Workshops are conducted by mental health professionals (i.e. MHPSS delegates, local psychologists).</p> <p>Workshops include MHPSS theoretical presentations alongside group activities, role play, video and patient case discussions.</p>	<p>Hospital and physical rehabilitation staff better understand and incorporate psychological considerations into their daily care practices.</p> <p>Effective screening and holistic case management of patients is ensured. Hospital and physical rehabilitation staff effectively identify patients' psychological and psychosocial needs.</p> <p>Hospital and physical rehabilitation staff effectively identify severe cases and refer them to a mental health practitioner (when available in the facility).</p> <p>Hospital and physical rehabilitation staff provide basic counselling to patients (when a mental health practitioner is not available in the facility).</p> <p>MHPSS data collection methods are used and integrated into hospital and physical rehabilitation data collection tools.</p> <p>Hospital and physical rehabilitation staff are involved in the mapping of other related actors, and establish and readily use a referral system.</p>
Training of local psychologist or counsellor	To acquire and/or improve skills in providing MHPSS to hospitalized weapon-wounded patients and people with physical disabilities.	<p>Workshops on the psychological needs of hospitalized weapon-wounded patients and people with physical disabilities, and on psychotherapeutic techniques to appropriately address patient needs.</p> <p>Workshops take place every week/ two weeks over several months (i.e. over a period of time that allows the necessary content to be covered).</p> <p>Workshops are conducted by ICRC mental health staff.</p> <p>Workshops include MHPSS theoretical presentations alongside group activities, role play, video and patient case discussions.</p>	<p>The local psychologist or counsellor provides quality MHPSS to hospitalized weapon-wounded patients and people with physical disabilities, including in relation to: identification and treatment of psychological distress symptoms (e.g. anxiety, anger, despair); sleeping difficulties; eating difficulties; impact of distress symptoms on physical condition (e.g. anxiety-induced palpitations, breathing difficulties, headaches, pain); impact of distress symptoms on physical rehabilitation (e.g. adherence to physical exercise plan, management of phantom limb pain); and issues related to social reintegration (e.g. coping mechanisms towards stigma, readjustment to family and social role).</p> <p>MHPSS data collection methods are used and integrated with hospital and physical rehabilitation data collection tools.</p> <p>Other actors are mapped and a referral system is established and readily used whenever possible.</p>

ACTIVITY	PURPOSE	METHODOLOGY	EXPECTED OUTCOMES
Supervision of hospital and physical rehabilitation staff and/or local psychologist/counsellor	Ongoing monitoring and support to use the knowledge and skills gained during training.	Regular meetings/discussions. Supervision of sessions where psychological support is being provided. Case discussions (about patients receiving counselling and/or psychological support).	MHPSS is sustainable and integrated in the hospital and/or physical rehabilitation facility. Quality psychological and psychosocial support services are provided to hospitalized weapon-wounded patients and people with physical disabilities. Severe psychological cases are identified and referred as appropriate (when specialized services are available). Other needs are identified and appropriately referred to other services (when available). MHPSS data collection methods are used and integrated with hospital and physical rehabilitation data collection tools. Issues that need further support are identified and addressed (e.g. through coaching or refresher training sessions).

MHPSS services for hospitalized weapon-wounded patients and people with physical disabilities and their families/carers

TARGET GROUP	HEALTH FACILITY	METHODOLOGY	EXPECTED OUTCOMES
Pre-operative patients	Hospital	Individual MHPSS for patients, in collaboration with the hospital team (to provide information on medical procedures and facilitate their expression of fears and concerns).	Patients' surgery-related anxieties are reduced. Patients' symptoms of psychological distress are reduced.
Post-operative patients	Hospital	Individual MHPSS for patients regarding pain management and adherence to post-operative care practices. Delivered by a mental health practitioner in collaboration with the hospital team.	Patients report pain reduction, and use of positive pain management coping strategies improves. Patients' symptoms of psychological distress are reduced (e.g. distress symptoms related to the hospital stay are reduced). Patients' adherence to post-operative care practices improves. Patients' medical recovery improves.
Family members and carers of hospitalized weapon-wounded patients	Hospital	Individual support and/or group discussions are provided by a mental health practitioner in collaboration with the hospital team. Family members and carers are informed about the patients' physical condition and related challenges (with the consent of the patient).	Family members'/caregivers' concerns related to patient's physical condition reduce. Family members/caregivers plan for home care of patient.

TARGET GROUP	HEALTH FACILITY	METHODOLOGY	EXPECTED OUTCOMES
People with physical disabilities	Physical rehabilitation facility	Individual support is provided and peer support groups run by a mental health practitioner in collaboration with the physical rehabilitation team.	<p>Patients report pain reduction, and use of positive pain management coping strategies improves (chronic pain and phantom limb pain).</p> <p>Patients accept their condition and support each another through the rehabilitation process.</p> <p>Patients improve their adherence to the physical rehabilitation plan.</p> <p>Patients' symptoms of psychological distress are reduced (e.g. depression and anxiety symptoms related to disability).</p>
Family members and caregivers of people with physical disabilities	Physical rehabilitation facility	Individual and/or group support is provided by a mental health practitioner in collaboration with the physical rehabilitation team.	Patients' families and caregivers understand and accept the patients' physical changes and acquire skills to facilitate the rehabilitation and reintegration of the patient.

MONITORING AND EVALUATION

To support the monitoring process, the ICRC has identified a number of indicators that can be used to assess the efficacy of programmes that provide MHPSS to hospitalized weapon-wounded patients (referred to below as “hospitalized patients”) and people with physical disabilities. The ICRC’s comprehensive MHPSS data collection tool provides a consolidated platform for data collection and analysis and, when relevant and feasible, is integrated into the health facility’s data recording mechanisms.

