Sababu Training Manual

Enabling Access to Mental Health in Sierra Leone
A programme funded by the European Union

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International Centre for Mental Health Social Research (ICMHSR)

KING'S HEALTH PARTNERS

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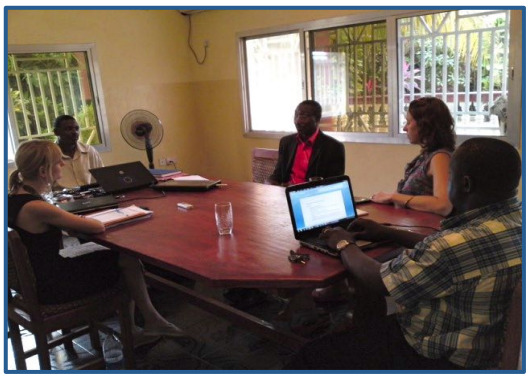
Contents

About the Author

Meredith Fendt-Newlin, MSc, BS is a researcher and PhD candidate in the International Centre for Mental Health Social Research (ICMHSR), University of York, where she is supervised by Dr Martin Webber to undertake research projects in a range of diverse contexts and countries. Having previously studied health psychology at King's College London and University College London, and serving on the Board of Directors and Trustees for two community development organisations in Africa, Meredith is passionate about empowering people through social innovation to improve mental and physical health care in low & middle-income countries.

"I've experienced this before, living in other sub-Saharan countries and feeling the desire to experience, learn and soak-up the culture as best I can, quickly feeling at home; but for some reason there was a unique draw for me to Sierra Leone. Maybe it was the inherently caring and welcoming nature of the Salone people, the rhythm and movement evidenced throughout Freetown, the excitement around progress and creative projects, or that stunning scenery! But especially, I was struck by the commitment of many people to change misperceptions around mental illness and of leaders taking action toward improving the care provided to those in need. This commitment and action led to the development and implementation of the Sababu Training Programme and Intervention, and has kept me returning for more."



Acknowledgements

The Sababu Training Programme and Intervention was developed through a collaborative process between the Mental Health Coalition (MHC) chaired by Walter Carew and co-ordinated by Joshua Duncan; Enabling Access to Mental Health Sierra Leone (EAMH) co-ordinated by Dr Carmen Valle; King's Sierra Leone Partnership of King's College London (KSLP) directed by Dr Oliver Johnson; University of Makeni (UniMak); and the International Centre for Mental Health Social Research at University of York (ICMHSR) directed by Dr Martin Webber. Contributions were also made by: Georgina Campbell, Tamsin Evans and Heather Weaver (EAMH); Katy Lowe and Stania Kamara (KSLP); KSLP Mental Health Group led by Peter Hughes; members of the Diaspora community in London facilitated by Stephen Jusu; Karen Watson-Newlin and Ric Genthe on sketches and graphics; and the Social Care Workforce Research Unit at King's College London (SCWRU) directed by Gillian Manthorpe. Authors would also like to express sincere gratitude to the many individuals in Sierra Leone and the United Kingdom for their input, feedback and guidance that have made the development of this training programme and intervention study possible. In particular the nurses involved in the training, for their willingness to share their experience and participate in this study to improve the services provided in Sierra Leone. THANK YOU!

Introduction

Mental health problems are often linked with social problems and the wider community. Research shows there are links between stronger social relationships and improved wellbeing and quality of life for adults with mental health problems. However, there is little evidence for effective mental health treatments that promote social engagement, particularly in low-income countries where mental health services have limited resources and infrastructure is weak.

Sierra Leone is making long strides in the development of mental health services, with efforts such as the Mental Health Coalition (MHC) advocating for and promoting the rights of people with mental health problems, and a CBM implemented and EU-funded project, Enabling Access to Mental Health Sierra Leone (EAMH) has been functioning for the past four years to train psychiatric nurses and works to integrate mental health into primary healthcare in the districts. These efforts need to overcome deeply entrenched challenges such as under capacity of health and social care workers. The present mental health system in Sierra Leone is not equipped to deal with large numbers of people seeking mental health support.

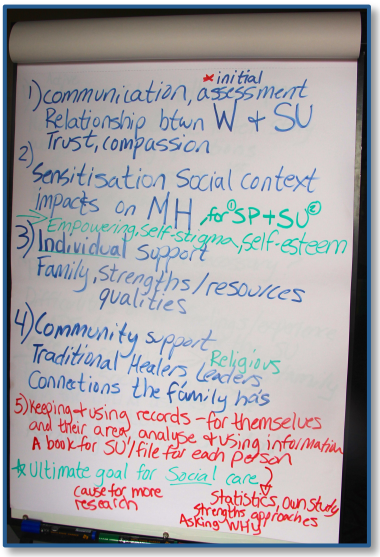
Sierra Leone is facing a major humanitarian crisis at an unprecedented scale and global reach. The exponential spread of the Ebola Virus Disease (EVD) in Sierra Leone—the largest in history and the first Ebola epidemic the world has ever known—has been widely attributed to weak health systems, traditional beliefs, and dangerous caring and burial practices. The outbreak is causing significant psychosocial distress and a disintegration of communities. Many of the problems faced by communities today are related to psychosocial distress; for example intense fear and worry, feelings of isolation and disconnection, low morale, grief over multiple losses and complex psychological needs. Amid a resource-limited system, there is an urgent call to address the psychosocial needs of individuals and families by enhancing the skills and capacity of the existing workforce.

Drawing upon our experience of developing and evaluating a model of good social work practice in the UK, the Connecting People Intervention, members of the research team are keen to understand how principles of co-production and enhancing social networks may be translated to diverse contexts. In particular, how collaborative ways of working with local stakeholders enables the development of culturally relevant, feasible and cost-effective solutions to the problems faced by communities. Evidence is emerging that links the restoration of social connections with mental health and community resilience in the face of complex emergencies. Establishing mental health services that are community-based, mobilising existing resources, is now recognised as a key strategy in rapid responses to crises.

The Sababu Training Programme and Intervention Study evaluates how a community-based model of practice can help to meet the needs of people with mental health problems in Sierra Leone amid the Ebola outbreak. By identifying and addressing the challenges of resource-limited mental health care in Sierra Leone during this crisis, this project provides specialised mental health nurses with response training to strengthen their knowledge and skills of mobilising social networks for people with mental health problems. The ultimate goal of this project is to increase mental health nurses' ability to provide quality care to service users—increasingly one of the most stigmatised and vulnerable groups in Sierra Leone.

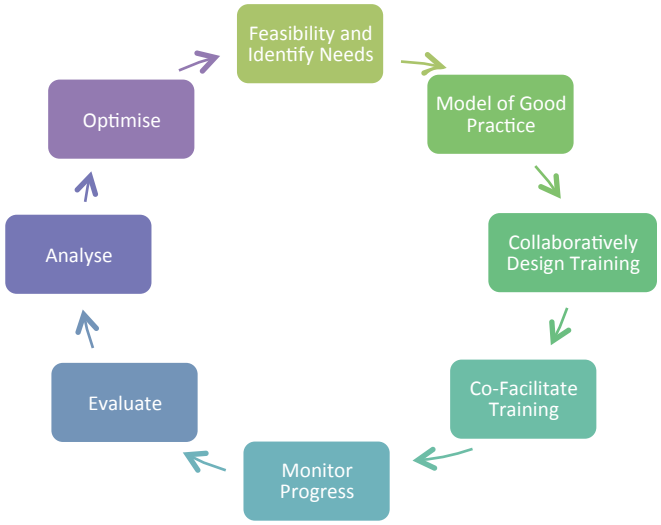
About this Manual

In partnership with key stakeholders, members of the research team have significant experience in training and capacity building of mental health workers internationally. The collaborators involved in the development of the Sababu Training Programme and Intervention Study have been working together since November 2012, starting with a feasibility study to identify needs and gain a greater understanding of mental health services across Sierra Leone. Early discussions with partners in Sierra Leone indicated the need to strengthen skill training to support existing services with evidence-based solutions.



In order to develop the training programme, participatory creative workshops were carried out with key stakeholders in 2014, which resulted in shared learning objectives and consensus of the topics to be covered in the training. When the first case of Ebola was identified in Sierra Leone in May 2014, it became clear that the intervention required adaptations for the changing needs of individuals and families affected by the outbreak. Addressing the fear and distress experienced by the general public and those diagnosed with mental illness is vital in the psychosocial emergency response initiative. Bespoke training workshops, manuals for professionals and measures to evaluate the intervention were written and adapted to address the changing needs of communities.

For partners in Sierra Leone, the main beneficiaries of this training programme are mental health nurses in Sierra Leone who participate in the study. They benefit from increased knowledge, skills and expertise in social methods of working with mental health problems, and the development of new service models to improve the quality of care delivered. This training manual has been designed with the objective of equipping mental health nurses to close the "service gap" in their own setting: district hospitals and clinics across Sierra Leone. Nurses are asked to bring skills and resources back to their workplace for further dissemination to other health professionals. Ultimately, people across Sierra Leone with mental health problems are also beneficiaries, gaining better quality mental health services in their communities by adequately trained and supervised care providers.



The Sababu Training Programme offers techniques for training mental health workers within a social intervention framework. In Krio, 'sababu' means connections with other people, in particular, benefiting from connections with other people. Suggested as a suitable name for the training programme by members of the MHC, Sababu relates to the notion of social capital, which describes the connections among people and the shared value that arises from such connections.

Training Overview

Purpose of the Manual

What is the Setting?
District level hospitals and health centres, and primary health facilities in Sierra Leone

Who are the Participants?
Those undergoing the training are specialist mental health nurses, supported by the MHC and initially trained in Freetown by College of Medicine and Allied Health Science, University of Sierra Leone (COMAHS)—Sierra Leone's only medical and pharmacy school and the main institution for basic and specialist nurse training, and EAMH—European Commission sponsored project designed to advocate for and on behalf of people with mental health challenges in Sierra Leone and ensure that best policies are made and fully implemented.

Who is the Facilitator?
Facilitators include Meredith Newlin (MN), Dr Martin Webber (MW) from the UK, and two local trainers involved in the development of the training programme George Bindi (GB) and Daniel Sesay (DS). These four facilitators have been chosen because the training is interactive and requires the facilitator to be creative, energetic and responsive to the participant group. All facilitators are mental health specialists with a range of experience in research and clinical practice.

Adapting the Training Manual
If utilised beyond the training of mental health nurses in Sierra Leone, this material is not intended to be prescriptive training package, but should be adapted to suit local needs (considering the national/regional mental health context, attendees, resources, time available to conduct training, etc.). The training material should be updated to include appropriate examples (or case-studies) and to suit local interest (e.g., benefits could be different in different regions).

How to use this Manual

The manual is divided into four parts:

- **Part One** (Day 1) is an introduction to the concepts of social determinants to mental illness and crisis situations
- **Part Two** (Day 2) is a training in community oriented psychosocial interventions, and specifically addresses the dimensions of the Sababu Intervention Model
- **Part Three** (Days 3 & 4) enhances learning in areas that were identified gaps for the target group amid coordinated response efforts and focus in mobilisation of family and other social networks
- **Part Four** (Day 5) uses a Training-of-Trainers approach to ensure learning can be assimilated into practice and disseminated to district-level mental health teams across the country

The manual in its entirety would exceed the five days training we've planned and therefore sections and activities should be used or discarded at the discretion of the facilitators. The Sababu Intervention Model has been developed with flexibility in mind as should be adapted to the audience and current situation where possible.

Aims and Learning Objectives

The overall aim of this training programme is to successfully build capacities of mental health nurses in Sierra Leone to strengthen their knowledge and skills of mobilising social networks for people with mental illness.

By the end of this training, participants will be equipped with skills to:

- Understand the social determinants of mental health
- Be confident in working with service users and their families to address social needs
- Identify at least two communication strategies to working with service users
- Promote social support and mental health prevention strategies in the community
- Counsel service users using strategies to enhance relationships with carers/family members, other people in their social networks, and local community members
- Indicate an ability to advocate for mental health in the community, including disseminate correct and relevant information on mental distress and coping with psychosocial effects of Ebola

Training Methodologies

- Interactive presentations – communicating information/concepts/theory and frameworks
- Participatory, small group activities – assimilating knowledge
- Role play and observation – contextualising key concepts
- Group discussions and brainstorming – deepening understanding of the topics
- Analysis and problem solving – critically appraise the utility of Sababu

Structure and Timeframe

Each session begins with aims and learning objectives clearly stated and generally consists of: (1) presentations that are given by the facilitator, (2) participatory activities, and (3) accompanying materials

Confidentiality and Sensitivity

Within the training it is important to realise the personal experiences that we each bring. The subjects of mental illness should not be talked about lightly or without sensitivity and their confidential nature should be respected. Should a participant reveal some confidential or sensitive information, the facilitator should express to them the thanks of the group and the information should remain within the group and session.

