Increasing Access to Mental Health and Psychosocial Support in Humanitarian Contexts

A Reflection Guide for Community Leaders

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Cohort 2, 2022-2023

For my dad, with love.

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Executive Summary

This Research Report and accompanying Reflection Guide offer a solution to the challenge of caring for the mental health and psychosocial wellbeing of individuals in the the acute period following a traumatic emergency and/or disaster event, particularly in contexts where mental health is a taboo subject, and where mental healthcare is lacking.

As emergencies and disasters become more frequent and intense (due to, for example, our changing climate, more complex global relationships, a more closely tied international community, etc.), there is a strong need to ensure that everyone is adequately and fully cared for in the midst of these crises.

At the same time, as mental health becomes more studied and understood, and as our awareness sharpens about how disasters and emergencies impact people's mental health, there is a strong need for those who respond to these disasters to understand how to care for individuals' and communities' psychological and psychosocial wellbeing.

Today, there are professional humanitarian actors who spring into action immediately following a disaster/emergency. However, it should not be forgotten that community members and affected individuals themselves themselves are also important actors in a humanitarian response. They can and should be proactive protagonists, who must participate in rebuilding both their own lives and their communities.

In this vein, the humanitarian experts who are aware of the importance of mental health treatment and psychosocial support (MHPSS), have a responsibility to involve community members and leaders in their efforts to treat people's psychological wounds.

After studying a wide range of resources from some of the world's foremost humanitarian actors, I discovered that the vast majority of the tools and resources that they develop regarding MHPSS are written for humanitarian professionals rather than for community members. This seems almost contradictory to the consensus that they all seem to promote about the crucial importance of developing MHPSS systems that are community-based.

This research and accompanying Reflection Guide, therefore, fills at least some of the space within this gap left by humanitarian agencies that on the one hand strongly advocate for community-based MHPSS and on the other hand develop resources with primarily humanitarian practitioners in mind. The Reflection Guide is designed specifically for community leaders, to help them to enhance their role as caretakers of their communities using the scientifically-backed practice of Psychological First Aid.

Increasing Access to Mental Health and Psychosocial Support in Humanitarian Contexts

Research Report

INTRODUCTION

Picture a real-life example of a disaster event (e.g. a natural disaster, war, etc.) – the first one that pops into your mind. Now, make a mental list of the elements that are needed to respond to this disaster. Perhaps you are imagining doctors working around the clock in hospitals to treat injuries and give life-saving medicine to the sick and wounded. Or perhaps you see humanitarian workers distributing food; setting up Water, Sanitation and Hygiene (WASH) stations to try to mitigate the risk of disease; or building shelters to provide protection to those who have lost their homes. Or maybe you've thought of people in your own community collecting money or in-kind items to send to disaster victims.

If you pictured any or all of these types of responses, you've created an accurate mental picture of a typical humanitarian response. All of these (and more) are examples of essential and life-saving goods and services that effectively meet people's immediate needs during and following a disaster event. After years of practice, study, and policy development, modern humanitarian actors are able to immediately and effectively spring into action to deliver these goods and services to victims in the wake of a disaster event.

Every second during and following an emergency event is important, and each one can mean the difference between saving lives and communities, or not. In this highly-sensitive time, reactionary responses are extremely common. That is, people react and respond to what they see in front of them: a doctor sees a wound, cleans it, treats it, and bandages it; a humanitarian worker sees people who have no means to eat, and gives them food. But what about people's needs that cannot be seen?

Disaster events affect people not only physically but also, and especially, psychologically. According to the World Health Organization (WHO), "Nearly all those affected by humanitarian emergencies experience psychological distress, with one in five likely to have a mental disorder such as depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia."[1] Disaster events are, after all, at their core traumatic events. They are large-scale and aggressively disruptive. In some cases, a person's psychological trauma can present as physical symptoms that we can see (e.g. shock, trembling, etc.) but in many cases these traumas go unseen to everyone except to those who experience them. They are easy to miss, therefore, in humanitarian actors' responses.

1) World Health Organization (2021), 'Providing Mental health support in humanitarian emergencies'

In the past two decades, as mental health itself has become more of a studied and understood topic in medical sciences, mental health has also become increasingly studied and integrated into modern humanitarian responses. However, mental health treatment – both in practice and perception – is at different stages all around the world. In many places, mental health is still viewed as a taboo subject, and there is a lack of popular awareness about its importance to one's holistic health. As a result, many healthcare systems around the world today are under-equipped to provide adequate mental healthcare to people.

Humanitarian actors themselves are well aware of this. For example, Médecins Sans Frontières (MSF) states that, "Even though mental health awareness has grown and effective treatments for mental health conditions are available, we know that in low- and middle-income countries, less than 10% of people in need receive adequate treatment." [2] According to the 2023 Global Humanitarian Assistance Report, 77% of the countries that are currently experiencing a protracted crisis are also flagged as being in a state of high socioeconomic fragility.[3] It can be concluded, therefore, that a sizeable amount of humanitarian crises (and therefore humanitarian responses) are currently taking place in low- and middle-income countries where mental health treatment is under- or simply unavailable. In the same article cited above, Médecins Sans Frontières' Mental Health Advisor, Marcos Moyano, pointed out that, "As there are almost no providers in the context where we work, we often have to create our own mental health programs." [4]

All of this shows that it is not guaranteed that mental health treatment can be easily (or at all!) integrated into every humanitarian response around the world.

The question that has inspired this research project stems from exactly this problem: how can humanitarian actors address and treat the mental traumas of victims of disaster events in places where mental health (as a concept and in practice) is not fully understood, or even resisted?

After reviewing theoretical and practical evidence, humanitarian actors and mental healthcare practitioners seemingly unanimously support the idea that one key solution lies in putting mental health treatment skills into the hands of community members themselves. I have found these arguments compelling, and I agree with this approach. In this vein, as a practical addition to this research project I have developed a Reflection Guide that will help community leaders to administer Psychological First Aid (PFA) in the crucial time immediately following a disaster or emergency event. The Reflection Guide has been designed to help the user to leverage their role as a community leader, so that they can perform PFA regardless of how mental health treatment is perceived in their community.

2) MSF (2021), 'MSF responds to mental health needs around the world'
3) Development Initiatives (2023), Global Humanitarian Assistance Report 2023, pp. 23-24
4) MSF (2021), 'MSF responds to mental health needs around the world'

This is a topic that is relevant to the Mercy World for three reasons:

1. **First, humanitarian responses are very closely tied with the Mercy themes of 'Displacement of People and Degradation of Earth'.** This research (and accompanying Reflection Guide) is a resource that will help more people to access mental healthcare in the context of the humanitarian programs that respond to these two themes (and many others, of course).

2. **Second, the research and Reflection Guide is a form of 'meeting people where they are'.** The purpose of this project is to help to increase access to even basic mental healthcare (and therefore promote mental and psychosocial wellbeing) for those who live in the (sometimes very wide) space between acute need and availability of care. The strategy to close the gap between need and care is to offer the care in a non-threatening way, rooted in community.