All indicators are specified prior to the start of the programme and given a time frame. Some examples of the output and outcomes indicators employed to measure the effectiveness of interventions include:

INDICATOR	REASON FOR USE
Output	
Total number of health staff trained to provide MHPSS	<ul style="list-style-type: none"> Provides information on the availability of MHPSS services for hospitalized weapon-wounded patients and people with physical disabilities
Total number of hospitalized patients and/or people with physical disabilities provided with MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Serves as a basis to calculate MHPSS services coverage Helps to plan human and other resources
Total number of referrals made by health staff to specialized mental health services	<ul style="list-style-type: none"> Provides information on the extent of MHPSS needs reaching the referral criteria Provides information on the feasibility, appropriateness and effectiveness of the continuum of care Provides information on the ability of health staff to identify cases that require referral and to make referrals
Outcome	
Number of hospitalized patients and/or people with physical disabilities with MHPSS needs who show reduced distress / Number of hospitalized patients and/or people with physical disabilities receiving MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services

INDICATOR	REASON FOR USE
Outcome	
Number of hospitalized patients and/or people with physical disabilities with MHPSS needs who show improved functioning / Number of hospitalized patients and/or people with physical disabilities receiving MHPSS	<ul style="list-style-type: none"> • Monitors the extent of MHPSS needs • Monitors the appropriateness and effectiveness of MHPSS services
Number of hospitalized patients and/or people with physical disabilities with MHPSS needs who show improved coping / Number of hospitalized patients and/or people with physical disabilities receiving MHPSS	<ul style="list-style-type: none"> • Monitors the extent of MHPSS needs • Monitors the appropriateness and effectiveness of MHPSS services
Number of hospitalized patients and/or people with physical disabilities whose adherence to treatment improved / Number of hospitalized patients and/or people with physical disabilities provided with MHPSS	<ul style="list-style-type: none"> • Monitors the appropriateness and effectiveness of MHPSS services • Provides information on the feasibility, appropriateness and effectiveness of the continuum of care

GLOSSARY OF TERMS USED IN MONITORING AND EVALUATING MHPSS PROGRAMMES FOR HOSPITALIZED WEAPON-WOUNDED PATIENTS AND PEOPLE WITH PHYSICAL DISABILITIES

MHPSS needs: Categorized by levels of distress, functioning and coping, measured using standardized scales.

Hospitalized patients: Weapon-wounded patients admitted to a hospital facility.

People with physical disabilities: People with new or existing physical disabilities who need physical rehabilitation.

MHPSS/MHPSS services: Support/services addressing mental health and psychosocial needs provided as part of the MHPSS programme.

Specialized mental health services: Services addressing the needs of people with severe/complex mental health problems including psychiatric disorders.

Distress: Levels of distress are measured using standardized scales.

Functioning: Levels of functioning are measured using standardized scales.

Coping: Coping mechanisms are measured using standardized scales.

Adherence to treatment: Baseline and follow-up assessed in consultation with health staff.

Referral: The specific needs of a patient are identified and the individual is then put in touch with an appropriate service to address his/her needs.

Trained to provide MHPSS: Levels of MHPSS training provided will vary depending on the needs of the victims, the availability of local mental health practitioners, the gap between needs and MHPSS services, and the competences and availability of the staff/actors being trained. It may include a range of basic psychological support techniques and/or more in-depth psychotherapeutic techniques tailored to the needs of patients

MAIN CHALLENGES FOR PROGRAMME IMPLEMENTATION

- Due to the critical physical condition of many hospitalized weapon-wounded patients, and the temporary nature of their hospital stay, providing MHPSS can be challenging. It is important that psychological support has clear objectives to address patients' immediate MHPSS needs (e.g. adherence to treatment) in a solution-focused way.
- Adjustment to a traumatic injury or a physical disability is a unique, dynamic and complex process. A successful adjustment process involves focusing on ability rather than disability, having realistic expectations of one's strengths and challenges, and integrating the physical condition into one's self-concept. These are key factors to keep in mind during the provision of effective MHPSS.
- Disabilities affect more than just one person. For example, family members may also have difficulties adjusting their expectations, roles, priorities and lives in general. Supporting people with disabilities therefore goes beyond simply caring for the patient; it also includes supporting their families and social networks. This process of involving several people and addressing their needs can be a challenging aspect of the programme.



6. PEOPLE DEPRIVED OF THEIR LIBERTY AND FORMER DETAINEES

ISSUES OF CONCERN

Persons deprived of their liberty are inherently vulnerable, particularly during armed conflict and other situations of violence, when detention systems may be badly disrupted. A surge in people being detained often overwhelms judicial and detention systems, resulting in neglected, overcrowded or gang-run facilities. Under such circumstances the humane treatment of detainees becomes more challenging – living conditions deteriorate, access to health care is obstructed, and authorities impose severe restrictions, such as segregation and isolation. Regardless of the reason for their detention, some groups are particularly vulnerable when detained, such as women, children, the elderly, people who are wounded, sick or disabled, drug users and people with mental health disorders.

Persons deprived of their liberty: According to the ICRC, people are deprived of their liberty – detained – when they are confined in a narrowly bounded place, under the control or with the consent of a State or non-State actor, and cannot leave at will. People are considered to be detained from the time they are apprehended or held without having permission or authority to leave, until their release.

Inhumane treatment, poor living conditions and a lack of governance in places of detention can be both physically and psychologically harmful to detainees. They may suffer physically when basic needs, such as food and medical care, are not met or when they are victims of violence from staff or other detainees. Among other factors, overcrowding and staff shortages are risk factors that result in an increase in violence among detainees. Detainees may also be exposed to physical, psychological and sexual abuse while detained. Conditions are exacerbated further when they are not allowed to notify their family or friends of their arrest, or do not have access to a lawyer or to a medical examination by an independent doctor.⁵⁷

In armed conflict and other situations of violence or times of political unrest, torture, ill treatment and extra-judicial killings often increase in detention centres. These types of horrific experiences have lasting physical, psychological and psychosocial effects on both victims and their families, long after the event is over.

⁵⁷ Association for the Prevention of Torture (APT), “Yes, Torture Prevention Works”: *Insights from a Global Research Study on 30 Years of Torture Prevention*, APT, Geneva, 2016

The term **ill treatment** is not a legal term, but it is used to cover the following acts:

Torture: Severe pain or suffering (1), whether physical or mental, inflicted (2) for such purposes as obtaining information or confession, exerting pressure, intimidation or humiliation.