Terms found in the Manual

LMIC – Low- and Middle-Income Countries
PHC – Primary Health Care
WHO – World Health Organization
MHC – Mental Health Coalition of Sierra Leone
EAMH – Enabling Access to Mental Health Sierra Leone
MH – Mental Health
CP – Community Participation
CHO – Community Health Officers
mhGAP – WHO's Mental Health Gap Intervention Guidelines
DMHU – District Mental Health Units
PFA – Psychological First Aid
IMC – International Medical Corps Sierra Leone
ToT – Training-of-Trainers
EVD – Ebola Virus Disease
COMAHS – College of Medicine and Allied Health Science, University of Sierra Leone
MoHS – Ministry of Health & Sanitation
MSWGCA – Ministry of Social Welfare, Gender & Children Affairs
ICMHSR – International Centre for Mental Health Social Research
PHU – Peripheral Health Units

Tips for Training Facilitators

- We hope this will be a flexible training manual. Plan for everything, but be willing to work with moments of uncertainty. You will need to continuously revise what has planned and be flexible (and enthusiastic!) in making changes according to the needs of the participants.
- Remember that the nurses are experts in their own setting; therefore ask them not to hesitate to inform the facilitator if any of the information is not appropriate for their setting. Also ensure that they feel comfortable to bring up any issue at any point.
- Avoid too simple explanations, or too technical terms. Avoid using abbreviations and acronyms that participants may not be familiar with.
- You may also need to repeat important concepts a number of times, from different perspectives, and with different case scenarios.
- Build in enough opportunity for people to ask questions and time to clarify
- Encourage participants to share relevant experiences with the group. Emphasize that you hope that the participants will learn equally from each other as from the training itself.
- Encourage lively discussions, asking open-ended questions, “Can you tell me about...?”
- Invite participants to answer each other’s questions by asking, “Does anyone have an answer to that question?”
- Encourage quieter participants to speak and provide them with encouragement.
- When appropriate paraphrase comments to check understanding.
- Summarise discussions to ensure that everyone understands the main points. Equally, summarise important points at the end of each day.
- At appropriate moments encourage the group to engage in brief energising activities that involve movement, e.g. after lunch. Ask participants to suggest local games that can be used for this purpose.
- Try to mix up the groups as far as possible in order to maximise opportunities to learn from each other.
- Show that you are listening to individual participants when they speak and reinforce key points to the rest of the group
- Keep the sessions running to time, otherwise you will run out of time.

Adapted from Basic Needs Training Programme

I. Module One—Welcome and Introduction

Session Aim: To welcome participants to the training and co-produce learning objectives for the training programme. To take baseline surveys for evaluations.
Session Tasks:

1. Introductions – discussion of current mental health context.
2. Baseline Questionnaire – nurses and supervisors (and consent forms)
3. Discuss the aim and objectives of this training course.

Session Duration: 60 minutes
Materials: Flip chart paper and pens, evaluation forms, question box, note cards

Welcome

Introductions from the facilitators and participants: Brief discussion of what has occurred since the last meeting (May 2014). Overview of the research (how we started and where we're up to today, what will happen during and after the training sessions, how we will evaluate the training and share this information). Reiterate why it is important that they have attended.

Icebreaker: Ask everyone to write on a piece of paper THREE things about themselves, which may not be known to the others in the group. Two are true and one is not. Taking turns they read out the three 'facts' about themselves and the rest of the group votes, which are true and false. This simple helps the group and leaders get to know more about each other.

Group discussion: Facilitate discussion with the nurses about their experiences (personally and professionally) over the past year, in particular with regards to the Ebola Outbreak and response of the health care system.

- How has the outbreak affected you personally? Professionally?
- Have you been resuming work in hospitals and clinics? What does your day-to-day work look like now, compared to one year ago?
- What are the main challenges you see facing communities?

Administer Baseline Questionnaire

Before starting the training, we would like your help in completing a brief pre-training survey. There are no right or wrong answers, but this survey will help us to structure the training programme as we go, tailored to your needs at this time, and will give us something to compare after completion of the training, to evaluate the programme based on the skills you gain. First go through information sheets and consent forms, then questionnaires. After completing the questionnaires, participants will receive the workbooks.

Expectations

Logistics and Practical issues
Briefly discuss the practical and logistic elements of the training such as: any transport/accommodation arrangements needed by participants; times of training; food arrangements; certifications etc.

Learning Objectives
Objectives may be defined as the learning needed to reach a particular goals. The training has been developed with specific learning objectives in mind for each module, but we are also curious to know the expectations and goals of the participants, and to be able to modify the sessions spontaneously as we go to ensure the training is most relevant or directly applicable to the real situations nurses face in their District Mental Health Units (DMHU).

Elicit expectations and write on flip-chart paper.

- What are your expectations from the training this week?
- What do you hope to accomplish?
- What information or skills do you feel is most important for you to learn?

Activity: Each participant is given a small coloured index card and invited to write a maximum of 3 things he or she expects to learn during this training. Cards are collected and pinned on the wall.

Ground Rules
Ask the group: what do you feel are important ground rules to establish for our training together?
Brainstorm ground rules together and makes list of these on a flip chart that is posted in front of the class.

- Maintaining confidentiality- how to discuss cases
- Listening to and respecting everyone
- No side conversations
- Being on time
- Letting everyone have a chance to speak, no interrupting
- Turn off mobiles
- Right to pass if you choose not to share

Learning Styles
There are three basic types of learning styles. Most people tend to prefer one style more than the other two.

1. Visual learners learn best by seeing information – words and numbers printed in text form, pictures, maps, graphs or other visual aids.
2. Auditory learners learn best by listening and talking – listening to someone present information and by being allowed to discuss the topic and ask questions.
3. Kinaesthetic learners learn best by carrying out a physical activity. These are the 'hands-on learners' who learn more easily when bodily sensations are involved – moving the body etc.

HOW do you learn best?

II. Module Two—Background to social determinants of mental health

Session Aim: To understand and be able to articulate the social determinants of mental illness and how/why psychosocial problems might exist for their service users.
Session Tasks:
1. Interactive session on the social determinants of mental illness
2. Small group activity to unpick these determinants using case studies

Session Duration: 90 minutes
Materials: Flipchart paper, pens

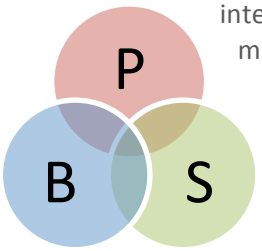
Interaction session: Facilitator asks participants to identify factors that may influence mental health and writes them down on a flip chart.

Mental health is defined by WHO as a state of wellbeing in which the individual:
- Realises his or her own abilities;
- Can cope with the normal stresses of life;
- Can work productively fully; and
- Is able to make a contribution to his or her community.
- A healthy person has a healthy mind and is able to think clearly;
- Solve problems in life;
- Work productively;
- Enjoy good relationships with other people;
- Feel spiritually at ease; and
- Make a contribution to the community.

Bio-psychosocial Model
Use the above exercise to transition into a discussion on the bio-psycho-social model. First, draw three overlapping circles and just the first letter (B, P, S) asking the group to fill in the blanks.

- **Bio** is the biological or physical aspects of a person and his/her biological needs.
- **Psycho** refers to a person's thinking, feeling, emotions, beliefs and attitude.
- **Social** refers to the way a person relates with his or her social environment including: family, friends, neighbours and community. The social aspects may also refer to conditions that are out of an individuals control, such as what is happening in the social context around them, or cultural influences like a belief in supernatural powers.

Mental, physical and social health are vital strands of life that are closely interwoven and deeply interdependent. Throughout the training we will be focussing on the social aspects of mental illness.



The social world around an individual creates context through the environment, culture, economics, traditions, spirituality, and interpersonal relationships with family, community and friends. As nurses, your primary focus is on the individual, and understanding their social context is crucial to understanding their overall wellbeing.

Definition: The word **psychosocial** underlines the dynamic relationship between psychological and social aspects that affect an individual's health and wellbeing.

Psychosocial problems are often related to interpersonal problems and refer to conditions and situations where a negative *psychological state* (feeling sad, feeling stressed, feeling irritable) is strongly related to and influenced by the current *social environment.* The individual may not be fully aware of the relationship of his state of mind with his or her environment.

Social determinants

Ask participants if they have understood the dynamic relationship between social and psychological experiences. Let's go back to this list we made first, can we identify which of these factors are psychosocial issues? How is the course of a mental illness influenced by social factors?

Examples may include:

- Family conflicts
- Loss of job
- Not feeling safe and secure
- Loss of a loved one
- Poverty or financial difficulties
- Loneliness
- Homelessness
- Experiencing violence, trauma or conflict
- Hygiene, health & safety
- Gender issues
- A life threatening illness
- Stigma and discrimination

Small group work

Divide participants into groups; assign each group one of the psychosocial problems. Ask each group to think of individuals they have worked with that have been dealing with that particular issue. What symptoms did they present with? How did you determine the root cause of their mental health problems? What other factors may have been involved?

Group presentations

Each group allocates a reporter who briefly presents the case. Sharing "success stories" peer learning and support, feedback from each other, as a group discussion explore options for treatment.

Let's talk:

- **Is there anything about today's session that you want to ask questions about?**
- **Is there anything that you don't fully understand?**
- **Is there anything you would like to add or remark on?**

EXAMPLE 1
Poverty and Mental Health

This often exists as a cycle, people living in poverty are more likely to experience mental disorders due to the stresses associated with being poor, and mental disorders are likely to worsen poverty.

Discussion: Invite participants to discuss ways in which communities can help break the cycle of poverty and mental disorders (e.g., employment opportunities including income generating activities and access to education).

EXAMPLE 2
Stigma and Discrimination

Friends, relatives, neighbours and employers may reject a person suffering from a mental health problem. S/he may then feel more lonely and unhappy, making recovery even more difficult.

Stigma also affects the family and carers, leading to isolation and humiliation. Stigma can cause delays in seeking treatment for a family member with mental illness.

Discussion: How can stigma and discrimination be reduced? People with mental disorders should be seen as active and valuable members of the community. Openly talk about mental disorders in the community to help people understand that a person with a mental disorder is a fellow human being and is entitled to be valued as such. Provide accurate information to family members and community groups on what causes mental disorders, how common they are, and that they can be treated.

EXAMPLE 3
Gender and Mental Health

- In some cultures it is more acceptable for men to drink alcohol, leading to more problems
- Domestic violence can place great stress
- In some cultures men do not discuss their problems with friends as often as women.
- Women's income is often lower, and they have less control over household finances.
- Women may not be able to independently access treatment due to cultural norms prohibiting her from travelling alone, or requiring her to obtain permission.

Discussion: Invite participants to discuss ways in which they may be able to break down gender issues with service users and families.

III. Module Three—Coping with crises, grief and loss

Session Aims: This module focuses on how people react to and deal with the loss and grief connected to crisis events. We will discuss cultural grieving processes and the importance of social support will be underlined.

Session Tasks:

1. Overview of crisis, coping grief, and loss specific to the EVD outbreak
2. Reflection on the nurses' experience in the past 12 months
3. Discuss what recovery and resilience mean for this population

Session Duration: 90 minutes

Materials: flipchart paper and pens

A **crisis** is understood as one critical event or series of events that leads to major changes in the lives of those who are affected. It is defined as "a severe disruption, ecological and psychological, which greatly exceeds the coping capacity of the individual" (WHO, 1992). It can be due to natural disasters (such as floods, earthquakes, disease outbreaks, etc.) and man-made events, (conflicts, population displacements, etc.).

Characteristics of crisis events:
Crises are often sudden and powerful. Crises usually occur outside the range of ordinary human experience- they are abnormal. During a crisis, there is a strong emotional effect on people, which may overwhelm the usually effective coping skills of an individual or group.

Group discussion: What reactions to crisis events have you seen in others or experienced yourself? How did others, or you, react? Who was involved? What made the biggest impression?

Crises typically disrupt a person's life in many ways and can lead to the loss of:

- loved ones
- control over one's life
- initiative to take action or seek help
- self-esteem and confidence in the future
- sense of security
- dignity, trust and safety
- home or job
- social infrastructure and cohesion
- access to services

Grief is a normal response to any loss. Each person's grief journey is unique, yet the process of grief is similar regardless of what was lost: a loved one, your own health, your income or your hopes and dreams.

Communities in emergency situations face unique challenges. The **social fabric** is often tested as families are scattered, community members mistrust each other, institutions, political and legal systems designed to protect and support people become strained. Frequently, an increase in social tension as well as damage to infrastructure impacts how people live and work to support themselves and their families, this sometimes results in an increase in poverty. Cultural notions and practices are under pressure and families lose their function as a safety net and support system.

Facilitated group discussion

- What does the community consider to be a 'normal' reaction to grief? What are 'normal' mourning periods? What are 'normal' coping styles, ways of dealing with problems?

- What is acceptable behaviour in reaction to loss of children, husband or wife, or parents?
- What is acceptable behaviour in reaction to loss of a house or material goods?
- When and where can people cry, or pray, or be angry? In public or only in their own house?
- What does a family do normally when someone dies? How is the burial done? Where are people buried – in a graveyard? Somewhere else? What rituals need to be done?
- What is *not*-acceptable behaviour in reaction to these things?
- How have some of these cultural practices of grieving changed in light of Ebola?

Coping Styles

Problem-focused (confronting the stressor or problem) = facilitates resilience

Emotion-focused (supressing or denying emotional reactions) = increase vulnerability

Coping Example

Drinking tea "ataya" in Sierra Leone is an important social activity for some people and a small shop, may quickly turn into a spontaneous community centre. The shop may represent a place of safety and security, a familiar place to go for a chat and social support. Social support is a strong contributing factor to regaining resilience and to healing. This example illustrates the effect of using community values, knowledge and practices to help rebuild lives during and after a crisis.

Individual work using case studies: How are the people you work with grieving their losses? Can you give an example of a person who never recovered after a significant loss? Or give an example of a person who was never able to resume their way of life after a loss? What about a person who seems to be grieving and coping well, in your perspective? Write down 1-2 cases on your own. These can be people you've worked with, or stories you've heard from others (10 minutes).

Group discussion using cases: What might be examples in Sierra Leone that illustrate community engagement and cultural practices of coping? Can we explore alternative coping strategies that remain in-line with Ebola public health messages? How can you facilitate these practices? (10 minutes).