3. **Third, it promotes the community-based support system that was so central to Catherine McAuley's vision of Mercy.** The Reflection Guide is a resource that puts mental health and psychosocial support (MHPSS) directly into the hands of community members themselves. In the process, it helps to foster a sense of responsibility for people to care for the psychological wellbeing of others in their community.

An Overview of Mental Health Treatment in Humanitarian Responses

Integrating mental health treatment into humanitarian responses is a relatively modern practice, having gained significant momentum only in the past two decades. The World Health Organization stated in a 2021 article that, "Historically, humanitarian assistance programmes have overlooked the need to incorporate mental health and psychosocial support services in response efforts – despite overwhelming evidence of heightened vulnerability among displaced communities to mental health conditions."[5] Given its relative novelty compared with more established humanitarian practices (e.g. physical healthcare, WASH, food security, etc.), there is less information available about exactly when, why, and in what contexts mental health treatment gained a footing in humanitarian responses.

5) World Health Organization (2021), 'Providing Mental health support in humanitarian emergencies'

Researchers in a 2011 Lancet article about the practice vs research of mental health treatment in humanitarian responses stated that, "A major finding of our review is the disconnection between research and practice. The focus of research and evidence relates to interventions that are infrequently implemented in mental health and psychosocial support (MHPSS) programmes."[6] In 2019, the World Health Organization (WHO) ordered an extensive review and analysis of the prevalence of mental disorders in conflict settings, and the authors claim to have found only 129 academic studies published between 1980 and 2017 on the topic of mental health disorders linked to conflict situations.[7] This scarcity of research combined with the nebulous practice of mental healthcare in emergency settings until the 2010s, means that a complete and accurate historical record of humanitarian actors' activities related to mental health is difficult to compile.

Since it is not possible to provide, then, a definitive historical overview of humanitarian mental health responses around the world, I will offer instead an analysis of how four of the world's leading humanitarian actors currently (and historically, as far as can be accurately gleaned) integrate mental health treatment into their humanitarian responses and policies. It should be noted that this is, by no means, an exhaustive list of all MHPSS activity and actors within the field of humanitarian aid. Rather, it is a 'highlight reel' of the activities and resources of some of the world's most influential and established humanitarian actors, and is intended to provide a broad overview of the history, trends, and practices of mental healthcare in humanitarian aid. I should also point out that little-to-none of the work outlined below was done in silos, and so there are countless other humanitarian actors that contributed to this work, even if they are not explicitly named in this report.

6) Wietse et al. (2011), 'Mental health and Psychosocial Support in Humanitarian Settings', p. 9
7) Charlson et al. (2019) 'New WHO Prevalence estimates of mental disorders in conflict settings', p. 244

MENTAL HEALTH RESPONSES BY HUMANITARIAN ACTORS

World Health Organization, and other United Nations Agencies

The World Health Organization (WHO) claims to be "the lead agency in providing technical advice on mental health in emergency situations",[8] and it is certainly true that their database of literature and tools about mental health both within and outside of humanitarian responses is quite extensive. With respect to the former, in their own words:

> *"The Organization works globally to ensure that the humanitarian mental health response is both coordinated and effective, and that following humanitarian emergencies, all efforts are made to build/rebuild mental health services for the long term. WHO's advice and tools are used by most large international humanitarian organizations active in mental health."* [9]

As the United Nations' primary agency for research and policy on health-related issues, the WHO's earliest work on mental health was done mostly from the perspective of medical science. The exact time that they broadened this view to include mental health as an element of humanitarian aid is unclear. In the aforementioned 2019 study, however, the WHO claims to have analyzed the correlation between mental health and emergency events in 2005 and that "[in 2019] the impact of conflict on people's mental health is higher than previous estimates [i.e. the 2005 estimates] suggest. Mental health care must be prioritized in countries affected by conflict, not least for the well-established links between mental health, [individual] functioning, and country development."[10] They ultimately conclude that, "The burden of mental disorders is high in conflict-affected populations. Given the large numbers of people in need and the humanitarian imperative to reduce suffering, there is an urgent need to implement scalable mental health interventions to address this burden."[11] These research initiatives show, therefore, that the WHO earnestly turned its attention towards mental health in humanitarian settings over the course of the first two decades of the 2000s.

This more nuanced focus on mental health has resulted in many collaborations between the WHO and other UN agencies and humanitarian actors. Notably, in 2007 the

8) WHO (2022), 'Fact Sheet, Mental Health in Emergencies'
9) ibid.
10) Charlson et al. (2019) 'New WHO Prevalence estimates of mental disorders in conflict settings', p.241, 247
11) ibid. p.240

WHO helped the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) to set up the Inter-Agency Standing Committee (IASC)[12] Reference Group on Mental Health and Psychosocial Support in Emergency Settings. This important reference group serves as a space where the WHO and other humanitarian agencies examine and develop tools and best practices for applying mental health treatment in the context of emergencies and humanitarian responses. It is the WHO, however, that remains the backbone of the United Nations' efforts to understand the links between mental health and humanitarian responses.

Resource List: WHO and other United Nations Agencies

The WHO is now prolific in its publication of policies and guidelines about how to effectively and ethically provide mental health in humanitarian responses. One of the earliest examples of a WHO publication on this topic is their 2003 report '**Mental Health in Emergencies**'. This document outlines principles and best practices for governments and NGOs to assist "populations exposed to extreme stressors" since "exposure to extreme stressors is a risk factor for mental health and social problems."[13] Another significant WHO publication is '**Guidelines on Mental Health and Psychosocial Support in Emergency Settings**', which they published in 2007 with the above-mentioned IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings. This document is "a multi-sectoral, inter-agency framework that enables effective coordination, identifies useful practices and flags potentially harmful practices, and clarifies how different approaches to mental health and psychosocial support complement one another."[14] As more information about mental health becomes available from Humanitarian practitioners, the IASC Reference Group publishes more tools related to the practical application of these guidelines. Notably, in 2017 the Reference Group published for the first time a '**Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings**'. This significant achievement means that humanitarian actors now have a common framework to use when tracking data about mental health in emergency settings and humanitarian responses. The longer-term implication of this, of course, is that from now on we will have a more complete and organized record of policies and practices of mental health treatment in humanitarian responses.

The WHO tool most specifically related to this project is their 2011 publication entitled '**Psychological First Aid: A Guide for Field Workers**' (which was written in collaboration with the War Trauma Foundation and World Vision International). This document is the closest tool to the Reflection Guide that I have developed alongside this research project, in that it offers non-specialists an easy-to-understand guide for providing

12) The IASC is the United Nations' official forum to coordinate humanitarian action, policies and priorities.
13) WHO (2003), 'Mental Health in Emergencies', p. 2
14) WHO & IASC (2007), 'Guidelines on Mental Health and Psychosocial Support in Emergency Settings', p.1

psychological first aid in the context of an emergency response. While the guide could of course be picked up and applied by anyone (i.e. including members of the affected community), the tone of the document is directed predominantly towards an outsider entering a community. For example, it contains a chapter called 'How to Help Responsibly' where the reader is briefed on how to adapt their practice of PFA when directing it towards someone of a different culture than their own.[15] Indeed, the title itself – 'A Guide for Field Workers' – indicates that field workers (i.e. humanitarian practitioners, medical personnel, etc.) are the target audience of this work, rather than community members. Nevertheless, it does offer a helpful and practical guide for any non-specialist in mental health to effectively administer PFA in a humanitarian response setting.