Cruel or inhuman (synonymous terms) treatment: Acts that cause serious mental pain or suffering, or that 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: Acts that involve real and serious humiliation or constitute a serious outrage upon human dignity and whose intensity is such that any reasonable person would feel outraged.

Definitions based on customary international humanitarian law⁵⁸

Many detainees are also at risk of developing mental health problems, whether or not they had mental health needs beforehand. Uncertainty about their situation, their treatment during detention and separation from the outside world often trigger or aggravate psychological distress in detainees. The increased vulnerability that detention brings and the lack of health services (especially mental health services) in detention facilities means that psychological difficulties are usually prevalent but mostly undetected and/or unaddressed.

People who have pre-existing mental health disorders are particularly likely to end up being detained during armed conflict and other situations of violence. When health services are disrupted, mental health patients are usually left without treatment. This may result in a worsening of their condition, leading to more disruptive, unpredictable and even aggressive behaviour, which may lead to a criminal conviction. Local systems often have nowhere to care for people with mental health disorders and detention facilities are used as an alternative to psychiatric facilities. Mental health difficulties are often neglected, as detention health care systems are mostly under-resourced and lack the psychiatric expertise needed to deal with these conditions systematically.

Even long after being released from a detention facility, former detainees⁵⁹ continue to suffer from the effects of poor nutrition, lack of medical care, loss of contact with family and community, stigma, and ill treatment and torture. Reintegration is a long and complex process that involves addressing the after-effects of detention as well as securing their physical, psychological and psychosocial well-being.

⁵⁸ ICRC, Customary IHL Database, Rule 90. Torture and Cruel, Inhuman or Degrading Treatment: https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule90

⁵⁹ Although the term “former detainee” is used for ease of reading in this document, the recommended term where possible is “a person who has been detained”.

MENTAL HEALTH AND PSYCHOSOCIAL NEEDS

High numbers of people with severe mental health disorders entering detention facilities present significant challenges. In many cases, adults with mental illnesses enter detention with a history of chronic health problems, unemployment, homelessness, financial instability, drug use and other high-risk behaviours. In most societies, people with mental health disorders face issues such as marginalization, stigma and discrimination in the social, economic and health spheres owing to widespread misconceptions about mental health disorders. They typically do not have a family and social support network, which is instrumental to covering their basic needs, nor supportive, positive and enduring relationships, which foster emotional health and stability.

Detention staff who are unfamiliar with mental health problems and care may use practices such as shackling and isolation for these detainees, which may exacerbate existing problems. It is common for detainees' mental health and general well-being to deteriorate rapidly when subjected to such practices. Furthermore, as conditions in detention facilities are not conducive to good mental health, all detainees are at risk of experiencing a decline in their mental state.

Mental health care within places of detention, including referral mental health services, is usually non-existent or inadequate, and where it does exist it is often solely focused on psychiatric care. The ICRC's field experience has confirmed that there are still many places of detention where health staff are poorly, if at all, trained in mental health, particularly in countries where there is a general shortage of mental health specialists (such as psychiatrists, psychiatric nurses and psychologists). Thus, detainees with mental health disorders do not receive effective support from health staff.

For detainees who require medication as part of their mental health care, a break in treatment may have extremely adverse effects and lead to a rapid deterioration of their psychological state. Detention systems may not be able to obtain the necessary medication and/or may fail to ensure the continuity of medical care when detainees are transferred from one place of detention to another and/or after they are released.

The physical, psychological and psychosocial consequences for detainees who experience ill treatment and torture while in detention can be devastating. Torture is a complex mechanism that can traumatize the body, compromise social functioning⁶⁰ and undermine the individual's autonomy, identity, sense of safety and ability to survive. Torture may also profoundly affect a person's connectedness and trust in family, friends and society at large. It can impair attachments and shake the person's belief system and how they see the world and their place in it.

In addition to the lasting physical reminders of torture and ill treatment, the psychological impact can be devastating. Although the effects vary considerably, according to the Istanbul Protocol,⁶¹ the most common psychological problems are major depression and trauma-related disorders such as post-traumatic stress disorder (PTSD). Reactions include reliving the event, avoidance and emotional numbing, living in constant fear, debilitating depression, damaged self-concept, panic attacks, somatic complaints, substance abuse and/or neuropsychological impairment. Victims of ill treatment and torture may continue to endure great suffering and be unable to live a normal life after their release.

⁶⁰ I. A. Kira, "Torture assessment and treatment: The wraparound approach", *Traumatology*, Vol. 8, No. 2, pp. 61–90, 2002

⁶¹ OHCHR, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* ("Istanbul Protocol"), HR/P/PT/8/Rev.1, Geneva, 2004

When detainees are released they often experience fears related to their future, problems readjusting to life with their families and in their social environment, and the effects of stigma. At a time when social support is essential to ensure positive reintegration, family relationships tend to be strained. Challenges may include emotional isolation from loved ones because they struggle to discuss their experiences while in detention, the feeling of being unable to meet their relatives' expectations in adjusting to life outside detention, and relationship problems related to sex and intimacy.⁶²

Whether physical problems, long-lasting psychological sequelae and/or social exclusion (at family, professional or community level), former detainees' needs have to be addressed in a holistic manner if the support is to be effective. Because they are suffering the consequences of ill treatment and torture alongside the already challenging issues surrounding release, they require further long-term clinical management after their release.

THE MENTAL HEALTH AND PSYCHOSOCIAL RESPONSE

Detainee-welfare activities, particularly those related to ensuring adequate and appropriate health care is available to detainees and former detainees, are a fundamental part of the ICRC's work. The ICRC's objective is to ensure that detainees are treated humanely and that their conditions of detention are acceptable and in line with international humanitarian law and international human rights law. To protect the physical and mental health and dignity of detainees, the ICRC provides a multidisciplinary response to individual and collective health needs in accordance with the ICRC's detention framework, policy on torture and assistance policy.

With regard to health care specifically, the ICRC's Health Strategy outlines a commitment to address the needs of detainees with psychiatric problems as well as the medical, psychological and psychosocial consequences of ill treatment and torture for former detainees.

Accordingly, the strategy adopted is two-pronged approach: *intra muros* and *extra muros*.