Other examples of coping:

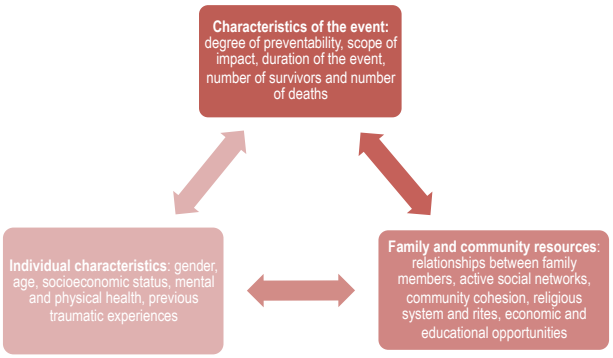
- Seeking or offering help from others
- Trying to make sense of what happened & why
- Going into isolation until fear has passed
- Funerals, burial practices
- Talking about what happened
- Using denial to minimise emotional impact
- Turning to religion or leaders for guidance
- Setting goals and future plans
- Seeking information about loved ones' experience

Group discussion

What does **recovery** mean for the service users and families you work with? What protective or risk factors affect the psychosocial impact of crises? What determines which individuals experiencing these psychosocial problems may develop mental illness?

Although potential factors for mental disorders are present in a community or in a single person, this doesn't automatically lead the person to develop a mental illness (as you may easily understand observing a family where the education, economic stability and culture are similar for all brothers and sisters but only one develops mental illness).

Protective and risk factors affecting the psychosocial impact of a crisis are determined by:



Research shows that after several months, as many as 50% of the population may show emotional effects related to a crisis. Many of these effects gradually subside, or new reactions to appear weeks or months later. However, after a year or two, there are still quite a number of people having some disaster-related distress; and in Sierra Leone this may be compounded by previous trauma experienced during the war.

Definition: We all experience adversity, from everyday changes and challenges to serious losses. Fortunately, people are able to adapt. **Resilience** is defined as the capacity to withstand stress and crisis. Individuals and communities are able to rebuild their lives even after devastating tragedies.

What contributes toward resilience?

1. Individual skills that are innate or learned, including social functioning, independence, self-efficacy, creativity, feelings of helplessness, coping styles
2. Family and close friendship relationships, networks in which people relate to others

For people with mental health problems, the normal patterns of care or assistance that they receive are disrupted by crises. Access to services, supplies, even food and water may be disrupted. This situation may drastically reduce quality of life. Anxiety and stress resulting from this situation may create disorientation, confusion, or deterioration in one's mental health status. As a result of not being able to care for themselves, they are at great risk for marginalisation and isolation.

When a traumatic event occurs, relationships between families, friends, and communities are affected. Whereas these relationships may be a source of support, in times of crisis relationships may be further strained. Encouraging supportive social networks, caring for the family system and encouraging a sense of independence all help to foster resilience.

Let's talk:
Let's summarise the key points in this module. Can we agree on the three most important messages? How are people feeling after this module? Are there any questions?

Case study

At age 15 Emmanuel lost his mother, brother and younger sister to Ebola. Emmanuel used to be very active and had many friends. He was enthusiastic about school and playing football. After the death of his family members, this changed. He thinks a lot about his family members, especially his brother, and misses him. He finds it hard to accept that they are not around anymore and that he will never see them again. He ponders questions like, "why them?" and "what have I done wrong to be punished like this?" He thinks he will never get past his feelings of sorrow and injustice. He feels angry that this has happened to him, in his community, and he wishes there was someone he could blame. Everyday activities have no meaning – he finds himself sitting around, unable to concentrate. He doesn't feel like seeing his friends and many of them said they do not want him to be around, for fear that he might carry Ebola or bad luck. He finds it hard to talk people about his thoughts and feelings. He is afraid that they will not understand

IV. Module Four—Psychosocial interventions

Session Aims: This module focuses on emergency psychosocial response interventions during times of crisis. There is also an emphasis on current referral pathways and connections nurses have with other health & social care services.

Session Tasks:

1. Briefly re-visit the nurses' PFA training, describe links to this
2. Discuss the intervention pyramid and referral pathway in Sierra Leone today
3. Think about individual and community recovery and restoration after crisis

Session Duration: 60 minutes

Materials: Flipchart paper, pens, A4 paper

Myth: All victims of crisis events need counselling to get back on track again.

Reality: Psychosocial support is only partly about individual therapy; it's also the work we do in assisting affected communities in their collective recovery.

Your work as nurses traditionally involves individual counselling. You have recently received training in Psychological First Aid (PFA), typically involving collective recovery. This training links the two practices by considering a community to be the social and psychological foundation for the individual. In emergency situations the role of mental health workers is to assist affected people to restore hope, dignity, mental and social well-being and a sense of normality within their immediate social context.

Group Discussion: Ask the nurses to recall their PFA training or any other trainings received regarding their role in the Ebola response. Discuss the objectives of PFA and how this links to their current position. How much of the PFA training have they been using day to day?

Discuss in small groups.

1. What does the intervention pyramid look like in Sierra Leone today? Where are the gaps? What is your role as a nurse? Who might you be working with in the other levels of the pyramid?

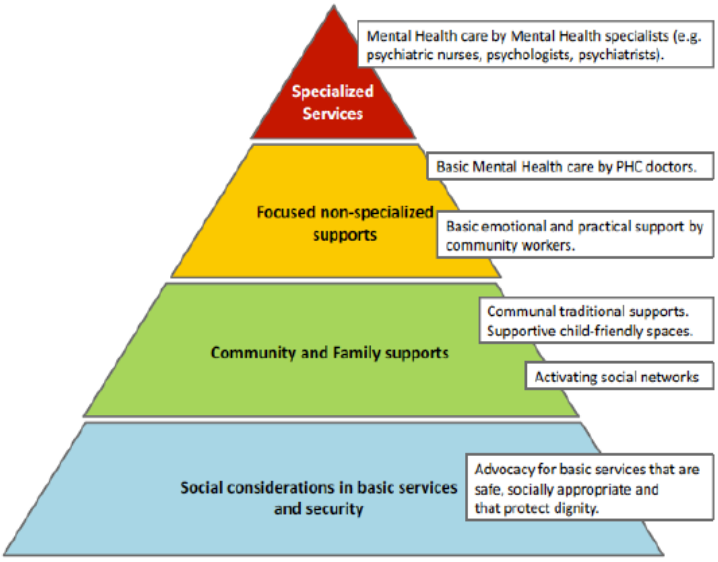
2. Ask participants to about psychosocial support and interventions for grief and coping. What is your role as a nurse? Who might you be working with in the other levels of the pyramid?

Brief overview of PFA (WHO, 2014)

- Establish a connection with people in a non-intrusive, compassionate manner.
- Help people to tell you what their immediate needs and concerns are, assess and gather additional information.
- Build supporting systems in cooperation and participation with local people. Connect people as soon as possible to social support networks, including family members, friends, neighbours, and community helping resources.
- Acknowledge traditional cultural ways of coping and dealing with distress. Highlighting individual strengths, and empower people to take an active role in their recovery.
- Provide information (psychoeducation) that may help people cope effectively with the psychological impact of the situation.
- Be clear about how people can access your services and (when appropriate) link people to another member of the response team or to local recovery systems, (e.g. health services).

Intervention Pyramid

Based on the IASC MHPSS guidelines (2007) and adapted by IMC Sierra Leone in the Ebola response (2014). Illustrates recommended levels of mental health and psychosocial intervention ranging from social considerations in basic services and security up to specialised mental health services.



As a wider group, brainstorm: Referral pathways and emergency response

- Who is coordinating mental health services in this emergency? Are there regular updates of the changing situation? Provide a list of agencies involved that may become collaborators.
- Was any other mental health needs assessments carried out? By whom and are copies available? What is needed to help families care for their members?
- Is the religious community responding to the crisis? What traditional practices may help Sierra Leoneans through this crisis (family networks, income generating activities, rituals of healing, etc.)?
- Is the community showing cohesion/solidarity or are there competing factions? Describe major obstacles, constraints, risks etc.

Hint: Encourage discussion around: referrals, building capacity within the community through existing structures, identifying local methods that are currently effective, identifying points of linkages, involving community in health awareness programs, etc.

It is important to learn about and build relationships with other services, agencies, and resources in the community that might help you and the service users you work with. All community members should be able to access needed services including those with pre-existing or crisis induced mental health, psychosocial or protection concerns. Refer clients to appropriate services and resources– navigating systems and services can be challenging, ask them how you can help to make a connection they need; follow-up with service users to make sure they attend; and advocate for your service users.

While health and social services have an important role to play, their work is most effective when complemented by other sectors such as education, recreation, environment, local government, industry and non-statutory / voluntary sector groups. Comprehensive community based mental health services should be set-up with local and national support to ensure sustainability of these services after the crisis phase has passed.

Individual and community recovery and restoration after crisis

- Restoration of family connections
- Return normal daily routines (school/work/recreation)
- Provision of practical support (basic needs met)
- Support groups for specific groups as children and youth, survivors, widows, staff
- Religious and cultural ceremonies and activities
- Interventions that focus on management of fear
- Building community resilience
- Risk and resource mapping and analysis

"There is a need and opportunity to work with the MoHS and MSWGCA to develop specialised mental health services and a robust referral system through trained Mental Health nurses working in the district health headquarters and accessing the CHO's trained in the WHO MH Gap training materials at community levels."
IMC Recommendations

V. Module Five—Social and Community Models of Practice

Session Aims: To think about social strategies for care and the importance of creating linkages in the community. To be knowledgeable about social interventions.
Session Tasks:

1. We will look at what communities mean for people who are part of them
2. To provide an overview of social & community models
3. In-depth discussion of the Sababu Model, its dimensions and application

Session Duration: 180 minutes
Materials: Flipchart paper, pens, A4 paper, Sababu models

The term *psychosocial intervention* refers to any programme of support that aims to improve the psychosocial wellbeing of people. But since there are many evidence-based interventions that might contribute to this overall goal, we will discuss certain dimensions that are key to supporting people in the context of Sierra Leone.

Empowering people to care for themselves, restoring the social fabric/ cohesion and building people's capacity starts when people recognise their own **resilience** (the ability to "bounce back" and to manage difficulties). Interventions should be targeted both at the **individual** and the **community** level by drawing on individual skills, knowledge and resources, as well as on social networks, support and common values.

Addressing the root causes of mental illness, including the **social determinants** we discussed in Module Two (family disputes, socio-economic problems like poverty and unemployment, stigma and isolation from the community, and loss of social roles), and finding culturally acceptable and feasible solutions to these problems are major challenges. To do this, we need a **multi-sectorial approach**, relying on the mental health services in collaboration with other health and social services, family and neighbours, and key community members to support recovery.

The impact crises events can have on a community are vast:

- Insecurity as social regulations and infrastructure break down
- The community reacts with signs of mistrust, fear and insecurity
- Religious and moral confusion
- Absence of respected leadership
- Social uprooting and destructive behaviour
- Social apathy and loss of trust and hope

Definition: A **'community'** can be described as a group of people that are recognised as sharing common backgrounds and interests, cultural, religious or other social features, and that form a collective identity.

A community is the psychological and social foundation for an individual, and might be inclusive and protective of its members; but it might also be socially controlling, making it difficult for marginalised sub-groups or individuals to express opinions and claim rights.

Working with marginalised people requires learning about members of their community, who are also stakeholders and play a role in the wellbeing of community members. Many groups of people within the community play important roles in a person's recovery from mental illness. Often, initial diagnosis and early treatment occur at primary health or outpatient clinics but supporting services often occur within the village or the home of the user.

The term **'community-based'** does not refer to the physical location of activities. Rather, it stresses that the approach involves the community as much as possible in the planning, implementation and monitoring and evaluation of the response. It is an approach that encourages the affected community to take ownership of and responsibility for the responses to the challenges faced. Interventions are more likely sustained if embedded within cultural strengths and local systems.

A community-based approach is a way of working in partnership with people experiencing difficulties. It recognises the resilience, capacities, skills and resources of individuals, and builds on these to deliver feasible solutions that also support the wider community's goals. A community-based approach can help communities work to prevent social problems and to deal directly with those that do arise.

The World Health Organisation (WHO) has been a driver of the community mental health agenda, forming the Global Forum for Community Mental Health in 2007 and publishing a number of reports promoting community care. The emphasis on strengthening mental health services in primary care has characterised many of WHO's interventions across Africa and in many LMIC.

Key dimensions

There exist a range of psychosocial interventions that are community-based, some of which have been tested in Sub-Saharan Africa. However, what works in one context (community, country, continent) may not be applicable in another. Therefore, we will discuss several key dimensions that make-up successful community-based psychosocial interventions and how these fit into the model of practice we've developed in Sierra Leone.

There is an emphasis on holistic interventions that attempt to take a 'whole of problem' approach to addressing mental illness. Not limited to a linear, single dose or treatment, rather these interventions include multiple inter-linking dimensions or 'active ingredients' to treat an individual in his or her entirety. This approach acknowledges that individuals are connected to people and components around him or her, and to better understand an individual's thoughts, feelings, character, and social relationships, a worker must take all influences into account.

Interactive session: for each dimension follow the steps below:

1. Explain the definition of each dimension
2. Ask participants for examples in their own practice that are related to these key dimensions.
3. Encourage participants to suggest local metaphors from Sierra Leone that encourage this dimension: they should brainstorm for the meaning of each metaphor given.

A. Equal partnership

The relationship built between the worker and an individual is essential for promoting empowerment, forming the basis for the individual to achieve their own independence, and a key to the success of an intervention. In Sierra Leone, a hierarchy often exists between professionals and laypersons. However, in practice there should be an equal partnership in which both people feel able to share and make changes is necessary.