Within their own field of expertise (i.e. health), it is also significant to include the WHO's **Mental Health Atlas** in this list of relevant resources. The purpose of the Mental Health Atlas is to collect, compile and disseminate data on mental health resources (i.e. policies, plans, financing, care delivery, human resources, medicine, and information systems) around the world.[16] The Mental Health Atlas has been updated five times between its first publication in 2001 and its latest publication in 2020. In May 2013, UN Member States at the World Health Assembly adopted the WHO's Comprehensive Mental Health Action Plan 2013-2020 (which has since been updated, and is now the **Comprehensive Mental Health Action Plan 2013-2030**). This document outlines clear actions for UN Member States, the WHO, and their various partners to make mental health attainable for and accessible to all. One of the important targets included in the updated 2013-2030 action plan is for countries to develop, improve and report on systems for mental health and psychosocial preparedness in emergencies and disasters.[17] The rationale is that if countries and actors build mental health treatment into their Disaster Risk Reduction (DRR) plans, mental health treatment will become about prevention and preparedness rather than reaction if ever the need arises. The Action Plan also includes the objective: 'To provide comprehensive, integrated and responsive mental health and social care services in community-based settings'[18] which highlights that the WHO champions the idea that mental health supports are most effective when they come from within the community itself. A common thread through these documents is that the WHO views humanitarian responses as a crucial setting for mental health treatment, and can even provide opportunities to create and strengthen mental health support systems.[19]

15) WHO (2011), 'Psychological First Aid: A Guide For Field Workers', pp.7-12.
16) WHO (2023), Mental Health and Substance Use: Mental Health Atlas https://www.who.int/teams/mental-health-and-substance-use/data-research/mental-health-atlas
17) WHO (2020), 'Mental Health Atlas', p. 111
18) WHO (2021), 'Comprehensive Mental Health Action Plan 2013-2030', p.25
19) For example, numerous humanitarian actors that I examined in my research cite the emergency responses to the Covid-19 pandemic as catalysts for some communities to begin to understand and accept the importance of mental health and mental healthcare.

In addition to the WHO, many other UN agencies that serve emergency victims consider Mental Health a topic of interest. For example, in 2015, UNOCHA (in collaboration with the WHO) published the **mhGAP Humanitarian Intervention Guide**. This document is an adaptation of the WHO's original Mental Health Gap Action Programme (mhGAP) Guideline for Mental, Neurological and Substance Use Disorders (first published in 2010, with **its third edition** published in 2023). The original WHO Guidelines are written for general healthcare providers to understand and provide treatment for mental health patients.[20] The Humanitarian Intervention Guide adapts this original document to offer guidelines for general healthcare providers to provide mental health treatment in emergency settings, taking into account the additional challenges of heightened urgency to prioritize and allocate scarce resources, limited time to train healthcare providers, limited access to specialists, and limited access to medications due to disruption of usual supply chain.[21] A second important publication from another UN agency is the 2017 UN High Commissioner for Refugees (UNHCR) handbook called '**Community-Based Protection and Mental Health and Psychosocial Support**'. The purpose of this handbook is, 'to help community-based protection actors and MHPSS practitioners understand the implications of their work for one another's field of expertise, and how they can together contribute to the wellbeing and protection of people affected by forced displacement.' [22] These resources from UNOCHA and the UNHCR show that humanitarian actors are increasingly interested in the mental health of the populations that they serve, and are investing significant resources to understand it better.

To conclude this section, the United Nations and its agencies offer the most prolific body of work regarding the policy and practice of mental health treatment in emergency situations. While these documents are extremely helpful for understanding the implications of disasters and emergencies on mental health and how mental health treatment can and should be administered in a humanitarian response, they are largely written by and for trained mental health and/or humanitarian practitioners. Nevertheless, they do all agree that putting tools like these into the hands of community members themselves would be an extremely effective way to ensure that mental health treatment is applied effectively, ethically and widely in emergency contexts.

Key Learnings

Humanitarian Responses are a crucial setting for mental health treatment, and can even provide opportunities to create and/or strengthen MHPSS systems.

Empowering communities to provide MHPSS support is an effective way to ensure that mental health treatment is applied effectively, ethically and widely in emergency contexts.

20) WHO & UNHCR (2015), 'mhGAP Humanitarian Intervention Guide', p.1
21) ibid., p.1
22) UNHCR (2017), 'Community-Based Protection and Mental Health and Psychosocial Support', p. 3

Sphere

The next significant humanitarian actor that I will examine is Sphere. Sphere is a global community of humanitarian practitioners and researchers that first came together in 1997 with the aim of improving the quality of and developing common standards of accountability for humanitarian work. Its founding members developed a Humanitarian Charter and a set of standards that, in theory, should be upheld in every humanitarian response. The Sphere community continues its work guided by the following two fundamental philosophies: [23]

1. People affected by disaster or conflict have the right to life with dignity and, therefore, the right to assistance; and
2. All possible steps should be taken to alleviate human suffering arising out of disaster or conflict.

Today, Sphere continues to be an authoritative and respected voice in the humanitarian community, as it brings together many important humanitarian actors to continuously improve the standards and practice of humanitarian assistance.

Resource List: Sphere

The most significant (and famous) work of Sphere is **The Sphere Handbook**, which was first published in 1998, and is now in its fourth edition (published in 2018). According to its authors, the principal users of The Sphere Handbook are "practitioners involved in planning, managing or implementing a humanitarian response. This includes staff and volunteers of local, national and international humanitarian organisations responding to a crisis, as well as affected people themselves." [24] The Sphere Handbook is divided into four foundational chapters that define and highlight the ethical and legal foundations of humanitarian responses, followed by four 'technical' chapters that outline minimum standards regarding WASH, Food Security and Nutrition, Shelter and Settlement, and Health activities in a humanitarian response.