Intra muros: Inside places of detention, the ICRC aims to ensure that the needs of detainees with psychiatric problems are addressed.

Intra muros support includes providing technical recommendations or assessing the skills and building the capacity of health staff to promote proper care for detainees with mental health disorders. Advocacy work is carried out among detention staff when psychosocial problems are identified, such as in relation to living conditions and hygiene, as part of the ICRC protection and health teams' multidisciplinary approach. The ICRC may also supply psychopharmacological medication in detention facilities that are experiencing temporary shortages.

⁶² C., Haney, "The Psychological Impact of Incarceration: Implications for Postprison Adjustment", in J. Travis and M. Waul (eds.), *Prisoners Once Removed: The Impact of Incarceration and Reentry on Children, Families, and Communities*, The Urban Institute Press, Washington, D.C., 2003, pp. 33–66

Extra muros: Outside places of detention, the ICRC aims to ensure that former detainees who have experienced ill treatment and torture have access to the medical, psychological and psychosocial care they need.

Extra muros support involves a multidisciplinary response to the needs of former detainees, and particularly the needs of victims of ill treatment and torture, that strengthens culturally-appropriate local services to meet those needs in the long term.

NEEDS ASSESSMENT

Intra muros

Intra muros needs assessments are conducted inside places of detention by MHPSS delegates in collaboration with detention doctors and nurses and ICRC protection staff. *Intra muros* assessments will, at a minimum, assess: the type, prevalence and onset of mental health problems among detainees; the factors underpinning these problems; and forms of discrimination that detainees with mental health problems face in terms of accommodation, food, water and health services.

During an *intra muros* needs assessment, the ICRC conducts individual interviews with detainees and health staff working in the facility. Psychiatric evaluations may be conducted of detainees with mental health disorders in order to assess their condition in more depth. Moreover, meetings with the relevant authorities are arranged in order to understand their position on detainee mental health and their readiness to provide appropriate care.

The assessment also maps existing services inside and outside detention facilities, and services delivered by the authorities or outside organizations that are specifically geared towards mental health (i.e. promotion, prevention and/or treatment services). Domestic legislation on the provision of mental health care to detainees also needs to be factored into the assessment.

Extra muros

An *extra muros* needs assessment, focused on the MHPSS needs of former detainees, is very similar to that conducted *intra muros*, but the assessor may have psychological rather than psychiatric expertise and adopt a broader, multidisciplinary approach.

Extra muros assessments will, at a minimum, assess: the type, prevalence and onset of psychological and psychosocial problems faced by former detainees; the factors underpinning these problems; the physical, psychological and social consequences of torture and ill treatment; and forms of discrimination that former detainees may face in terms of accommodation, livelihood and access to health services after their release.

For an *extra muros* needs assessment, the ICRC conducts individual interviews with former detainees and, wherever possible, with their families, with the aim of gaining a solid understanding of the physical, psychological and social challenges they face. Moreover, interviews with the relevant service providers and authorities are conducted in order to map and assess the services available (e.g. medical, physical rehabilitation, social services, administrative support) and the readiness of the authorities to support former detainees.

The assessment maps and evaluates the technical quality of existing mental health services (i.e. promotion, prevention and/or treatment services) delivered by the authorities or outside organizations. Domestic legislation on the provision of mental health care to former detainees also needs to be factored into the assessment.

An *extra muros* assessment encompasses psychosocial aspects too, such as an individual's needs concerning their interpersonal relationships and social environment. It is important to look at the local culture and identify and address both positive practices (e.g. that foster former detainees' resilience) and negative ones (e.g. stigma). Social networks (e.g. family, caregivers, friends, colleagues) are assessed, as this is a significant factor to consider when identifying potential challenges to former detainees' social reintegration.

A comprehensive *intra muros* or *extra muros* needs assessment takes **1 to 3 months** depending on the ICRC's access to places of detention and contact with former detainees. Depending on the type of assessment, it will be conducted by an MHPSS delegate who is either a psychologist (*extra muros*) or a psychiatrist (*intra muros*).

PROGRAMME DESIGN AND IMPLEMENTATION

Mental health and psychosocial support is provided as part of the ICRC's broader, multidisciplinary response to the needs of detainees and former detainees.

Following an assessment, a programme is drawn up on the basis of the needs identified and the existing local resources. The implementation requires the presence of an MHPSS delegate for a period of **12 months**. Ideally the delegate works in collaboration with a local mental health practitioner who has extensive psychiatric expertise or a solid background in clinical psychology. The local psychiatrist/psychologist is trained to eventually take over the implementation on their own, providing there are no security risks for local staff working in places of detention or with former detainees.

TARGET GROUPS

1. Direct:

Intra muros: Detainees with mental health disorders.

Extra muros: Former detainees, in particular victims of ill treatment and torture.

2. Indirect: Family members of detainees and former detainees, community members in general, and all those associated with detention facilities.

SPECIFIC OBJECTIVES⁶³

The programme aims to deliver:

Psychiatric care for detainees with severe mental health disorders

In [specify number and types of target places of detention and /or geographic area], people deprived of their liberty and suffering from severe mental health disorders are diagnosed properly when attending existing (prison) medical services and receive appropriate medical care in line with international treatment protocols throughout their detention.

Medical, mental health and psychosocial support for former detainees

Upon release from (SPECIFY), XX former detainees suffering from the physical *and/or* psychological consequences of ill treatment *and/or* prolonged detention receive appropriate medical care *and/or* mental health care as well as psychosocial support in line with international recommendations.

These objectives can be achieved *intra muros* by building the capacity of health staff and raising the awareness of general staff in detention facilities, and *extra muros* by building the capacity of local service providers to help former detainees, particularly the victims of ill treatment and torture, overcome the consequences of detention and achieve reintegration.

METHODS

Intra muros: Technical support to ensure detainees with mental health disorders receive care

When providing *intra muros* support, the ICRC aims to ensure that detainees with mental health issues in places of detention receive adequate care. These efforts can also improve conditions for the entire detainee population.

⁶³ Depending on the needs of the former detainees in each context (i.e. psychosocial vs physical), the specific objective will be led by the Health Care in Detention team or the MHPSS team.