First impressions are critical and consistency in communication overtime is then needed to build trust and encourage openness throughout the relationship. Other factors key to the partnership includes confidence, flexibility, lived experience, openness, and hope. People feel more comfortable opening up and sharing their experience when they know they can relate to the person they are talking to. We also call this process **'co-production'** when both service users and service providers are equally responsible to develop and take-on the support together.

B. Empowerment

On an individual level, empowerment is defined as gaining control of the decisions that impact one's life. This includes the capacity to make informed decisions and the freedom to take action. Empowerment is NOT something that is done to someone, it the process by which a worker may support a person to increase his or her capabilities that lead to self-confidence, self-esteem, initiative and control.

On a community level, empowerment allows the community to analyse their situation, to define their needs and be able to create solutions for solving those needs. The expansion of resources for marginalised people to participate in, influence, negotiate with, are aspects of empowerment that seek to improve equity and quality of life within communities. Psychosocial interventions focus on the empowerment of communities by mobilising existing resources, such as traditional healers and existing support groups.

C. Individual assets and capacity

An **'asset-based'** or **'strengths-based'** approach to care (phrases often used interchangeably), is characterised by first looking at the skills, capacities and resources people have that enable them to cope with challenges in life. These might include:

- their personal resources, abilities, skills, knowledge, potential
- their social network and its resources, abilities, skills, support
- the community resources available to them

People need to be seen as more than just their risks or care needs – they need to be experts and in charge of their own lives. Identifying an individual's own human capacity is the same as realising his or her own strengths and values. In initial assessments this means not only focusing on the needs of an individual, but also the skills they have within and around them to recover.

D. Meaningful social participation

'Social participation' is an essential right of individuals, promoting inclusion in the community and reducing feelings of powerlessness and isolation. Participation in meaningful community activities such as gardening to grow one's own food, or being involved in local decision-making meetings, is important to rebuilding self-esteem and self-confidence; and helps people cope with the challenges they faced during crisis. The level of participation will depend upon how rewarding people find the experience and whether they gain something from the process of contributing in their community.

Participation emphasises the "bottom up" approach in planning and implementation of interventions, where people are seen as active participants; compared to the conventional "top down" approach, where people are considered as passive recipients of programmes designed for them by professionals and Government policies.

E. Integration and mobilisation of existing resources

It is essential that workers have good local knowledge of what resources are available in the community. By focusing on an integrated approach, interventions should address the range of people's needs, especially during crises, and turn to those individuals and institutions that are available to offer local support. It is more efficient, cost effective and sustainable to mobilise the existing infrastructure when supporting people. For example, by connecting with community members and local groups, stigma of mental health is reduced and mainstream services can be accessed.

A recent study by WHO about community integration suggested two broad ways of promoting this approach: **FIRST** through awareness raising and understanding of mental health problems and **SECOND** through access to information and knowledge about mental health service programmes and projects.

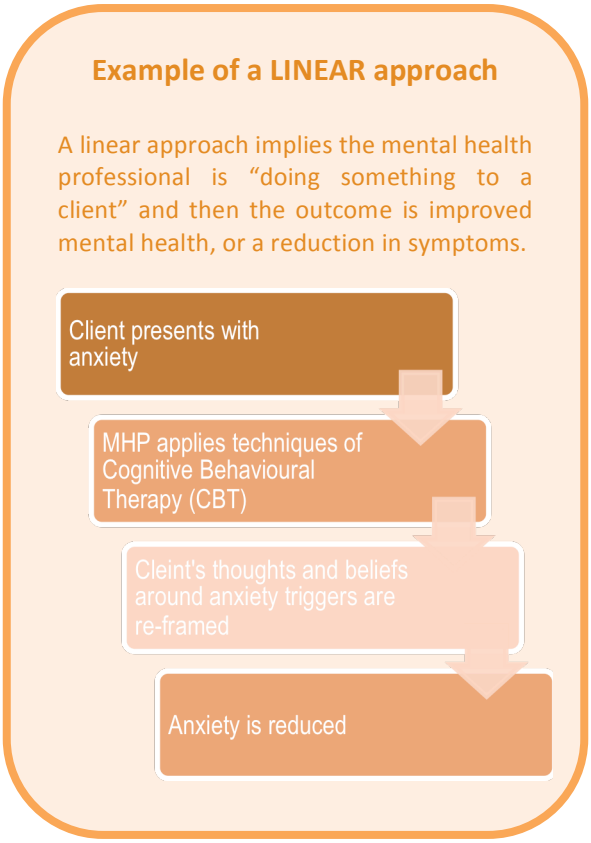
Group discussion: Why use this approach?

- It builds or strengthened the capacity and autonomy of individuals and communities.
- It promotes respect for rights and the accountabilities of leadership strictures, agencies.
- It underpins age, gender and diversity mainstreaming.
- It improves the quality and effectiveness of operations.
- It provides a basis for sustainable responses and durable solutions.

Sababu Model and Intervention

These dimensions are the critical aspects of the model we've created for mental health practice in Sierra Leone. Called Sababu, meaning connections that benefit individuals in the local language Krio, the model provides a framework for using social interventions in Sierra Leone. Initially created from our fist visits to Sierra Leone and in collaboration with a variety of stakeholders (including yourselves!) the Sababu model and intervention has undergone several iterations, each version identifying current needs of individuals and their communities and finding culturally-appropriate ways of addressing those needs. It has been contextualised in language, activities and theory to ensure cultural sensitivity, and emphasises flexibility to be adapted to your own practice as necessary.

The Sababu Intervention is not a linear process you often find with specific therapies. Instead of the mental health worker "doing something" to the client, is a shared process between two individuals. It is flexible to enable each nurse to adapt the model to each service user and the social world in which they're living. In the training we discuss **'what'** the intervention is and we look to your own practice to learn **'how'** it can be applied to the individuals families, and communities with which you work.



Sababu is an evolving narrative of a young woman experiencing mental distress, the trusting relationship she builds with her mental health worker, the acknowledgement of her own strengths, capacities and skills to be an active contributing member of her community, and how her family and community are mobilised to support her recovery.

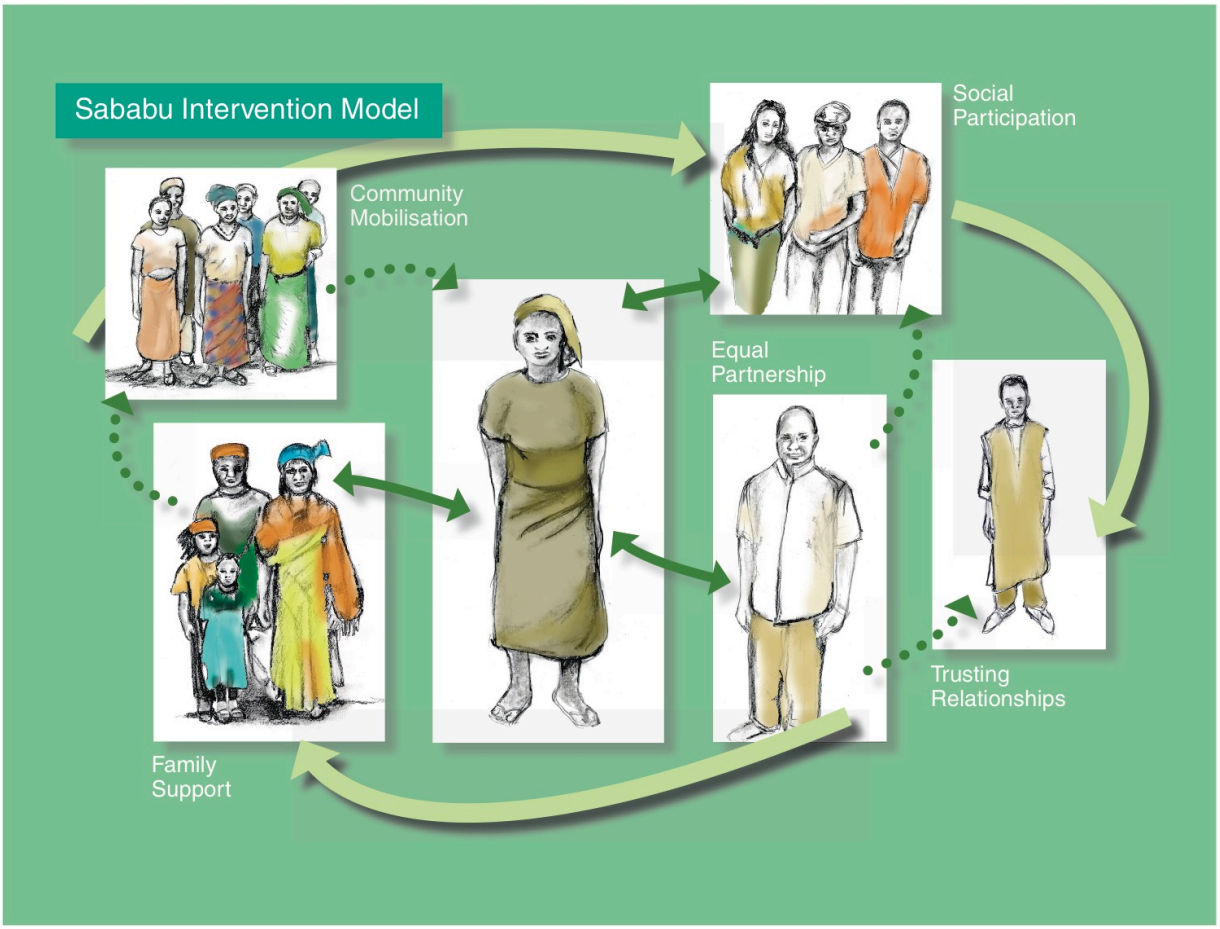
The main aim of the Sababu Intervention is to help nurses in supporting service users to connect with people in their communities and enhance a person's social networks. These may be neighbours or people living locally. They may be people interested in the same hobby, sport or leisure pursuit. They may even be family or friends with whom the individual has lost contact...there are many possibilities. It is up to the service users to decide how many people or with whom they want to connect with. Sometimes nurses may need to act on behalf of service users, advocate for their rights and minimise the stigma they face in the communities.

Due to the dynamic nature of the intervention, there is no set method to achieving success. The model uses the following dimensions to reflect stages that an individual with mental health problems might go through during the intervention, but these should be modified to suit the needs, capacities, and time available to the nurses and service users.

We will go through each dimension in detail during the next modules of training.

A. Equal partnership
B. Empowerment
C. Individual assets and capacity
D. Meaningful social participation
E. Integration and mobilisation of existing resources

At the core of the intervention is the trusting relationship that is built between the nurses and service user. This forms the foundation for a person to achieve their own independence and be empowered. The service user is just as responsible as the nurse for the success of the intervention process. In turn the nurse needs to be open to listening to the service user and identifying exactly what they hope and need to get out of the process.



Training Exercise Module 5

Mapping Practice onto Sababu Model

Aims: To create our own version of the Sababu Model and Intervention to articulate how it fits with existing practice.
Materials: A4 paper for each person, pens

Individually: Create your own version of the Sababu Model. You can either do this using one case example of a person you've worked with and how you supported them, or think holistically about your practice and different ways you've helped people. Include people you've worked with such as family members, community groups/organisations, relationships you might have fostered with religious or community leaders, activities you've supported people to do or get involved with (15 minutes)

In pairs: Share your model with a neighbour. Critique one another's models; whom might you have forgotten to include? Can you offer advice to your peer about how to achieve one of the dimensions? (10 minutes)

In small groups (4-6 people). Use the flip chart to map practice, pulling together each of your individual maps and discussing how you might each approach the mode (20 minutes)

Group discussion: Provide feedback to the wider group, share the flip charts from each groups. How did you find that? What was challenging, what was enjoyable? Is this something you've done with service users? Would you consider using this tool with them? Why/why not? (15 minutes)

Let's talk:

- **Is there anything about today's session that you want to ask questions about?**
- **Is there anything that you don't fully understand?**
- **Is there anything you would like to add or remark on?**

VI. Module Six—Communication and Building Trusting Relationships

Session Aims: To explore basic communication and counselling skills in this section by discussing the values that underlies the counselling process as well as the principles of building an equal partnership and relationship with service users.

Session Tasks:

1. Discuss the importance of communication and partnership building
2. Explore communication techniques in-depth and apply them to cases
3. Learn about reflective practice and role-play in small groups

Session Duration: 90 minutes

Importance of communication

Communication is not only about using words, but it also includes listening and observation. It is a two-way street and helps us to understand the thoughts and feelings of others. We've all seen the busy clinic waiting rooms, felt the pressure of many people to see in one day. Sometimes those 'shortcuts' we take to minimise time actually harm the service we provide. Good communication is the foundation of quality care.

There is much more to communication than just the words, people will remember how you made them feel, whether you shared kindness, understanding or patience. Only **7%** of communication is using words, **55%** non-verbal body language and **38%** tone of voice. We all have unique ways of communicating that may depend on the context we're in. For example, the way you communicate at work might be different from home.

Group discussion: When you think about communicating in your personal lives, what are some of the difficulties you face? With family/ friends? What about in your professional lives? What are the barriers to communication? When do you know you're doing it well? Think about some techniques you may use in your personal lives to communicate.