In its original 1998 publication, the Handbook did not mention mental health at all. However, the 2004 updated edition included Standard 3.3: 'Mental and social aspects of health: people have access to social and mental health services to reduce mental health morbidity, disability and social problems'.[25] The aforementioned 2003 WHO

23) Sphere Association (2018), The Sphere Handbook, p. 4.
24) ibid., p. 4.
25) Sphere Association (2004), The Sphere Handbook, pp. 291-293.

publication, 'Mental Health in Emergencies' is listed by Sphere as a recommended resource to learn more about this topic. The latest 2018 edition of the Sphere Handbook covers mental health and psychosocial support (MHPSS) extensively. In their technical chapter on Health, Sphere categorizes mental health as an 'essential healthcare' stream, and its standards of practice are outlined in Standard 2.5 'Mental Health Care: People of all ages have access to healthcare that addresses mental health conditions and associated impaired functioning'. [26] This standard names Psychological First Aid as a key recommended action to achieve this standard, and includes a short paragraph of guidance notes on administering PFA in a humanitarian response. The main points of these guidance notes are that PFA is an effective first line of response for those who have been exposed to traumatic events, and that it can be performed by community leaders and other non-specialized actors after receiving training. [27] From 2004 to today, therefore, the Sphere Handbook has been a resource that has helped to develop standards of practicing mental health treatment in humanitarian responses.

As one of the most widely-used documents referenced by humanitarian actors to provide high quality and ethical humanitarian aid, The Sphere Handbook's notes on mental health can be considered widely influential in terms of how and why mental health should be integrated into humanitarian responses around the world. The latest Handbook (like many of the aforementioned UN documents) outlines the importance of empowering communities to provide mental health and psychosocial support (including PFA):

> *"Strengthening community psychosocial support and self-help creates a protective environment, allowing those affected to help each other towards social and emotional recovery. Focused individual, family or group interventions – including clinical interventions – are important, but do not necessarily have to be provided by mental health professionals. They can also be provided by trained and supervised lay people."* [28]

Despite this claim, the Handbook does not offer any concrete tools specifically for community members to use to increase their capacity to perform even basic MHPSS interventions. Moreover, as stated earlier the Handbook itself is written for and primarily used by humanitarian professionals. It lacks effectiveness, therefore as a tool to empower community members to develop and implement MHPSS systems for themselves.

Key Learnings

Psychological First Aid is an effective first line of response for those who have been exposed to traumatic events, and it can be effectively performed by community leaders after receiving training.

26) Sphere Association (2018), The Sphere Handbook, pp. 339-342.
27) ibid., p. 341
28) ibid., pp. 15-16

Médecins Sans Frontières

As one of the world's foremost healthcare-focused humanitarian organizations, Médecins Sans Frontières (MSF) has a rich pool of knowledge and tools regarding mental healthcare in humanitarian responses. MSF claims that their first mental health and psychosocial interventions took place in Gaza in 1990, and that since then they have implemented MHPSS interventions in over 40 countries worldwide.[29] A 2011 article indicates that MSF implemented a 230% increase in mental health consultations in their projects between 2001 and 2011.[30] In 2022 alone they claim to have provided 425,5000 individual mental health consultations in their humanitarian programs.[31] Indeed, the **mental health webpage** on the MSF website contains a huge database of articles, practical information and statistics about how MSF is providing and constantly adapting mental healthcare in various humanitarian responses around the world. Years of practice and learning have led to MSF now being a champion of integrating effective mental health responses into humanitarian responses.

Resource List: Médecins Sans Frontières

Given that they are so active in providing MHPSS initiatives in their work, MSF has developed a number of helpful tools and resources about how to apply mental healthcare in humanitarian settings. Their most extensive publication is their 2011 guideline document, '**Psychosocial and Mental Health Interventions in Areas of Mass Violence: A Community-Based Approach**'. While the guidelines focus specifically on mental healthcare during conflict and human-made emergencies, MSF claims that they have tested them out in instances of natural disasters with positive results.[32] Moreover, while MSF acknowledges that these guidelines could be picked up by any layperson, they specifically indicate that the guidelines will be most helpful to "people in coordination positions (medical and programme management) [who] strategize, plan, supervise, and coach a psychosocial or mental health programme component." [33] These guidelines name Psychological First Aid as an effective strategy for acute crisis intervention, and while they do not offer a detailed toolkit for people to learn how to perform PFA, they do highlight a short series of best practices to reduce harm and encourage self help when administering PFA.[34]

29) MSF (2011), 'Psychosocial and Mental Health Interventions in Areas of Mass Violence', p. 5.
30) MSF (2021), 'MSF responds to mental health needs around the world'
31) MSF (2023), 'Medical Activities: Mental Health'.
32) MSF (2011), 'Psychosocial and Mental Health Interventions in Areas of Mass Violence', p. 5.
33) ibid, p. 5
34) ibid, pp. 36-37

On a more practical level, MSF's online learning portal, Tembo, offers a wide range of free online courses that anyone can access to learn new or sharpen existing skills. Tembo offers a wide variety of courses on mental health, including two on Psychological First Aid – one to understand its basic principles, and one for applying it in the context of a crisis event. All of these courses are free of charge, and anyone (i.e. not only MSF staff) can create a free account on the Tembo portal. This resource is extremely helpful for learning skills quickly (e.g. the PFA courses each take 5 and 6 hours, respectively).

Again, these resources are very helpful tools that are based on the tried-and-tested methodologies of over 30 years' worth of MHPSS programmes in MSF's humanitarian responses. However, as we saw with the UN and Sphere, even though MSF recognizes the important role that community members can and should play in supporting mental healthcare, much of the MSF literature is directed towards humanitarian and healthcare practitioners rather than directly at community members themselves. One interesting admission in their 'Psychosocial and Mental Health Interventions' guidelines, is that MSF acknowledges that, "cultural differences do not favour a standardized approach to protcols."[35] In other words, it would be quite difficult for any member of any community in the world to find standardized protocols and guidelines (even those of MSF) useful, even if they are based on best practices. Ultimately, when the best practices are readily understood and implemented in one community or context, there will always be a risk that they will lose at least some of their relevance when applied in a different community or context. This is why it is so important to primarily support community members to participate in developing and implementing MHPSS in their own communities - because THEY are the experts in the context of what will be accepted or rejected by their community.

Key Learnings

Much of the MSF literature is directed towards humanitarian and healthcare practitioners, rather than to community leaders.

Best practices learned in one community/context and successful methodologies developed by 'experts' can still lose some of their relevance (and therefore effectiveness) when applied in a new community/context.

35) MSF (2011), 'Psychosocial and Mental Health Interventions in Areas of Mass Violence', p. 5.

International Red Cross and Red Crescent Movement

The final humanitarian actor that I will examine is the International Red Cross and Red Crescent Movement (IRCRCM). As the world's largest humanitarian network, the IRCRCM has extensive experience and a broad range of knowledge when it comes to responding to emergencies. On their Mental Health webpage, the ICRC claims to have run over 230 MHPSS projects around the world, reaching over 554,000 beneficiaries. However, they also acknowledge the following challenge:

> *"In many contexts, mental health and psychosocial needs are not well understood and as a result, people can face rejection, discrimination and stigmatization. This makes it difficult for them to get the assistance they need and leaves them vulnerable to ill-treatment"* [36]

They go on to state that their goal is to close the gap between need and access to care, by building the capacities of local communities to ensure the mental health of individuals. In 2019, the IRCRCM conducted a movement-wide survey to gather baseline data about the MHPSS activities carried out by the movement's members. The survey was repeated in 2021, and the progress made was captured in the 2023 Report '**Mental Health Matters: Progress Report on Mental Health and Psychosocial Support Activities with the International Red Cross and Red Crescent Movement**'. Significant insights from this report include the data that, as of 2023, 90% of ICRC members engage in MHPSS activities, with Psychological First Aid being the most common activity carried out (83% of members reported that they provided PFA).[37] Their members reported that PFA is "usually delivered by trained volunteers but is often supervised by someone with a more advanced background in psychology/social work/health."[38] They conclude this report by calling PFA a 'cornerstone' activity of the movement, and point out that the large number of staff and volunteers trained in the practice "is a demonstration of the Movement's commitment to building capacity." [39] This evidence shows that the IRCRCM and the majority of its members are very active in providing MHPSS services in the wake of a disaster and emergency, and especially favour a community-based approach.