Intra muros support may be provided through the following activities:

ACTIVITY	PURPOSE	METHODOLOGY	EXPECTED OUTCOMES
Advocacy/ Infrastructural support	To ensure detainees with mental health disorders are treated humanely and live in appropriate conditions.	Advocate to senior management through information and sensitization activities (e.g. group discussions or individual meetings) to improve housing, sanitation and recreational facilities.	Senior management understands the importance of adequate conditions/facilities for the health and recovery of detainees. Senior management is committed to ensuring that detainees with mental health disorders are treated humanely by all staff.
Capacity-building for detention staff (including health staff working with detainees)	To improve screening and identification procedures for detainees with mental health disorders (upon arrival and periodically thereafter).	Detention facilities are given screening tools. / Current tools are reviewed and staff trained to use them. Detention staff are provided with basic psychoeducation to better identify detainees with mental health disorders and interact with them.	Detention staff have a better understanding of mental health disorders and show improved interaction with detainees with mental health disorders. Stressors in places of detention (e.g. lack of family visits, solitary confinement, no access to educational materials, no access to fresh air) are reduced.
Protocol creation and referral	To develop appropriate protocols and treatments (including referral) for different mental health disorders, depending on their type and severity, and on cultural attitudes.	Detention health staff are given appropriate protocols to interact with detainees who have mental health disorders, and refer them appropriately. Detention facilities are supplied with the necessary psychotropic medication.	Detainees with mental health needs/disorders receive treatment, adequate handling and therapeutic care, or referral (e.g. transfer to psychiatric hospitals, psychotropic medication alongside counselling, psychotherapy). Collaboration with the authorities or other services inside or outside detention facilities (e.g. specialized NGOs or associations) ensures that detainees enjoy care equivalent to that of the general population.
Information	To ensure detainees are informed about services available after their release.	Detainees and their families are given information on the support services or organizations available (ideally this information is provided to detainees before they are released, or upon their release when they approach the ICRC for assistance).	Detainees and their families know about the support services or organizations available.

Extra muros: Addressing the consequences of detention, in particular those arising from ill treatment and torture

When providing extra muros support, the ICRC aims to facilitate the provision of comprehensive care (including medical, psychological and psychosocial support) to former detainees who are coping with the consequences of prolonged incarceration, ill treatment and/or torture.

Extra muros support may be provided through the following activities:

ACTIVITY	PURPOSE	METHODOLOGY	EXPECTED OUTCOMES
Advocacy / Structural support	To facilitate efforts to ensure that there is continuity of health care for former detainees as part of an integrated approach (medical, mental health and psychosocial services).	Establish/strengthen partnerships with existing service providers (private and/or public) to ensure that the needs of former detainees are addressed. Sensitize and train service providers in the specific needs of former detainees.	The needs of former detainees are addressed by existing service providers in the community. Former detainees and their families are supported by these services after release.
Care provision and referral	To help former detainees return to society and ensure that their physical, psychological and psychosocial needs are addressed.	Former detainees are encouraged by detention staff and/or ICRC staff working in detention facilities to contact post-release services soon after their release for medical, mental health and psychosocial check-ups. Former detainees are referred to the relevant ICRC team and/or identified service providers to address additional needs, e.g. mental health, socio-economic and/or legal needs. In the absence of existing services, former detainees are supported for a limited time period by ICRC staff (multidisciplinary, depending on needs), while the ICRC advocates for the creation of local services to meet the long-term needs of former detainees.	Former detainees seek, attend and receive medical, mental health and psychosocial check-ups. Former detainees know about and use other service providers. Relationships with local services that can address the long-term needs of former detainees are developed/strengthened.

Ideally, in future programmes, the ICRC's post-release medical assistance programme should be based on a holistic approach and be expanded to include detainees' families. This would have to be done in partnership with local organizations that can provide long-term support to former detainees and their families.

The list of activities outlined above is by no means exhaustive. It is simply intended to illustrate the many areas that can be addressed through quality mental health and psychosocial support even if resources are limited.

MONITORING AND EVALUATION

To support the monitoring process, the ICRC has identified a number of indicators that can be used to assess the progress of MHPSS programmes for detainees and former detainees. For *intra muros* programmes, MHPSS data is entered into the ICRC's health in detention database in order to provide a comprehensive overview of health needs and facilitate the data collection and analysis process. For *extra muros* programmes, more in-depth data on psychological and psychosocial issues is collected in addition to the health care in detention records.

It can also be useful to assess the ability of the national/local system to meet the MHPSS needs of detainees and former detainees (e.g. sensitization of local authorities, financial resources) from a qualitative perspective.

All indicators are specified prior to the start of the programme and given a time frame. Some examples of the output and outcomes indicators employed to measure the effectiveness of interventions include:

Intra muros programmes

INDICATOR	REASON FOR USE
Output	
Number of detention facility health staff trained on mental health issues	<ul style="list-style-type: none"> Provides information on the availability of MHPSS services (i.e. trained health staff) for detainees
Number of detention facility staff who attended information sessions (on how to better identify detainees with mental health disorders and how to interact with them)	<ul style="list-style-type: none"> Provides information on the ability of detention facility staff to identify detainees with mental health disorders and interact with them appropriately
Outcome	
Number of detainees presenting mental health disorders who are accessing mental health care / Number of detainees	<ul style="list-style-type: none"> Monitors extent of mental health needs Provides information on the use of and access to mental health care Serves as a basis to calculate mental health services coverage Helps to plan human and other resources
Number of detainees with mental health disorders who are receiving follow-up / Number of detainees receiving mental health care	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services
Number of deaths of detainees with identified mental health disorders / Number of detainees with identified mental health disorders	<ul style="list-style-type: none"> Monitors the mortality rate of detainees with mental health disorders Monitors the extent of vulnerability of detainees with mental health disorders Monitors the appropriateness and effectiveness of MHPSS services Provides information on the ability of detention staff to support detainees with mental health disorders
Number of deaths of detainees with identified mental health disorders / Number of deaths of detainees without mental health disorders	<ul style="list-style-type: none"> Monitors the difference in mortality rate between detainees with and without mental health disorders Monitors the extent of vulnerability of detainees with mental health disorders Monitors the appropriateness and effectiveness of MHPSS services Provides information on the ability of detention staff to support detainees with mental health disorders