Positive characteristics of Communicating

- Listening carefully
- Being honest and direct
- Trying to understand the other person's point of view
- Use 'I messages' to speak for yourself
- Involve context, get to know the social situation
- Be sensitive to feedback about specific questions
- Revisit topics if necessary
- Avoid suggesting solutions and giving advice.
- Be willing to compromise, ask for help when needed
- Encourage development of self-esteem.
- Encourage people to develop skills to help themselves
- Be compassionate

Techniques:

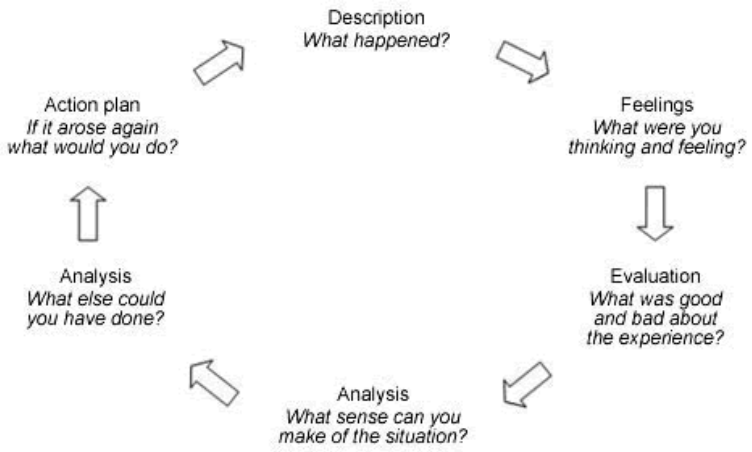
- Active listening
- Building a trusting relationship, rapport
- Motivational interviewing
- Summarising/Paraphrasing
- Open-ended questions
- Non-verbal cues, observe body language
- Storytelling

Nurse and Service user Expectations

Treating mental illness is not a quick fix. The duration of physical illness in Sierra Leone is short (e.g., real threats come more from malaria than diabetes) and the idea that mental illness is chronic and long lasting may be incongruent with physical health conceptions. So when service users come into the clinic, what are their expectations? What do they hope to 'get from' the experience of meeting with a mental health nurse? If service users are looking for something tangible, but you're not offering medication for their illness, what do you give them? How do you describe the treatment they will receive?

Reflective practice

Group discussion: What does **'reflective practice'** mean for individuals in the group? What does it mean for the cohort of nurses as a whole? How often do you reflect? (10 mins)



Definition: **Reflective Practice** is the capacity to reflect on action so as to engage in a process of continuous learning.

Skills session in groups of 3. Allow 15 mins for each person to adopt each role (45 mins)
One person is the **supervisor**, one person is the **nurse** and the other is the **observer**. Everyone will play each role in turn. (Find a quiet space to do this in, as it is easy to become distracted by noise of other people). Highlight that this is not a discussion about practice but a reflective session and therefore 'supervisors' need to ask questions etc.

Nurse: Needs to talk about a difficult case/situation they are currently working with. Outline the situation/case and seek guidance/support on what to do. Describe all of the information that you have on this client and the various factors that make it a particularly tricky case. What aspects of working with this person do you find particularly difficult?

Some examples of tricky cases might include:

- How might you deliver bad news in a supportive manner?
- How might you deal with angry, very anxious, suicidal, psychotic or withdrawn patients?
- How to respond to the sharing of extremely private and emotional events, such as sexual violence or losing a loved one due to Ebola?

Supervisor: Try to offer support and guidance. It's OK if you don't have the solution, but encourage the worker to think around the problem and find a solution for him or herself. Use constructive criticism where appropriate. If you can, refer to the model to help the worker to think through the problem.

Observer: Listen quietly to conversation. When it is ended, provide feedback on what you they have observed. Feedback on worker's ability to discuss the case and reflect on it. Feedback also on supervisor's role in encouraging this reflection.

Whole group feedback but keep comments very short: How did you find that exercise? What did you learn about your ability to reflect? How can reflecting on practice help you to be more effective in your work? What can you do differently as a nurse to reflect more effectively on what you are doing?

Let's talk:
Let's summarise the key points in this module. Can we agree on the three most important messages? Write them down on the flipchart and add to the wall. Are there any questions?

Training Exercise Module 6

Aims: In groups of 5-6 people, define the communication technique assigned to your group; provide an example of how you use this in practice.

Materials: Flip chart paper, pens, markers, blu-tack

Brainstorming about communication techniques

Small group discussion

Each group is assigned a communication technique. As a group, complete the following tasks, and then we will come back as a wider group for feedback and to present the cases. You can take notes in the workbooks.

Group One: Building a trusting relationship, building rapport with service users

1. What does the term mean? Define.
2. How might this technique be useful in your own practice? How do you do this?
3. Please provide a specific example or write down a case of how this technique can be used in practice and what happens when you communicate like this.

For example

Active listening - why?

- Facilitates and stimulates communication and expression
- Respects the person's problems and feelings
- Enables the person to feel our warmth, acceptance and to feel understood
- Helps a person express his or her pent-up feelings/emotions.

Active listening- how?

- Seek first to understand, then to be understood. Listening for meaning.
- Concentrate on what is being said and how it is being said
- Listen and look for the feelings and basic assumptions underlying remarks.
- Do not interrupt, especially to correct mistakes or make points and pause to think before answering.
- Avoid judgement, be aware of your own biases or values but clarify the message and describe the situation without showing approval or disapproval
- Do not insist on having the last word
- Use non-verbal and verbal communication skills

Active listening- Scenarios

1. Christina: "I'm feeling so tired and run down lately. I don't think I'll be able to go to fetch water with you today"
   Marie: "OK that's fine, I'll ask my daughter to come and fetch extra water for you"
2. Christina: "I'm feeling so tired and run down lately. I don't think I'll be able to go to fetch water with you today"
   Marie: "It sounds like you're having a really tough day. I can go a bit later and stay to chat for awhile, do you want to tell me why you're feeling so low?"

Training Exercise Module 6

Aims: In groups of 5-6 people, define the communication technique assigned to your group; provide an example of how you use this in practice.
Materials: Flip chart paper, pens, markers, blu-tack

Brainstorming about communication techniques

Small group discussion
Each group is assigned a communication technique. As a group, complete the following tasks, and then we will come back as a wider group for feedback and to present the cases. You can take notes in the workbooks.

Group Two: Summarising / Paraphrasing

1. What does the term mean? Define.
2. How might this technique be useful in your own practice? How do you do this?
3. Please provide a specific example or write down a case of how this technique can be used in practice and what happens when you communicate like this

Group Three: Open-ended questions

1. What does the term mean? Define.
2. How might this technique be useful in your own practice? How do you do this?
3. Please provide a specific example or write down a case of how this technique can be used in practice and what happens when you communicate like this.

Group Four: Storytelling

1. What does the term mean? Define.
2. How might this technique be useful in your own practice? How do you do this?
3. Please provide a specific example or write down a case of how this technique can be used in practice and what happens when you communicate like this.

See example of 'active listening' on the first page

VII. Module Seven—Individual Social Support and Asset Approaches

Session Aims: To explore the asset based approach to working with service users and empowering them to build self-confidence in their abilities, knowledge, skills and resources

Session Tasks:

1. Overview of asset-based approach and how it differs from needs assessment
2. To practice creating asset-maps

Session Duration: 90 minutes

Materials: A4 paper and pens, one's own hand!

Shifting the emphasis from **PROBLEMS → STRENGTHS**

Group discussion: Referring back to Module Five, Social and Community Models & Introduction to Sababu, can anyone tell me what an asset-based or strengths-based approach is?

Instead of looking only for an individual's problems, vulnerabilities and at what he or she cannot do, by taking an asset or strengths-based approach we look first for what individuals and those close to them can do and at what they have the potential to do with a little help.

Definition: An **asset** is any factor or resource, which enhances the ability of individuals, communities and populations to maintain health and wellbeing. These assets can operate at the level of the individual, family or community as protective and promoting factors to help people cope with challenges in life. Source: National Institute for Health and Clinical Excellence (NICE), 2009

When problems are chronic and overwhelming, often people's sense of their own strength is pushed into the background and they feel hopeless and helpless. This is furthered by stigma and discrimination when others around the person don't believe in them or their capacity. Talking about abilities can often be used to overcome problems.

The nature and extent of the resources available and accessible may vary with age, gender, the socio-cultural context and the crisis environment. A common error in work on mental health and psychosocial wellbeing is to ignore these resources and to focus solely on deficits – the weaknesses, suffering and pathology – of the individuals seeking services.

Fundamentally, the shift from using a deficit-based approach to an asset-based one requires a change in attitudes and values. The asset approach values the capacity, skills, knowledge, connections and potential in a community. In an asset approach, the glass is half-full rather than half-empty.

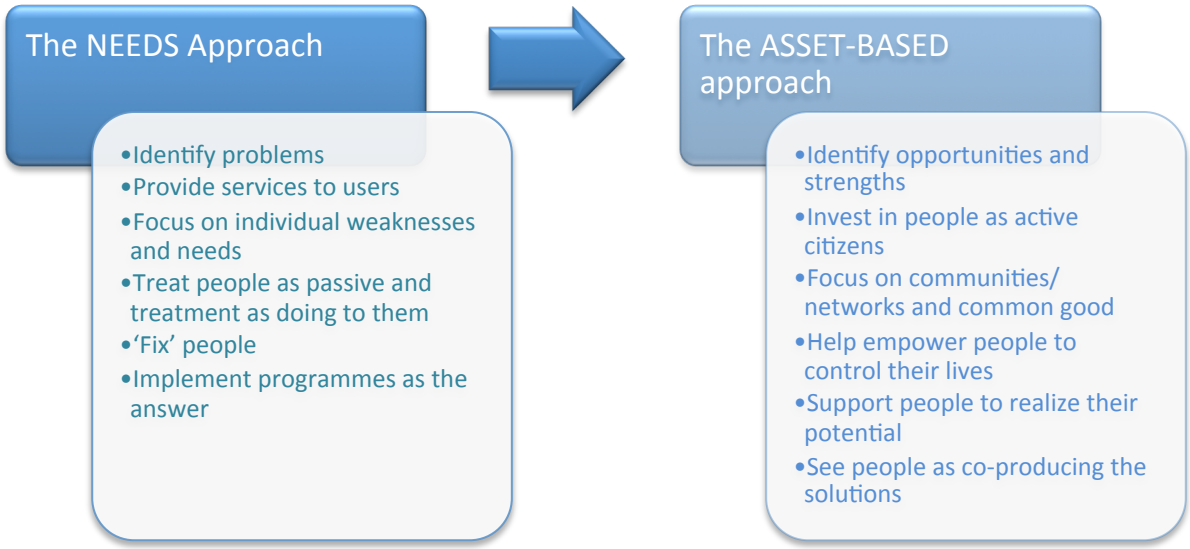
*An **asset** is any of the following:*

- The practical skills, capacity & knowledge of people: problem-solving, negotiating, communication
- The passions and interests of people that give them energy for change
- The networks and connections – known as **'social capital'** – in a community, including friendships, work and family relationships. These are all the social resources available to people: community leaders, traditional healers (in many societies), women's groups and community planning groups, etc. Within these networks are also a range of skills and capacities that individuals can draw upon.
- The community resources that are economic (e.g., land, crops, animals); educational, (e.g., schools, teachers); and health (e.g., clinics, staff). To plan appropriate interventions it is necessary to know the nature of local resources, whether they are helpful or harmful, and the extent to which people can access them.

So, how do we practice an asset-based approach?

- Be flexible and perceptive of an individual's situation and needs.
- Have an understanding of the person's condition.
- See people as the co-producers of mental health and wellbeing, rather than the recipients of services. What makes this person strong?
- Look at the whole community and be aware of the support available from that community. What makes this a good place to be? Consider how the individual might contribute to the local community, and hence be better integrated in the wider society around them.
- Gauge their interests, passions, hobbies. These may have been lost in difficult times. If so, ask what they USED to enjoy doing. When are they happiest? Who or what around them makes them feel good?

Moving from a deficit/needs approach to an asset approach



Asset mapping

What is it?

Participants make a map or inventory of the resources, skills and talents of individuals, social networks and communities. Discover and collate the links between the different parts of the assets and resources. This knowledge can be used to revitalise relationships and mutual support, and to rebuild communities.

How is it done in practice?

Creating a map or inventory is more than just gathering information; it is also a development and empowerment tool. The process of discovering the potential assets in a community creates new relationships and new possibilities.

Categorise assets – actual and potential – on several levels:

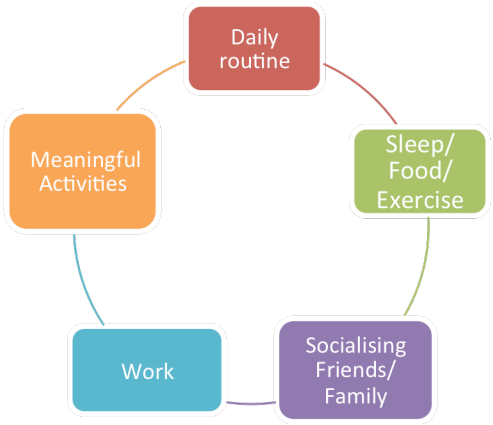
1. The assets of individuals: these are skills, knowledge, networks, time, interests and passions.
2. The assets of others in one's social networks: Whom do they go to for spiritual advice? Who can they turn to when trying to learn a new skill?
3. The assets of communities, the ways that people come together: services delivered locally, recreation spaces, schools, organisations, economic opportunities
4. The cultural assets: this involves mapping opportunities to engage in music & dance, art, and creative ways that people express themselves.

Group discussion: together, draw an asset map for Sierra Leone communities. Think about all four levels.