36) ICRC (2023), 'Mental Health and Psychosocial Support'
37) IRCRCM (2023), 'Mental Health Matters', p.2
38) ibid., p.5
39) ibid., p. 34

Resource List: International Red Cross and Red Crescent Movement

The IRCRCM and its members, with their significant practical experience, have documented their learnings into resources that have helped to develop humanitarian actors' understanding of MHPSS activities in emergency situations. For example, in 2017, the International Committee of the Red Cross (ICRC) published **Guidelines on Mental Health and Psychosocial Support**, which gives an overview of MHPSS activities, implementation strategies, and monitoring and evaluating processes carried out by the ICRC. In this publication they state that, "The ICRC has an established first aid response, which covers both physical first aid and basic psychological and psychosocial support… 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." [40] They explicitly point out that these Guidelines are not a training manual, but the document is rather intended for the ICRC to give insight into its MHPSS processes and practices, to raise awareness about the importance of mental health in humanitarian responses and to promote clear and effective operational standards.[41] The guidelines lay out processes and best practices for administering MHPSS to 6 commonly encountered demographics in a humanitarian response (families of missing persons, victims of violence, helpers, hospitalized weapon-wounded patients and people with physical disabilities, and people deprived of their liberty and former detainees).

A second important IRCRCM resource is their 2018 publication, **A Guide to Psychological First Aid for Red Cross and Red Crescent Societies**. In the introduction, this document clearly states that the guide has been developed "for the staff and volunteers of Red Cross and Red Crescent Societies and other organizations working in situations where PFA may be relevant." [42] This guide is a helpful resource for a person at any level of understanding of MHPSS to familiarize themselves enough with the principles of PFA to provide this treatment to someone in need. Particularly helpful for emergency settings is the section on complex reactions and situations.[43] It should be noted as well that many National and Local Red Cross organizations (for example the Canadian Red Cross, American Red Cross, and Australian Red Cross, among many others) offer in-person and online PFA training, in the same way that they commonly offer basic physical first aid training. The IRCRCM and its organizations are very influential when it comes to training people to be able to administer PFA.

40) ICRC (2017), 'Guidelines on Mental Health and Psychosocial Support', p. 66
41) ibid., p. 4
42) IRCRCM (2018), 'A Guide to Psychological First Aid for Red Cross and Red Crescent Societies', p. 11
43) ibid., p.43-50

Once again, the IRCRCM and its members have compiled a significant database of resources that give insight into and training for providing MHPSS treatment at a high quality level in emergency settings. They clearly advocate for the importance of a community-based approach to mental healthcare, however at the international level of the IRCRCM we see that their main focus is to train their own members, staff and volunteers to carry out MHPSS initiatives in humanitarian settings. Trainings targeted towards community members occur far more frequently at the local level.

Key Learnings

Psychological First Aid is a 'cornerstone' activity of MSF, and is an effective tool to increase individuals' and communities' capacities and resilience.

A community-based approach to mental healthcare ensures effectiveness, scalability and sustainability.

THE CASE FOR A COMMUNITY-BASED MENTAL HEALTH FIRST RESPONDER SYSTEM IN HUMANITARIAN AID

Following this brief summary of the main MHPSS activities of four of the world's most influential humanitarian actors, I would like to draw attention to three main points.

1 Mental Healthcare is here to stay in Humanitarian Aid

Mental healthcare is by now firmly entrenched in modern and high-quality humanitarian responses, in the same way that physical healthcare has always been foundational to humanitarian activity. Its importance is rising alongside the increase in knowledge about mental health, best practices to care for people's mental wellbeing, and how disasters and emergencies affect people psychologically. Therefore, it is certain that mental healthcare will only rise in importance and become a more studied and professionalized stream in the world of humanitarian aid. As the world experiences more frequent and more severe natural disasters and as conflicts become more complex, caring for people's mental and psychosocial wellbeing will continue to be a critical part of effective humanitarian responses.

2 Community leaders are the key gateways through which MHPSS can reach individuals in any community

A common concept that came up numerous times in my research of humanitarian and mental health practitioners alike is the importance and effectiveness of community-based MHPSS programming. For example, in their 2023 Progress Report, the International Red Cross Red Crescent Movement claims that 48% of their members train community actors in basic psychosocial support.[44] The WHO Mental Health Action Plan 2013-2030 includes the objective: 'To provide comprehensive, integrated and responsive mental health and social care services in community-based settings' [45] In the IASC Reference Group Guidelines, the authors state:

> "*From the earliest phase of an emergency, local people should be involved to the greatest extent possible in the assessment, design, implementation, monitoring and evaluation of assistance. …Externally driven and implemented programmes often lead to inappropriate MHPSS and frequently have limited sustainability.*" [46]

Community buy-in is especially crucial (even if it is harder to achieve) in cultural and religious settings where mental health and its care are viewed with suspicion or outright rejected. If one can gain even a few community leaders as mental health allies, this can go a long way in ensuring appropriate care for the mental and psychosocial wellbeing of community members – even if this is not explicitly named as 'mental health' or 'mental healthcare' – in the long term.

Who exactly constitutes a 'community leader' varies from context to context, and so it would not be productive to make a definitive list of all types of community leaders. However, for the sake of naming a short list of examples, it could mean healthcare practitioners, or it could mean people like religious sisters, teachers, chiefs, elders, etc. In short, anyone who holds a degree of influence over their community, in whole or in part, may be considered a community leader. In Action Sheet 5.2 of the IASC Reference Group Guidelines ('Facilitate community self-help and social support'), the authors state:

44) IRCRCM (2023), 'Mental Health Matters', p.2
45) WHO (2021), 'Comprehensive Mental Health Action Plan 2013-2030', p.25
46) WHO & IASC (2007), 'Guidelines on Mental Health and Psychosocial Support in Emergency Settings', pp.10-11

> *"All communities contain effective, naturally occurring psychosocial supports and sources of coping and resilience. Nearly all groups of people affected by an emergency include helpers to whom people turn for psychosocial support in times of need. In families and communities, steps should be taken at the earliest opportunity to activate and strengthen local supports and to encourage a spirit of community self-help."* [47]

Who exactly is the best-poised community leader to provide MHPSS in a time of emergency depends entirely on the dynamics of each individual community.