Extra muros programmes

INDICATOR	REASON FOR USE
Output	
Number of MHPSS detention facility staff who attended MHPSS sensitization and/or capacity-building sessions on the support required by former detainees	<ul style="list-style-type: none"> Provides information on the availability of MHPSS services for former detainees and awareness of their needs
Number of former detainees referred to specialized mental health services / Number of former detainees with MHPSS needs	<ul style="list-style-type: none"> Provides information on the extent of MHPSS needs that reach the referral criteria Provides information on the feasibility, appropriateness and effectiveness of the continuum of care Provides information on the ability of service providers to identify cases that require referral and to make referrals
Outcome	
Number of former detainees who show reduced distress / Number of former detainees receiving MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services
Number of former detainees who show improved functioning / Number of former detainees receiving MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services
Number of former detainees who show improved coping / Number of former detainees receiving MHPSS	<ul style="list-style-type: none"> Monitors the extent of MHPSS needs Monitors the appropriateness and effectiveness of MHPSS services

GLOSSARY OF TERMS USED IN MONITORING AND EVALUATING MHPSS PROGRAMMES FOR PERSONS DEPRIVED OF THEIR LIBERTY AND FORMER DETAINEES

Detention facility health staff: Includes medical personnel working in or in association with detention facilities.

Detention facility staff: All other staff working in the detention facility, which may include prison officers, social workers and management staff.

Follow-up: Detainees with mental health disorders who consult health staff more than once.

Mental health disorder: Groups of symptoms classified by a psychiatric diagnosis.

MHPSS service providers: Any other organization providing MHPSS services; in this case, addressing the needs of former detainees and/or accessible to former detainees.

MHPSS needs: Categorized by levels of distress, functioning and coping, measured using standardized scales.

Distress: Levels of distress are measured using standardized scales.

Functioning: Levels of functioning are measured using standardized scales.

Coping: Coping mechanisms are measured using standardized scales.

MHPSS/MHPSS services: Support/services addressing mental health and psychosocial needs provided as part of the MHPSS programme.

Specialized mental health services: Services addressing the needs of people with severe/complex mental health problems, including psychiatric disorders.

Referral: The specific needs of an individual are identified and he/she is then put in touch with an appropriate service to address his/her needs.

MAIN CHALLENGES FOR PROGRAMME IMPLEMENTATION

- Substance abuse remains a widespread issue in places of detention, though it is a relatively new area of work for the ICRC. Determining the most feasible and sustainable strategies to address the health-related aspects of this issue will require further field practice.
- While highly prevalent, mental health issues are often a taboo subject among detainees. To identify detainees with mental health disorders, the ICRC must advocate for the provision of mental health care while also building trust between health staff and detainees.
- Mental health support for detainees with mental health disorders and former detainees requires a long-term commitment and close follow-up by mental health professionals.

Support for former detainees relies heavily on local capacity. The quality of this support will depend on whether local/national service providers are aware that long-term needs exist and whether they are able to meet those needs adequately.



7. PEOPLE AFFECTED BY EMERGENCIES

ISSUES OF CONCERN

Whether emergencies arise from natural or man-made disasters, they result in wide-spread, life-threatening destruction. Severe damage to homes, communities and local services leaves people in urgent need of life-saving assistance, such as shelter, food, water and health care. People living in low-income countries and communities are particularly vulnerable, as they have fewer resources to prepare for and recover from an emergency. In these situations, the magnitude of the needs and the loss of life is likely to be even greater.

An emergency is declared when a humanitarian situation suddenly and significantly changes (in scale, urgency or complexity of needs), large segments of the population are at acute risk of dying, suffering greatly and/or losing their dignity, and there is a lack of humanitarian response capacity on the ground to cope with the crisis.

Definition based on the IASC Transformative Agenda Protocols⁶⁴

When an emergency is declared, large-scale multifaceted humanitarian assistance is mobilized. The priority of this response is to ensure that people are safe and that their basic needs are met. In addition to these core imperatives, a key component of the response is providing medical, psychological and social services.

During and long after emergencies, people suffer a wide range of acute and long-lasting mental health and psychosocial consequences. These may be brought on by the emergency itself (e.g. injuries, death of loved ones, family separation, loss of livelihood, rise in violence, loss of community support), by pre-existing conditions (e.g. mental health disorders) and/or by the humanitarian response (e.g. overcrowded shelter, lack of privacy). Although MHPSS needs may be acute in the short term, they can also undermine the long-term well-being of the individuals and communities affected.⁶⁵

During emergencies it is therefore essential that comprehensive efforts are made at the individual, family and community levels to protect and support people's mental health and psychosocial well-being. An effective MHPSS response involves strengthening social networks, providing basic psychological support and providing access to specialized mental health services. In recognition and support of MHPSS activities in emergencies, the *Humanitarian Charter and Minimum Standards in Humanitarian Response*⁶⁶ outlines a set of minimum multi-sectoral responses that incorporate MHPSS as part of an all-inclusive emergency response model. The 2007 *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*⁶⁷ further outline how to plan, establish and coordinate MHPSS as part of emergency response strategies.

⁶⁴ IASC, "What does the IASC Humanitarian System-Wide Level 3 Emergency Response mean in practice?", IASC, 2015

⁶⁵ WHO, *Mental Health in Emergencies: Mental and Social Aspects of Health of Populations Exposed to Extreme Stressors*, WHO, Geneva, 2003

⁶⁶ The Sphere Project, *Humanitarian Charter and Minimum Standards in Humanitarian Response*, The Sphere Project, Geneva, 2011

⁶⁷ IASC, *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, IASC, Geneva, 2007

MENTAL HEALTH AND PSYCHOSOCIAL NEEDS

Mental health and psychosocial difficulties are closely interrelated, especially in emergencies, when personal, social and economic devastation is immediate, severe, widespread and hard-hitting.