Training Exercise Module 7

Aims: Use case studies to practice goal setting and applying the asset-based approach to assessments.
Materials: Flip chart paper. Pens

In order to help rebuild a person's life – think about how they should spend their time. Set goals with the person, write them down and then check a few weeks later to see what the person has achieved. Important goals to work on are:



20 mins – Split the group into pairs by counting so they are with people they might not have worked with previously. If space permits they can move into other rooms. Ask everyone to consider a difficult case they have worked with (preferably someone on their current caseload) who has been unable to set their own goals, this might be a person who is resistant to think about what they have achieved or what they would like to achieve, for example saying 'no' to any ideas you may have provided.

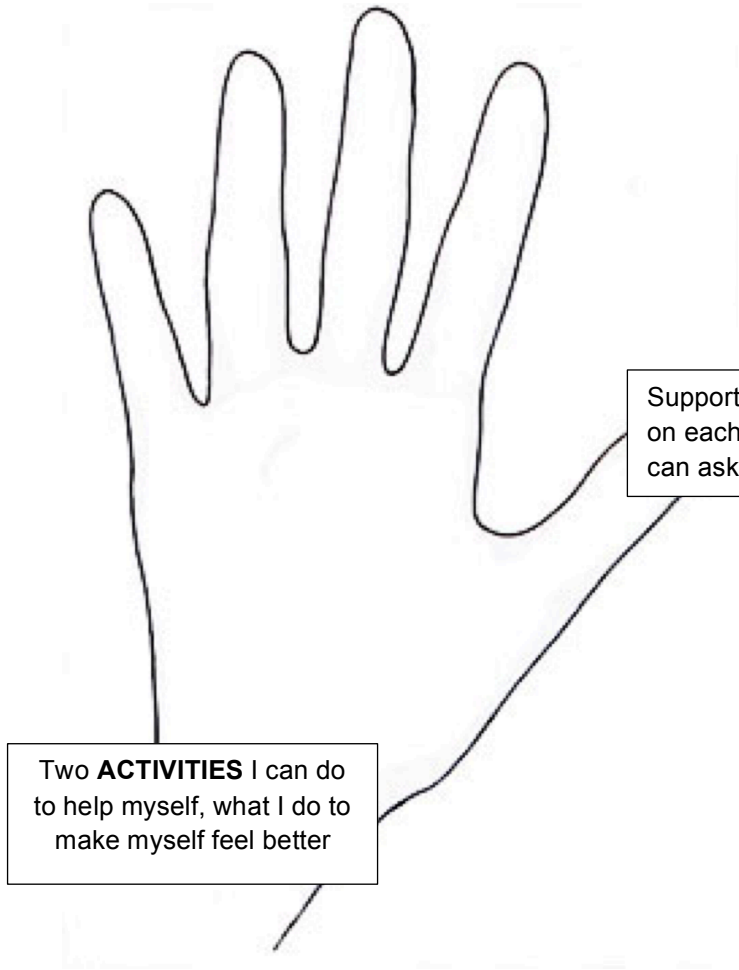
Taking turns with the exercise, the first person will take five minutes to present the case, partner is writing down assets and important information about the case. The partner is then asked to suggest three new ideas or approaches that the worker can try with this individual in order to help the individual set their own goals.

Then switch to the second case
15 mins – Switch to new pairs and put these action plans into practice. Role-play with the new partner, using an issue of one's own (personal or professional) that has been a struggle recently. After presenting the problem the partner will use one of their three new approaches (given by previous partner) to assist the partner in setting new goals.

10 mins – Coming back for a short group discussion, ask nurses to present one of the ideas given to him or her for setting goals with this difficult case. What worked well in the second role-play, what didn't work so well?

Training Exercise Module 7

Helping Hand Social Support



Supportive **CONTACTS** on each finger, someone I can ask for help

Two **ACTIVITIES** I can do to help myself, what I do to make myself feel better

Two **PROVERBS** or mantras that bring me comfort

Let's talk:
Let's summarise the key points in this module. Can we agree on the three most important messages? Write them down on the flipchart and add to the wall. Are there any questions?

VIII. Module Eight—Care for the caregiver and family support

Session Aim: To In the next session participants deal with how to care for themselves as caregivers, they explore various stressors in their environment and ways of recognising their stress. Then, this learning is translating into working with families.
Session Tasks:
1. Interactive session on self-care and recognizing stress in themselves
2. Discuss and role-play working with families to engage their support

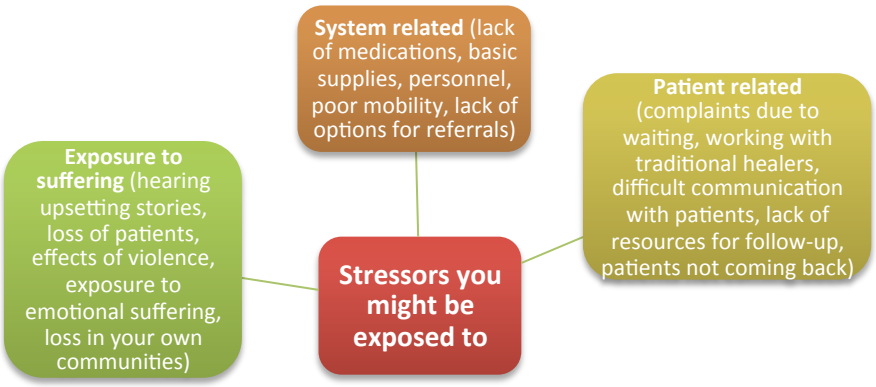
Session Duration: 90 minutes
Materials: Flipchart paper, pens, volunteers for role-play

Group discussion: You've had training in self-care before, what is self-care? How would you define it? What does it mean for you personally?

Definition: The WHO defines **self-care** as: "The ability of individuals, families and communities to promote health, prevent disease, and maintain health and to cope with illness and disability without the support of a health care provider." It is the ability to proactively enhance our health by building resilience and promoting holistic wellbeing at several levels: psychological, social, physical, and spiritual.

Working in health care can be one of the most rewarding fields as you offer valuable and critical services in your communities. You are respected in your communities as you help people to overcome suffering and you can save lives. It can also be difficult to sustain your role overtime, and particularly with added pressures and recent changes to your role and health system. If your mental health is not good then it not only affects your own wellbeing but also your ability to work properly and support others.

Let's start to think about some of the stressors you all face as mental health workers, and those that might be particularly high during and after the Ebola outbreak.



Individual: Let's take a moment to reflect on some of these stressors. (3 min silence)

Work in pairs: Then we'd like you to discuss with a partner: How do you care for yourself? What strategies do you use to cope with negative impacts of stress? How have your strategies for coping with stress changed since becoming a nurse? Since the outbreak? Who do you go to for support?

Ideas might be: relaxation techniques, creative/fun activities, socialising, look to peers, time for yourself.

Group discussion: Let's think about the most rewarding aspects of your job. In what ways have these challenges improved your work, and you personally? Do you see any benefits to your role now that you didn't see previously?

Proverb: "A tree cannot be a forest"

What does this mean to you?
What does it say about other people?
How might this be related to your work?
Who are the other trees that make up the forest?

Involvement of carers/family members

This section is about the needs of carers or family members who are involved in the care of service users. In this section we will discuss some of the ways that your own strategies for self-care and coping with stressors might be translated to the work you do with families.

The mental health and needs of carers is important to consider alongside the service user. Families/carer(s) often provide most of the support and care for a person with a mental disorder living in the community. Families/carer(s) play a big role in the lives of the person they are caring for, (e.g., they are often responsible for taking the person to clinic, making sure that treatment plans are adhered to, and notifying the health professional if symptoms worsen). For this reason, it is very important for workers to have a good relationship with the families/carer(s) of people with mental disorders.

Mental illness can be very upsetting for the families/carers of the person who is unwell. Families/carers often do not understand the symptoms of mental illness, and therefore need information about the problems that the person they are caring for is experiencing.

They can feel ashamed, angry and guilty and this can affect how they treat the person with the mental illness; they can experience all types of distressing emotions:

- Sadness to see a loved on suffer
- Physical burden to look after their basic needs
- Fear of catching the disease (both in terms of mental health and Ebola)
- Anger at the person who is mentally unwell for having made life more difficult
- Frustration and hopelessness that things won't change in the future
- Social isolation, many people find it hard to make time to socialise or carry on with their own hobbies or interests
- Low self-esteem, carers may lose confidence in self and abilities to do things outside of caring responsibilities
- Guilt because of these negative thoughts

Group discussion: Without help in managing their own stress, carers may unintentionally behave in a way that creates more stress for the person with the mental disorder, which will have a negative effect on his/her health. How can you help families/carers in distress to better cope? What are the barriers you face in working with families? Brainstorm solutions together.

Some ideas might include…

A. Helping carers to learn how to talk about mental illness and explain it to others (psychoeducation)

- Speak to them about their spiritual beliefs. Many people think that it is wrong or goes against their spiritual beliefs to take medicine or treatment for mental illness. Always respect the beliefs of others but politely explain that treatment for mental illness can usually be seen as acceptable to any person's religious beliefs
- Stress that the way the family reacts to the person with mental illness will influence how they recover – if they are too critical, or too hostile then the person will become more stressed and fall ill once again.

B. Be a role model!

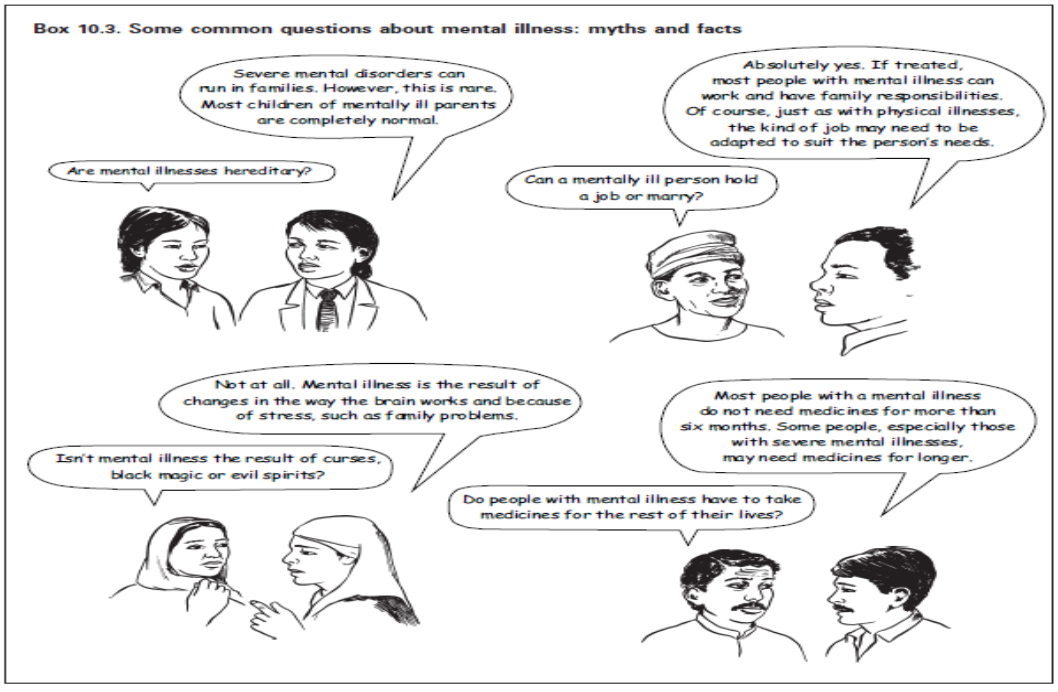
- Help the family to learn to use effective interpersonal skills amongst themselves, i.e. new ways to interact with another
- Demonstrate a different way of negotiating differences during family meeting
- Take time to listen to carer's concerns and feelings. Counsel them on stress management and self-care

C. Developing strengths for family problem-solving counselling

- Teach the family new positive ways to address recurring problems through discussion and implementation of alternative solutions
- Address concrete difficulties; help the family to define small, achievable tasks that will change the way they manage the situation
- Teach or assist the family how to access and use internal and external resources when they feel isolated or overwhelmed

D. Networking with other individuals and community organisations

- Involving other family members, sharing concerns about the service user and asking for help
- Provide information on support groups- or look at starting one in your own clinics
- Networking among resources in the community, who can families/carers go to and who can service users go to? Are they are same or different? How might these resources link?
- Involve them in goal setting with the service user.
- Involve the family in helping the person rebuild their life.



Recap:

Let's summarise the key points in this module. Can we agree on the three most important messages? Write them down on the flipchart and add to the wall. Are there any questions?

Training Exercise Module 8

Aims: To build confidence in discussing mental illness with carers/families and plan activities for involving family members in counselling.
Materials: Four chairs in the front of the room. Flip chart paper.

Family role-play

To what extent do you feel confident explaining mental illness to a family?

Prep 3-4 volunteers before this session: 1) the nurse, 2) a loving and supportive mother, 3) an angry father who is ashamed of his son/daughter, 4) person with mental illness

Ask them to use **psychoeducation** to build awareness and skills among family caregivers of people living with serious mental illness. Think about the following key messages:

- Mental illness is nobody's fault.
- Mental illness is NOT caused by witchcraft or spirits.
- Mental illness is not infectious and will not be caught by touching the person who is mentally ill or sharing their food.
- Mental illness is treatable.
- People with mental illness can lead a normal life with some adjustments. They can marry, have children and work in most types of jobs.
- The person who has had a mental illness is exactly the same person as they were before they became unwell.
- Talk to the family about their spiritual beliefs and how they might cope with and heal emotionally.
- Involve the family in helping the person rebuild their life.
- Remind them that they can help the person manage stress so that they do not fall unwell again.
- The way the family reacts to the person with mental illness will influence how they recover – if they are too critical, or too hostile then the person will become more stressed and fall ill once again.