It is very widely the consensus, therefore, that already-established community leaders are absolutely crucial for ensuring the mental and psychosocial wellbeing of a community. Many communities, as the IASC Reference Group acknowledges above, already have strong mechanisms in place to support each other in times of individual and/or collective crisis. **When done ethically and respectfully, these support mechanisms have the potential to be enhanced (not replaced!) by scientifically-backed MHPSS techniques (e.g. Psychological First Aid), which in turn may make them even more effective and sustainable.**

3 Psychological First Aid is an effective tool to address and treat trauma at its earliest stage, and sets a trajectory for positive outcomes in one's entire spectrum of mental healthcare

The acute period following a disaster or emergency event naturally coincides with the ideal beginning of the spectrum of MHPSS care of someone who has experienced trauma. As such, all of the humanitarian and mental health practitioners that I examined unanimously agree that providing at least basic mental health and psychological support to trauma victims as early as possible is key to achieving positive, long-term mental health outcomes for both individuals and communities. One of the most well-established and widely-used methods of providing this early MHPSS intervention, across the board of humanitarian actors that I examined, is Psychological First Aid.

47) WHO & IASC (2007), 'Guidelines on Mental Health and Psychosocial Support in Emergency Settings', p.100

According to the 'Johns Hopkins Guide to Psychological First Aid', PFA can be defined as follows:

> "*Perhaps the best way to conceptualize PFA is as the mental health analogue to physical first aid. PFA may be simply defined as a supportive and compassionate presence designed to stabilize and mitigate acute distress, as well as facilitate access to continued care. PFA does not entail diagnosis, nor does it entail treatment. PFA is a tactical variation within the 100-year-old field of psychological crisis intervention*." [48]

In the same way, therefore, that one does not have to be a doctor or a nurse to perform physical first aid (and anyone can receive physical first aid training), one of the greatest appeals of Psychological First Aid is that anyone can be trained to administer it. This makes it a perfect type of intervention in contexts where community-based MHPSS structures are the goal. In fact, the authors of the Johns Hopkins Guide cited above point out that, "PFA enjoys virtually universal recommendation for implementation in the wake of trauma and disaster." [49]

The wide acceptance of PFA as an effective intervention in humanitarian settings, therefore, is based on:

1. its ease to mobilize (i.e. anyone can be trained in a relatively short amount of time),
2. its effectiveness in initiating a continuum of care for victims of trauma, and
3. its effectiveness in helping people to regain control of themselves and their situation after experiencing an emergency or disaster.

Again, in the same logic as physical first aid, Psychological First Aid is proven to be a way of addressing acute mental trauma at the earliest possible stage in a way that decreases the likelihood that these mental traumas will go unchecked and develop into something more serious and difficult to treat.

48) Everly et al. (2017), 'The Johns Hopkins Guide to Psychological First Aid', pp. 3-4
49) ibid., p. 16

A Three-Pillar Approach

All three of these points taken together give direction to my proposed solution to the question that I posed at the beginning of this report. Since:

1. **MHPSS is becoming more integrated not only in the responses but also the Disaster Risk Reduction strategies of humanitarian actors and countries**
2. **Community leaders are the gateways to reach individuals and communities with MHPSS (especially where mental health and its treatment are viewed with suspicion or rejected outright), and**
3. **Providing immediate (even if basic) mental healthcare is such a crucial step in helping individuals and communities rebuild and thrive after an emergency or disaster,**

...then a capacity-strengthening resource must be made available for community leaders to provide this type of service to their community, ideally before a disaster event occurs.

When caring for people's mental wellbeing in an intentional, scientific way (especially in sensitive contexts where mental health is not widely accepted) it is essential that those administering Psychological First Aid create a perfect balance between their unique identity as a community leader and their identity as a mental health first responder. In contexts where mental health is a 'taboo' subject, if people assume the profile mostly of a **mental health first responder**, they will not be able to access people. Conversely if they try to provide mental health treatment only from the perspective of, say, **their training as a sister or an imam** (just to name two examples), they may not provide MHPSS that is as effective as it could be. In the moment that they are performing PFA, they have to be both community leader and mental health first responder in equal parts.

There are many benefits of creating a resource with this community leader-first approach. First, it helps to establish the community-based MHPSS system that most humanitarian and mental health practitioners say is so important. Practitioners hired in a humanitarian response, unless they are from the affected community directly, will always be seen as outsiders to the community. Putting PFA skills into the toolboxes of people who are from the affected community and who are already trusted leaders will increase the reach of the PFA treatment.Moreover, when the support is rooted in the community, it increases the likelihood that all necessary follow-ups in the PFA process can take place (because those

administering it are already at home in the community, and can ensure proper follow-up). Second, if community leaders can train in PFA and use this Reflection Guide before any disaster strikes, it will help to integrate PFA into a community's Disaster Risk Reduction Plan, as is recommended in the WHO's Mental Health Action Plan 2013-2030.[50] And third, it is easy to put into action (and even to scale up) quickly because it is easy to train many people in PFA in a short amount of time.

CASE STUDY 

In order to explore the effectiveness of community-based PFA, to make the case for the helpfulness of a resource like the Reflection Guide that I offer, I will briefly describe the PFA response to Typhoon Haiyan in the Philippines in as an example of community-based PFA in action.

Typhoon Haiyan (2013)

In the wake of Typhoon Haiyan in the Philippines in November 2013, a group of researchers from three Filipino Universities conducted a study to examine the experiences, adaptations, observations and insights of training and dispatching Filipino PFA providers to communities affected by the typhoon. It should be noted that the nineteen people trained in PFA were all from larger cities and all already had a background in psychology.

One interesting adaptation that came from this study is that, while PFA is usually administered in an individual one-to-one setting, in the Filipino context it was more effective to offer this intervention in a group setting.[51] The PFA providers also reported adapting the PFA model to integrate the local counseling models of pagdadala ('burden bearing').[52]

In terms of results, the PFA providers reported observing certain changes among those to whom they administered this MHPSS support. For example, they noticed a change in facial expressions and body language (from burdened to relieved), a change in attitude (from victim to survivor, and an awareness about the source of their stress), and a change in emotions (from anger, stress and sadness to relief, gratitude and hope) in the people who received PFA from them.[53] Ultimately the authors attribute much of the success of the PFA programs in this study to the PFA providers being able to understand how to adapt the core principles of PFA to the cultures and customs of the communities in which the PFA was being performed.[54]

50) WHO (2020), Mental Health Atlas, p. 111
51) Landoy et al. (2015), 'The Application and Adaptation of Psychological First Aid', pp. 87, 95-96.
52) ibid, pp. 94-95.
53) ibid. pp. 97-99.
54) ibid. p. 100.

Key Learnings

PFA became even more effective than its original form (i.e. the form that one may encounter in a textbook or PFA course) when those who administered it were able to understand how to tailor it to the customs of the community that they were treating.