Emergency-induced psychological reactions include sadness, fear, anger, being on guard, insomnia, nightmares, irritability, guilt, suicide ideation, shame (so-called “survivors’ guilt”), confusion, hopelessness, withdrawal and disorientation. High levels of anxiety are common due to a general lack of information and access to basic services, and pre-existing psychological distress, such as depression, anxiety, and complicated grief, is likely to be exacerbated. Psychological distress may also manifest in physical symptoms, such as headaches, fatigue, loss of appetite, aches and pains.

Most people suffering from these acute reactions will cope, in time, provided they are able to meet their basic needs and resume their daily functioning, and provided they receive the support they need. However, some people experiencing trauma- and stress-related symptoms continue to suffer long after the emergency episode and may meet the criteria for a diagnosis of post-traumatic stress disorder. To deal with the situation and subsequent distress, people may develop negative coping mechanisms such as substance abuse, aggressive behaviour and/or social isolation.

The upsurge in mental health and psychosocial needs often overwhelms any existing MHPSS services, which were probably underdeveloped to begin with and which deteriorate further during an emergency. A lack of services, alongside the overwhelming devastation and unmet basic needs, means that MHPSS needs are likely to be neglected. People with pre-existing or newly developed mental health disorders are particularly vulnerable in an emergency. Not only might the situation cause their condition to deteriorate rapidly, but they are also likely to receive little or no treatment, and previous treatment is likely to be discontinued.

THE MENTAL HEALTH AND PSYCHOSOCIAL RESPONSE

When emergencies occur, the ICRC works in close coordination with other members of the International Red Cross and Red Crescent Movement (e.g. National Red Cross and Red Crescent Societies), as well as with various governmental and non-governmental organizations. The ICRC focuses primarily on protecting and assisting people affected by ongoing armed conflict and violence.⁶⁸

In emergency and disaster situations, various levels of psychological and psychosocial support are provided with a view to meeting the range of MHPSS needs of different groups and to preventing the emergence of new MHPSS needs and the exacerbation of existing ones. This response strategy fits in with the multi-layered support system outlined in the IASC intervention pyramid, with basic services and security at the base, followed by community and family support, then focused non-specialized support, and specialized services at the top.⁶⁹

⁶⁸ Agreement on the Organization of the International Activities of the Components of the International Red Cross and Red Crescent Movement – the Seville Agreement, Seville, 1997

⁶⁹ IASC, *IASC Reference Group Mental Health and Psychosocial Support Assessment Guide*, IASC, Geneva, 2012

The ICRC provides psychosocial support by addressing basic needs and social stressors, disseminating essential information and sensitizing groups about issues of concern. In response to psychological needs, basic psychological support systems are strengthened through health care providers or community actors. Moreover, specialized service providers addressing the needs of those with severe mental health disorders are identified and supported.

NEEDS ASSESSMENT

In order to conduct a thorough assessment, the ICRC regularly deploys an MHPSS delegate for a minimum of **3 to 4 weeks**.

That delegate conducts an assessment of MHPSS needs and resources, including an analysis of the community's capacity to cope with the emergency, using the MHPSS rapid assessment tool.⁷⁰ This tool sets out a comprehensive methodological framework encompassing: (1) a brief description of the event; (2) at-risk groups or people affected; (3) an inventory of services and interventions already provided; (4) available mental health and psychosocial support; (5) concerns, problem areas and priority issues; and (6) recommendations and suggestions.

Accordingly, an effective MHPSS emergency assessment will identify needs, cultural perceptions of distress, individual and community coping mechanisms, mental health and psychosocial vulnerabilities, and available services. Given the urgency of psychological and psychosocial support in such situations, it is important that the assessment is conducted and activities begin as soon as possible after the emergency occurs.

As well as collecting data and identifying needs, the assessment is itself a means to provide a first response. While interviewing affected individuals and communities, basic psychological and psychosocial support can be provided in the form of information-sharing, normalization (i.e. providing information about common psychological reactions to abnormal situations) and psychoeducation (i.e. sharing positive coping strategies to deal with these reactions).

As per the IASC guidelines,⁷¹ the MHPSS delegate coordinates with other stakeholders that are responding to the emergency. This includes the staff and volunteers of National Red Cross and Red Crescent Societies, health service providers, governmental and non-governmental organizations, and community and religious organizations. Among the specific groups of people whose vulnerabilities are exacerbated during an emergency are victims of violence (including victims of sexual violence), unaccompanied minors, front-line workers, weapon-wounded patients and people with physical disabilities. Each group requires particular attention during the assessment. Recommendations for supporting these groups are set out in the relevant chapters of these guidelines.

A more comprehensive overview of the impact of the emergency can be obtained by assessing the specific needs of different demographic groups (i.e. grouped by age, gender or ethnicity). Special attention is also paid to local cultural aspects – both those that foster resilience and those that hamper recovery through harmful practices.

⁷⁰ W. V. Laurel, "Development of the rapid assessment tool for mental health and psychosocial support in the Philippine health emergency setting", *Southeast Asian Journal of Tropical Medicine and Public Health*, Vol. 40, No. 1, 2009, pp. 88–95

⁷¹ IASC, *IASC Reference Group Mental Health and Psychosocial Support Assessment Guide*, IASC, Geneva, 2012

PROGRAMME DESIGN AND IMPLEMENTATION

Following the assessment, the needs identified are analysed and prioritized. In most emergencies, the ICRC integrates mental health support into health facilities. This maximizes access to mental health care for those who need it, as many people will immediately seek help owing to physical and somatic manifestations of psychological distress.

Most acute psychological distress symptoms can usually be managed without medication and can instead be addressed with basic psychological and psychosocial support. This involves crisis intervention (e.g. short solution-oriented therapeutic techniques), normalization, psychoeducation and referrals to service providers that address basic or specific needs. It is important that quality specialized service providers that support people with mental health disorders are mapped and that that information is shared among the relevant stakeholders in order to establish an effective referral system. In emergency settings, practical considerations surrounding patients' navigation of the referral system become even more significant. These include aspects such as arranging transport options, covering transport costs, and regularly updating the map of available service providers, as they may change constantly.