Group discussion: After the group of four has had a chance to role-play, ask the wider audience to reflect on their performance. What did each of them do well? Was this a realistic situation? How can you support your peers by providing advice to improve their ways of working with families?

IX. Module Nine—Engaging and Mobilising Social Networks

Session Aim: To look at how building relationships with supportive people and in the wider community can be developed for both workers and individuals. Reference the focus that the model has on creating relationships with the community.

Session Tasks:

1. Begin with discussion of building relationships and making connections
2. Think about how to engage existing resources in the community
3. Explore mapping one's own social network and developing this tool

Session Duration: 180 minutes

Materials: Flipchart paper, pens, A4 paper, social network examples

Building relationships

People who have relationships that are caring and supportive are more likely to have good mental health. For most people, close relationships with spouses, parents, children, and partners provide joy when we are happy and support when we are distressed. This is why helping people to maintain and rebuild relationships during difficult times is so important for mental health and wellbeing.

Similar to Ebola public health messages such as advising people to wash hands frequently and avoid touching others, so too may we advise people to resolve problems in close relationships to prevent problems or improve mental health.

"Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. Social networks have a larger impact on the risk of mortality than on the risk of developing disease, that is, it is not so much that social networks stop you from getting ill, but that they help you to recover when you do get ill." Marmot (2010) Fair Society Healthy Lives Final Report.

Why do relationships breakdown?

- Major life events: happy and unpleasant events can cause relationships difficulties. Sometimes, one event may cause good and bad reactions. For example, the arrival of a new baby is an exciting time for a couple, but may also lead to financial difficulties or loss of intimacy between them.
- Financial problems: One of the most common issues between spouses is when a shortage of money occurs and can lead to resentment, conflict and arguments.
- Illness (physical or mental): sickness can impact relationships, especially chronic problems or when it impacts a person's ability to live and work independently.
- Substance misuse problems: People with drinking or drug problems can become violent, angry, and destructive of relationships around them.
- Violence: violence in relationships is very difficult to deal with and most often victimises women. Emotional and physical violence can be equally damaging to relationships.

Social connections are good for you!

Research has found that social networks help you to find work, live longer and to improve your mental health and quality of life.

How can I help rebuild relationships?

Mental health workers play an important role in facilitating the rebuilding of relationships that have broken down, or establishing new ones in the community. One key to remember is that an unhealthy relationship can lead to or exacerbate a mental health problem. Also think about how you build trust and strong communication with service users, how might you

be able to help them do the same with their family and friends? A first step is to talk to both people involved, engage family members in your meetings and reach out to the people who might best be able to support service users in their homes and communities. Improving communication and encouraging them to share their feelings and thoughts is a helpful way to rebuild trust.

Discussion in pairs: with a partner discuss ways you have helped people to rebuild or maintain relationships. What strategies can you share with your peers?

Some actions you might consider:

- Speak about high/lows of the day; what was the best and worst part of the day?
- Creating time to enjoy activities together, linking people with others in meaningful participation
- Finding common, trusted individuals who might also be able to mediate. For example, a neighbour or person in the church/mosque who knows both people well.

Engaging the wider social network

You are particularly well placed to enhance social networks at an individual level- you might know of other people in the community who have similar assets, interests or hobbies to the service users you work with. For example, you might be aware of an elderly person who has been feeling lonely and a single mother who needs help with her children but cannot afford formal childcare, might these be people you link?

Definition: **Social inclusion** for an individual means access to supportive relationships, involvement in group activities and civic engagement. A **socially inclusive society** is defined as one where all people feel valued, their differences are respected, and their basic needs are met so they can live in dignity. **Social exclusion** is the process of being shut out from the social, economic, political and cultural systems, which contribute to the integration of a person into the community.

Any psychosocial interventions should be embedded in, and linked to, initiatives and services that already exist in the community. Following your initial assessment of the **needs and assets** an individual has within his or her social networks. Your conversation then entails discussing which types of available services and resources might be appropriate for the problems identified in the needs assessment and where the person may contribute his or her own assets.

Collaboration with existing services (informal and formal), such as schools, health care and traditional healing, should be actively sought. Importantly, psychosocial care services should link with non-mental health care, such as religious practices, nutrition projects, micro-finance schemes, youth clubs, etc.

Involvement with local social networks has a dual function, (i) it ensures sustainability and responsibility of community members, and (ii) it is also a strategy to improve psychosocial wellbeing. By establishing a good networking and referral system you may be able to minimise the burden of care placed on the limited services you and your teams in the DMHUs are able to offer.

Mobilising an individual's social network to enhance opportunities for income generation

You may not be able to create jobs for people but as mental health workers your views are respected in the community. You might be able to connect service users to people or places that could offer voluntary or paid work. Keeping people engaged and active is an important way to prevent mental health problems and also aid in recovery. For example, there might be occupation and job skills training with local NGOs, small jobs at local offices (e.g., cleaning the health clinic, gardening group). Income generating activities give service users a valuable role in their community; teach skills in managing their own daily life and money, and boost confidence and self-esteem.

Training Exercise Module 9

Aims: To create our own social network maps and conceptualise the social world around us. This can be a tool used with service users.

Materials: A4 paper for each person, pens

Individually: map your own social network to visualise the social system around you. Include names of people with whom you have relationships, organisations and activities you're involved with. Think about how people participate in your network, what are their roles? (15 minutes)

In pairs: Share your map with a neighbour. Try to add as many additional names to the other's network as possible; that might you have forgotten? (20 minutes)

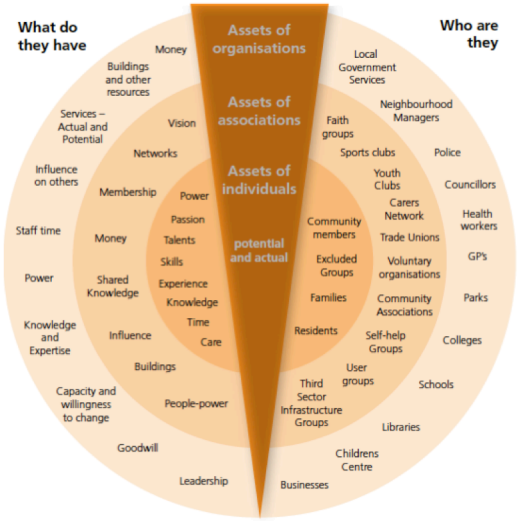
Consider the following:

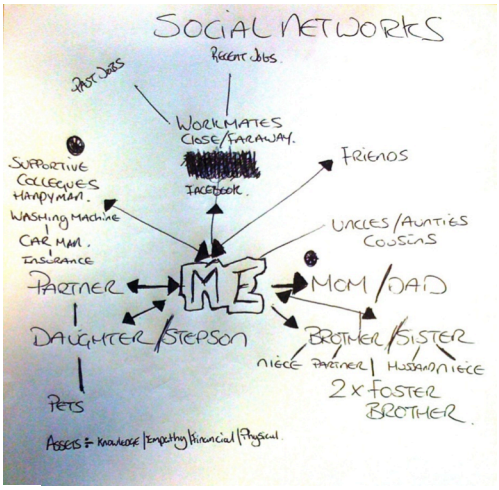
- What do you give to these relationships? What are your assets?
- Try to work out which direction each relationship on your network goes in and draw arrows to demonstrate this. It could be a two-way arrow if the relationship reflects this.
- Is there anyone on your network who is a negative influence? Why? If there isn't, can you think of anyone, or any type of person, who would be?
- Are these relationships, and the directions of them, constant over time? Do they fluctuate? Why?

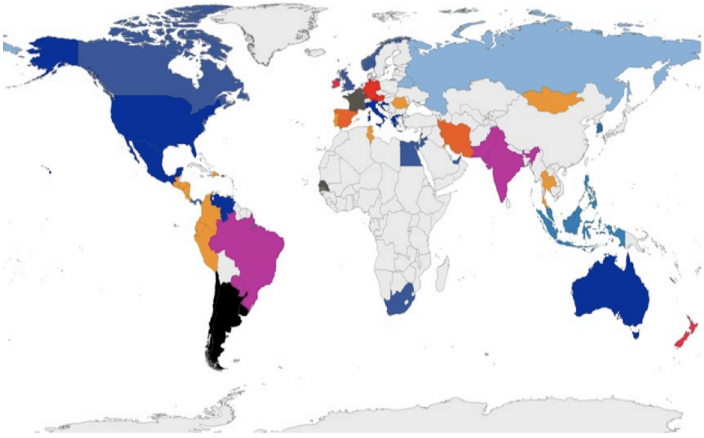
Group discussion: How did you find that? What was challenging, what was enjoyable? Is this something you've done with service users? Would you consider using this tool with them? Why/why not? (10 minutes)

Asset mapping and social network mapping can be a useful tool in your assessments with service users to identify gaps in resources and support. This helps people to visualise the social system around them and enables you to learn who and how you might work with their social network to mobilise support for the service user. Think about how each person or group on the map might be able to support recovery with the service user. The next step is working with family members or a supportive person for the individual, engaging them in the process.

Training Exercise Module 9







X. Module Ten—Community Engagement and Mobilisation

Session Aim: To understand the importance of using psychoeducation, awareness-raising and advocacy techniques to enhance community participation.
Session Tasks:

1. Overview of related terms and definitions, and to gain full understanding of what is meant by social mobilisation and why it's important in EVD response
2. Discuss the IMC recommendations and the role for nurses
3. Activity practicing community mobilization and presentations to the group

Session Duration: 180 minutes
Materials: Flipchart paper, pens, music or other art materials

Group discussion: Ask participants what they understand by the terms **community participation** and **engagement**, **social mobilisation**, **advocacy**. Write the answers on the flip chart. Can we identify distinctions between them? To what extent is this part of your role? Has the amount of community work you're involved with changed over the past year? Why is it important? If not you, then who else might be doing this? Mention management and capacity building opportunities in the new District MH units.

Definition: **community engagement** is a method of improving communities by working collaboratively to identify and address local ideas, concerns, and opportunities affecting their health and wellbeing. It is the first step in moving from passive victim to active participant. It encourages ownership and responsibility, motivation for change and sustainability in the future.

As we've discussed, disease outbreaks have the potential to severely disrupt community life. They are not isolated events but occur within, and are perpetuated by, existing social, cultural, political and economic settings. It is these settings and experiences that greatly influence the beliefs around the outbreak—how people understand the public health risk—and ultimately how they respond emotionally and behaviourally. In an outbreak, **social mobilisation interventions** have focused on affected communities and participatory approaches, viewing affected communities as partners in finding solutions to control and contain the outbreak.

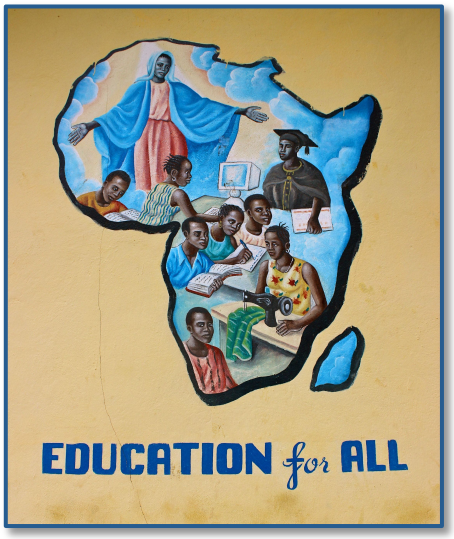
UNICEF is the lead agency for the UN on social mobilisation in the Ebola response and is co-chairing the **Social Mobilization Pillar** with the Health Education Division of the MoHS as well as the Child Protection and Psychosocial Support Pillar with the MSWGCA. Social mobilisation is a top priority in the EVD response and involves mental health services.

Definition: **Psychoeducation** is a community-based intervention that promotes the awareness of mental health and adverse psychological reactions. It acknowledges there is a lack of understanding in the community and involves a deliberate process to influence positive change and to address specific needs. The development and production of information, education and communication materials are integral to a psychosocial response.

Related terms: Sensitisation, mental health promotion, awareness raising, advocacy

Often, social mobilisation is focused on distributing key public health messages- the communications to minimise risk and keep communities informed. When we think about the psychosocial impact of EVD, we need to consider more than the public health messages, we also need to think about the social fabric that is being disrupted and how mental distress may be experienced through fear, loss and isolation. Ensuring engagement from the community has the potential to reduce distress, relieve boredom and isolation, and improve self-esteem, lack of control and morale, all of which are risk factors for developing mental

health problems. Community Participation would also ensure that the services and activities are set up appropriately, are culturally relevant and meet the needs of the affected population.



There are many different inter-related ideas and concepts around community participation to promote mental health and wellbeing, but generally the process involves change at a number of levels including individuals and the family, organisations, communities and society.

Overall, combined activities aim to achieve the following:

1. Increasing understanding (normalisation) and identification of psychosocial problems being faced in the community. Provide information about the reactions that are common and normal among people in crises, as well as information about the severe reactions and problems that needs extra attention, this can strengthen coping and healing strategies.
2. De-stigmatisation of mental health problems. Explaining mental health and psychosocial problems and care plays a crucial part in reducing stigma attached to these concepts.
3. Empowerment of local leadership. It is essential to community participation that local leaders are identified and involved. Gaining such involvement seeks to increase social inclusion and participation.
4. Mobilisation of existing resources and roles. Enhancing safe and secure neighbourhood environments; developing health and social services; reducing structural barriers to mental health; reducing discrimination and inequalities through initiatives that promote access to education, housing, meaningful full employment, housing and services for those who are vulnerable.