The students who were trained in this example shared similar enough values and culture to the community members whom they treated, that they were able to adapt PFA in a helpful and non-threatening way. However, ultimately they themselves were not members of these communities. While they effectively performed PFA in the aftermath of Typhoon Haiyan, the fact that external students rather than community members were trained means that this exercise will not sustainably help these communities to incorporate MHPSS to their Disaster Risk Reduction plan for the future.

REFLECTION GUIDE FOR COMMUNITY MENTAL HEALTH FIRST RESPONDERS

Many of the humanitarian and mental health actors that I studied in my research have PFA guides for practitioners that are not specialized in mental health. Why do we need another one? What was missing in my research, and the need that I intend to fill with this project, is that there were no PFA or MHPSS resources that were directly addressedto and created specifically for community leaders and that guide community leaders to provide MHPSS to their peers (i.e. performing PFA) in the most appropriate and effective way possible.

In this research project, I have developed a new tool as a practical resource to implement the three-pronged approach to providing MHPSS in emergency responses described above. This guide, called 'A Reflection Guide for Community Leaders acting as Mental Health First Responders' is a guide specifically designed for community leaders to perform effective Psychological First Aid on their community members, irrespective of how mental health is regarded by their community or the level of mental health treatment currently available in the community.

The novelty and innovativeness of this resource is that it is designed specifically for community leaders, to be used specifically by community leaders. All of the other resources that I found in my research (even the ones that highlighted the importance of

community-based mental health supports) were written by humanitarian and/or mental health practitioners, largely for humanitarian and non-specialized (i.e. in mental health) emergency practitioners. Community leaders, therefore, have been expected to use the same tools and resources as these humanitarian and non-specialized emergency practitioners. The Reflection Guide that I have developed was designed exclusively for community leaders, and this is what makes it unique.

Ultimately, this Reflection Guide is a tool that is designed to help community members leverage precisely their role as community members, in caring for the mental and psychosocial wellbeing of individuals in their community (and, by extension, the community as a whole).The Guide steers the user into a mindset where they can strike the perfect balance: between being a mental health first responder who cares for the mental and psychosocial wellbeing of individuals in their community, and being a community leader (in whatever form is their own, e.g. an imam, a grandmother, etc.) who protects the wellbeing of their community and helps to restore it to a state safety and control. Other resources that I found in my research simply (albeit very well) outline the basic theories and methods of Psychological First Aid and offer guidance about how to successfully implement them in emergencies.

What this Reflection Guide is not, is a course on how to understand and administer Psychological First Aid. It is designed to be a resource that compliments formal training on PFA. The user, therefore, must do the legwork to learn the basic principles of PFA and how to practice them before attempting to use this guide. The Guide lists various resources (including online resources and books, which are particularly helpful for those who live in areas where in-person training is unavailable) on where a community leader can find such training. The basic principles and practices of PFA are largely universal at this point (for example, using reflective listening, not offering solutions to fix the person's problems, reading body language, etc.) with a few nuances based on context. As a result, any PFA course (as long as it comes from an instructor that is professional and qualified) is a suitable prerequisite for a community leader, before using this guide.

It is also not a resource that tries to change an individual's or a community's attitude towards mental health. While it does assume an appreciation of the importance of mental health and wellbeing in the user, the primary goal of this resource is simply to assist community leaders to provide basic support to members of their community who have experienced trauma that has impacted their mental and psychosocial wellbeing. As stated previously, the IASC Reference Group rightly points out that most communities already have existing psychosocial support mechanisms woven into the fabric of their community and traditions (even if they don't explicitly call it this). This Guide is not intended to replace these community supports with Psychological First Aid, but rather to use the principles of Psychological First Aid to enhance these existing support mechanisms, using scientifically-backed methodologies that promote psychological wellbeing.

And this is precisely why developing a resource written specifically for community leaders - who are at the heart of these existing community MHPSS systems – is so important. By using this tool, community leaders can help individuals (and their whole community) to return to a state of safety and control in a responsible and effective way, so that the initial psychological 'scars' incurred in the initial phase of trauma do not go untreated and (potentially) worsen into more difficult conditions later on.

CONCLUSION

It is a positive development that mental health and psychosocial support are becoming more and more entrenched in humanitarian responses. While physical scars are physically painful, in many cases psychological scars have much more long-lasting effects on individuals and communities. Left untreated, these psychological scars have the ability to hold individuals and communities back from rebuilding and thriving again after a disaster or an emergency event.

Because mental health is such a universally controversial topic, it is prudent for humanitarian actors to acknowledge that it will not always be easy to implement mental healthcare in their responses to emergencies and disasters. The less easy it is to bring mental healthcare into a community, the more important it is to make every effort to plant the seeds and let its basic practices and principles organically grow up from the grassroots of the community.

The most fertile ground to plant these seeds are in the pre-existing social support mechanisms of a community, the caretakers of which are traditional and established community leaders. It is my hope that the Reflection Guide offered here – although it is founded in extensive research about humanitarian actors' ideal MHPSS action plans and what is missing from the resources developed on this topic – is a helpful resource for communities and individuals. To be clear, this Resource Guide is not designed for humanitarian actors so that they can check off their boxes of standards and protocols (although, if used properly of course it will give them more than a few boxes to check off).Rather, if it gives more individuals and communities the mental and psychosocial support that they need to rebuild their lives, families and communities in the wake of a traumatic experience (in particular if they would otherwise experience a wide gap between need and care), then the Reflection Guide will fulfil its intended purpose.