It is essential to carry out psychosocial activities to ensure that the MHPSS services that are available are recognized and accessed by those affected. The most effective way to reach people with MHPSS needs, especially the most vulnerable groups, and to facilitate their access to services is by setting up outreach teams. These mobile teams organize information and sensitization activities in locations where they can reach both communities as a whole and specific target groups.

TARGET GROUPS

1. **Direct:** Depending on the kind of emergency, the vulnerable groups identified in the respective chapters of this document (families of missing persons, victims of violence, helpers, hospitalized weapon-wounded patients and people with physical disabilities, and people deprived of their liberty) that are particularly affected by the emergency
2. **Indirect:** Individuals and communities affected by emergencies

SPECIFIC OBJECTIVES

The programme aims to deliver:

MHPSS support to the most vulnerable groups affected by the emergency

In XX emergency, target population(s) XX [SPECIFY (victims of violence, helpers, hospitalized weapon-wounded patients and people with physical disabilities, families of missing persons, detainees)] in location(s) XY [SPECIFY, e.g. geographic area] have reduced their vulnerability to mental health and psychosocial problems.

These objectives can be achieved by building the capacity of the available health staff (or, if unavailable, of key community actors) and by establishing outreach teams and supporting the development and use of referral pathways.

METHODS

MHPSS for people affected by emergencies is provided through the following activities:

AIM	PURPOSE	METHODOLOGY	EXPECTED OUTCOMES
Training health staff (and/or key community actors)	To train health staff (and/or key community actors) on MHPSS needs and consequences in order to improve the response to MHPSS needs in emergencies.	<p>Develop relevant training tools and information/sensitization materials, depending on the specific situation and target audience.</p> <p>Training is provided to health staff (or when not feasible, to key community actors) on MHPSS issues, such as normal and abnormal psychological reactions, symptom identification, screening of acute stress reactions, provision of basic psychological support, and referral thresholds and pathways.</p> <p>Facilitate the establishment of outreach teams and identify the most effective mechanisms for information-sharing and sensitization activities (e.g. radio, hotline, leaflets, theatre).</p>	<p>Health staff and/or community actors (depending on the local resources and availability) have sufficient knowledge and skills to provide basic psychological support to people with MHPSS needs in emergencies.</p> <p>Health staff and/or community actors have the ability to identify cases of severe psychological distress and psychiatric conditions and facilitate appropriate referrals (when specialized services are available).</p> <p>Information on MHPSS needs and the services available in an emergency are disseminated to the individuals and communities affected.</p> <p>Access to MHPSS services is ensured.</p>
Referral	To ensure people with specialized mental health needs and other specific needs are referred appropriately.	<p>Map and/or share a map of quality specialized mental health service providers and support the development of referral pathways.</p> <p>Continually update the referral map.</p> <p>Collaborate with and support local authorities and other agencies involved in the MHPSS response.</p> <p>Exceptionally, provide direct mental health support to individuals (only when the whole system has collapsed and there are acute symptoms that need to be addressed urgently).</p>	<p>People with mental health disorders are correctly identified and referred to specialized services.</p> <p>People with other needs are identified and referred to relevant services.</p>
Supervision	Ongoing monitoring and support of health staff and/or key community actors to use the knowledge and skills gained during training.	<p>Provide regular coaching and supervision to trained health staff and/or key community actors in relation to providing basic psychological support.</p> <p>Regular visits to health facilities and regular meetings/discussions with health staff and/or key community actors, as required.</p> <p>Occasional participation in sessions where basic psychological support is being provided as well as case discussions.</p>	<p>Quality psychological and psychosocial support services are provided by trained health staff and/or key community actors.</p> <p>Severe psychological cases are identified and appropriate referrals are made (when specialized services are available).</p> <p>Other needs are identified and appropriately referred to other services (when available).</p> <p>MHPSS data collection methods are used.</p> <p>Issues that need further support are identified and addressed (e.g. through coaching or refresher training sessions).</p>

The list of activities outlined above is by no means exhaustive. It is simply intended to illustrate the many areas that can be addressed through quality mental health and psychosocial support even if resources are limited.

MONITORING AND EVALUATION

Evidence-based programmes are essential to providing good quality MHPSS support in humanitarian emergencies. Data collection and analysis is more challenging in these situations due to the uncertain and shifting nature of emergencies, but the process is crucial to ensure the efficacy and success of both the emergency response and potential long-term interventions. Early planning and a flexible approach can help, and qualitative data may be particularly relevant.

Please refer to the corresponding chapter of these guidelines for examples of the indicators used by the ICRC for different target group(s) – namely families of missing persons, victims of violence, helpers, hospitalized weapon-wounded patients and people with physical disabilities, and people deprived of their liberty.

MAIN CHALLENGES FOR PROGRAMME IMPLEMENTATION

- In emergencies, mental health and psychosocial support is not always considered a priority because organizations need to address the overwhelming prevalence of unmet basic needs and are restricted by operational and security considerations. However, in many contexts an early MHPSS response provides critical care to vulnerable individuals and helps reduce long-term mental health and psychosocial problems.
- Where health services have been severely disrupted or are non-existent, it is particularly difficult to integrate mental health care.
- In emergencies it is extremely important for the ICRC to work with National Red Cross and Red Crescent Societies and other service providers to provide a comprehensive and coordinated MHPSS response. Mapping service providers and establishing a synchronized and collaborative response can take time, something which is often lacking during an emergency response. This is even more challenging because service providers change frequently in emergency settings – new service providers begin working while others cease their activities.

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The ICRC helps people around the world affected by armed conflict and other situations of violence, doing everything it can to protect their dignity and relieve their suffering, often with its Red Cross and Red Crescent partners. The organization also seeks to prevent hardship by promoting and strengthening humanitarian law and championing universal humanitarian principles. As the authority on international humanitarian law, it develops and monitors compliance with it.

People know they can rely on the ICRC to carry out a range of life-saving activities in conflict zones, including: supplying food, safe drinking water, sanitation and shelter; providing health care; and helping to reduce the danger of landmines and unexploded ordnance. It also reunites family members separated by conflict, and visits people who are detained to ensure they are treated properly. The organization works closely with communities to understand and meet their needs, using its experience and expertise to respond quickly, effectively and without taking sides.

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