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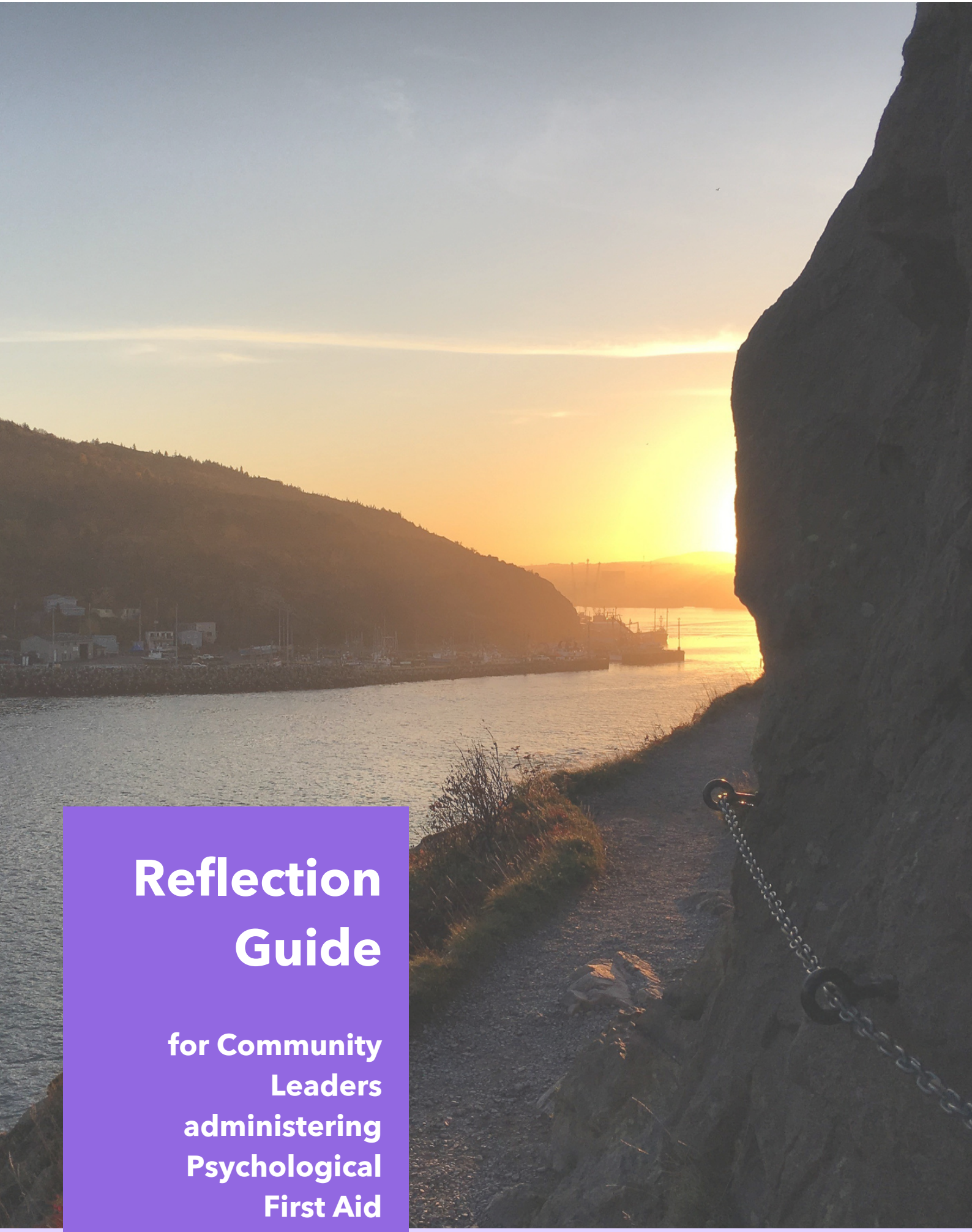

Reflection Guide

for Community Leaders administering Psychological First Aid

Rebecca Rathbone
Mercy Emerging Leaders Fellow 2023

REFLECTION GUIDE
for Community Leaders administering Psychological First Aid

INTRODUCTION

This Reflection Guide has been specifically designed for Community Leaders to help members of their community to process trauma immediately following a disaster or emergency event. It is designed to help the user to leverage both their identity as a community leader, and their training in Psychological First Aid (PFA) in a way that allows them to help as many community members as possible, as effectively as possible.

The reflection prompts have been designed to bring community leaders into the headspace of perfectly balancing their identities as both a community leader and as a mental health first responder. In this way, they will be equipped to enhance the psychosocial support systems that already exist in their community (and that they may already provide as a community leader) with scientifically-proven methods that help people to process the initial traumas of a disaster event/emergency in a way that puts them on a trajectory of recovery.

This Reflection Guide is not intended to act as or replace training in Psychological First Aid. Rather, it should be used to supplement formal training in PFA. It has been particularly designed for community leaders who practice PFA in contexts where it is difficult for most people to speak about and/or access mental health treatment.

The goal of this guide is to help to integrate mental health and psychosocial support into any society, (no matter what their beliefs are about mental health) in a non-threatening yet effective way. This is achieved by helping you to balance being a mental health first responder with being a community leader. Ultimately, it will guide you to apply your formal training in PFA from the perspective of your unique identity as a community leader.

How to use this Reflection Guide:
It is recommended that you reflect on the questions in this guide both before and after each session in which you administer Psychological First Aid. You may choose to reflect on each question in your thoughts, or to journal your reflections directly in the guide. Take as much time as you need, in a space that is comfortable and allows for deep reflection. This reflection guide consists of:

- Five questions for you to reflect on **before** administering PFA to people
- Five questions for your to reflect on **after** administering PFA to people

Let's begin by naming your community identity. What title would you give to your function as a community leader? (e.g. a religious sister, teacher, councilor, etc.)

_____

Write this 'identity' word in all of the places where you see a _____ throughout the guide

5 QUESTIONS TO PREPARE

Review your answers, especially those that point out the commonalities between your identity and values as a mental health first responder and as a _____, and allow them to guide you as you interact with survivors.

1

Why is being a mental health first responder important to me?

Where is there commonality between these two answers?

Why is being a _____ important to me?

2

Name 3 personal traits/motivations that make you trustworthy as a mental health first responder

1.

2.

3.

Where is there commonality between these two answers?

1.

2.

3.

Name 3 personal traits/motivations that make you trustworthy as a _____

5 QUESTIONS TO PREPARE (continued)

3

What does my training on PFA say about listening, and letting survivors guide the conversation by sharing their experience?

Where is there commonality between these two answers?

What do my values as a _____ say about respecting the dignity and autonomy of every person?

4

What does my training in PFA tell me about holding back my personal biases and projecting solutions on others?

Where is there commonality between these two answers?

What do my values as a _____ tell me about serving others, and the value of humility?

5

WW 'they' D? (i.e. What Would <u>They</u> Do?

Think of someone who you consider a role model as a _____. What would they do if they were performing PFA? Think of them, and try to model what their behavior would be.

QUESTIONS TO REFLECT

Review your answers, especially those that point out the commonalities between your identity and values as a mental health first responder and as a _____. Allow them to guide your own self care, and enhance your duties both as a mental health first responder and as a _____.

How do I feel after my interactions with survivors? Name at least 5 emotions. Was my own dignity respected, by others and by myself?

1.

2.

3.

4.

5.

What do my values as a mental health first responder say about self-care?

Where is there commonality between these two answers?

What do my values as a _____ say about self-care?

5 QUESTIONS TO REFLECT (continued)

When did I act more like a mental health first responder in my interactions with survivors?

When did I feel that these two identities were in perfect balance?

When did I act more like a _____?

In what ways did I perform my role well as a mental health first responder?

Where is there commonality between these two answers?

In what ways did I perform my role well as a _____?

In what ways did I not perform my role well as a mental health first responder?

Where is there commonality between these two answers?

In what ways did I not perform my role well as a _____?

HELPFUL RESOURCES FOR PSYCHOLOGICAL FIRST AID TRAINING

-Coursera Course (Online)
Professor George Everly, Jr, PhD

Accompanying Book:
Everly, George and Jeffrey M. Lating. 'The Johns Hopkins Guide to Psychological First Aid' (Second Edition). Johns Hopkins University Press, 2022.

Tembo Learning Portal (Online), Médecins Sans Frontières

Contact your **local Red Cross and/or Red Crescent Organization**, to inquire about their in-person or online trainings.