IMC Recommendations: Let's take a look at the recommendations from IMC, how can these be achieved?

→ Engage the communities in psycho-education and health promotion messages around Ebola and peoples' reactions to Ebola.

- Encourage existing coping strategies (e.g. forms of worshipping/rituals, community gatherings)
- Encourage existing care systems (e.g. traditional healers, self-help groups, priests/Imam)
- Encourage existing social support systems (e.g. family, neighbours, religious or community leaders)
- Encourage peer activities (e.g. recreation, sports, dancing, youth clubs)
- Re-establishment of normal schooling, employment and daily routines

→ Work collaboratively with other organisations to set up survivors/ EVD affected people's associations and support groups/peer support networks in the communities

→ Providing accurate information about the psychosocial responses to EVD so that people can keep themselves safe when coming together but also understand importance of social support.

→ Encourage families to remain in contact with patients (by phone or visiting)

→ Actively involve the community in general social consideration (above) and in structured meaningful activities to increase control and participation.

Training Exercise Module 10

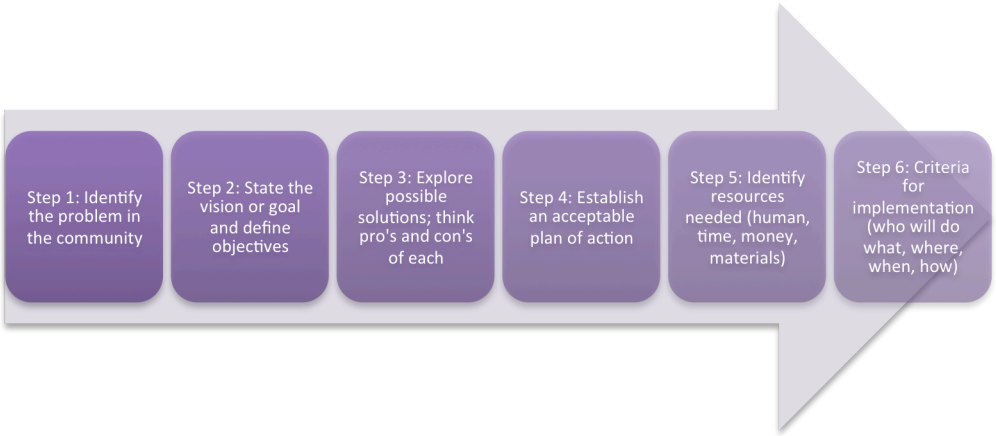
Aims: In groups of 5-6 people, design a community intervention to address one of the psychosocial problems facing communities in Sierra Leone amid the EVD outbreak

Materials: Flip chart paper, pens, markers, blu-tack

Split into four groups. Each group is given an issue facing communities in Sierra Leone today. You are asked to create an intervention using community participation to address the issue. You can use any form of community activity you think fits best with the issues (song and dance, posters, social gathering, support groups, use of media, etc.). **Be creative!**

In planning community-based activities, an intervention must take into account the norms and values of community members. This relies on community participation and ownership, and gives priority to activities that foster family and social support that seek to increase relationships and bonds between community members.

Overview of planning community activities and engagement:



Group One: Address social isolation of EVD survivors

Families and survivors are being isolated and marginalised from their communities. Many survivors reported being discriminated against, feeling hopeless, being distressed by their bad experiences in the ambulances and treatment/holding centres and experiencing very complex grief. Many survivors were also being told to stay away from people and family. Those survivors who had earned money before the illness by cooking or selling produce at market are now being refused work so they stay at home and do nothing. Social support is one of the major factors that can protect people from developing mental health problems.

How can you develop an intervention to address the social isolation of survivors and the psychosocial needs they have in seeking support from others?

Training Exercise Module 10

Aims: In groups of 5-6 people, design a community intervention to address one of the psychosocial problems facing communities in Sierra Leone amid the EVD outbreak

Materials: Flip chart paper, pens, markers, blu-tack

Group Two: disengagement of existing resources

Communities cannot meet and socialise in the same way they used to due to Avoid Body Contact (ABC). Restrictions on gatherings and movement means that it may not be possible to use traditional forms of support such as meeting socially, hugging or shaking hands, and visiting family. As a result, people may feel especially isolated and distressed. Social support is one of the major factors that can protect people from developing mental health problems. These support networks are important but need to be re-envisaged to ensure the safety of people and minimise the risk of spreading EVD.

How can you develop an intervention that will encourage existing coping strategies, care, systems, social support networks, peer activities?

Group Three: Lack of communication between local leaders and community members

When schools have closed and jobs are limited, people are experiencing low self-esteem and report they have no role in society. There is a desire from community members to know more about EVD and take a role and responsibility in wanting to control the epidemic within their communities. Actively involving community leaders in meaningful participation on the response enables people to become more empowered in supporting community recover and prevention of Ebola.

In designing the community intervention, your group may wish to consider the following questions:

- How to identify community leaders (look for those who are locally accepted, trusted, respected; accurately represent their communities; will work toward collective goals)?
- How to initiate a dialogue and interact with community leaders?
- How to attract other community members?

Group Four: Stigma and discrimination of people experiencing mental distress.

Rationale, what's the purpose of psychoeducation? Why do people in the community need information on psychosocial problems and mental health?

- Reducing the incidence of mental illness and suicide by enhancing individuals, families and the community's the ability to cope in stressful situations.
- Countering fear, ignorance, and stigma about mental illness and creating a more positive social environment in which it is more acceptable to talk about feelings, emotions and problems.
- Preventing deterioration of an existing mental illness.
- Improving the quality of life of people with long-standing, recurrent or acute mental health problems.
- Maintaining and improving social functioning.

How might you use psychoeducation to reduce stigma and discrimination of people experiencing mental distress during the outbreak? What materials/people/media would you use in a community intervention?

Training Activity

Aims: In groups of 5-6 people, role play the following community intervention

Materials: props?

Group One

Forming local partnerships, establishing trust, obtaining permission from the community to provide mental health services and make links in the community. Role play your meetings with these leaders- you may need to try several different people or routes before you're successful!

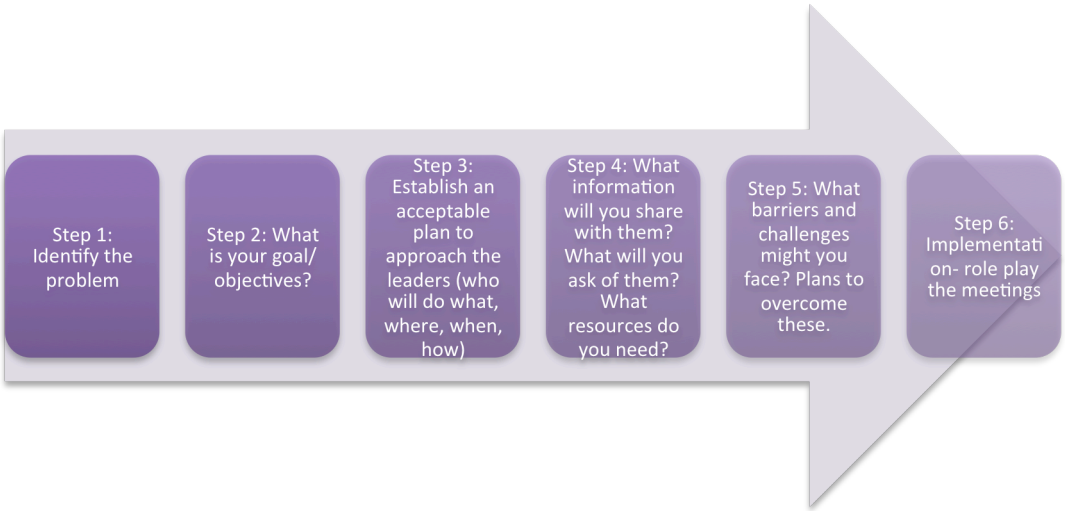
Roles:

- Chief or Mammy queen
- Influential business person
- Mental health nurse
- District Health Officer
- Religious leader

Think about:

- How to identify community leaders (look for those who are locally accepted, trusted, respected; accurately represent their communities; will work toward collective goals)?
- How to initiate a dialogue and interact with community leaders?
- How to attract other community members?

Follow these steps in developing the role play:



Training Activity

Aims: In groups of 5-6 people, role play the following community intervention

Materials: props?

entation to build
t the barriers you
ealth problems, how
the community might support that person, coping strategies and where they can go for referrals.

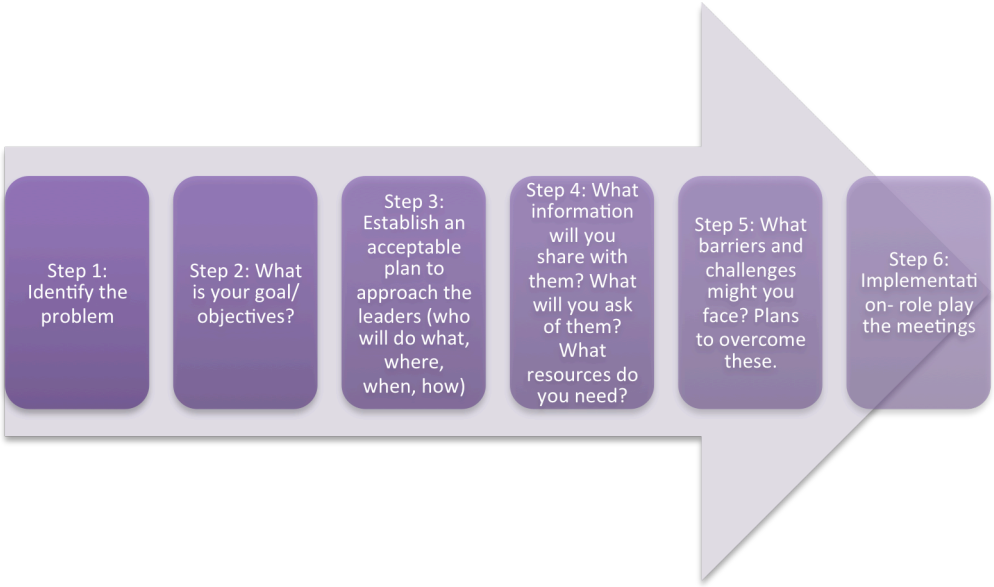
Roles:

- Mental health nurse
- Community leader
- Sceptical community members- those who believe it's witchcraft
- Advocate who understands the importance of mental health

Think about:

- How to identify community members to include in the forum (look for those who are locally accepted, trusted, respected; accurately represent their communities; will work toward collective goals)?
- How to initiate a dialogue and interact with community members?
- How to attract other influential people?

Follow these steps in developing the role play:



Training Activity

Aims: In groups of 5-6 people, role play the following community intervention

Materials: props?

Group Three

Using the following case study, role play how you identify existing resources around the service user, community assets, referral pathways, and connecting the service user with these resources, making introductions and supporting them to develop relationships.

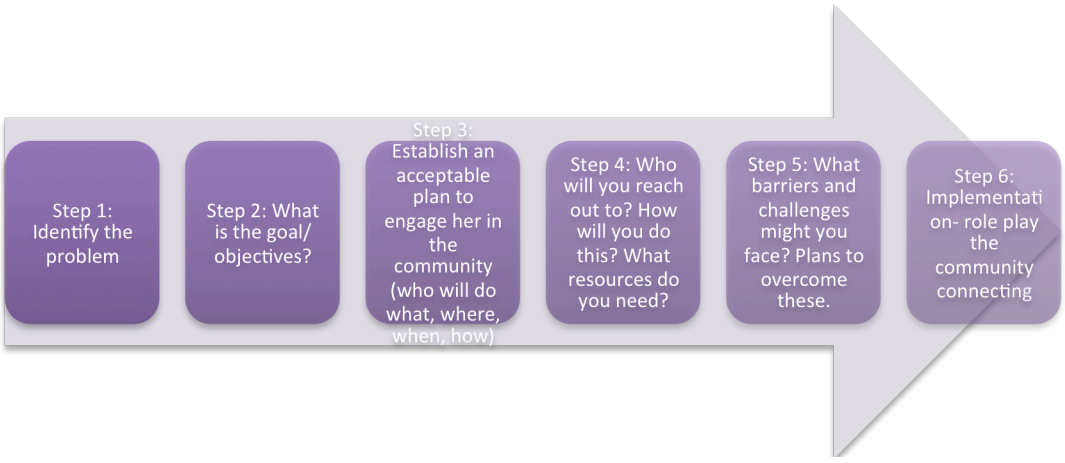
Case study:

A married woman in her late 50s, Josephine, lives with her husband in Kenema and was diagnosed with depression in your earlier assessment. Josephine had eight children, though four of them have died in the past 15 years. One died as a young child, another whom Josephine was very attached to left home ten years ago and married but she received information that her daughter had died about three years ago. She never saw the body nor found out where she was buried. In the past year, two of her children died, one of Ebola and another of a health complication and he was unable to get to hospital for treatment. Together with her husband they had educated their children and the remaining four live in neighbouring communities and one is in Freetown. Lately Josephine spends most of her time crying, she has intense anger, low energy and difficulty sleeping, eating, concentrating. She describes how since the latest deaths she's been staying at home and irritating her husband, to the extent that he is unable to tend to his land. She was making country cloth for a living but due to her concentration problems has had difficulty mixing the colours. She wants to be back to work but can't seem to feel any better.

Roles:

- Mental Health nurse
- Service user
- Husband
- Community members

Follow these steps in developing the role play:



Training Activity

Aims: In groups of 5-6 people, role play the following community intervention

Materials: props?

Group Four

Create a collaborative treatment plan that involves the service user, family members, community members, and any other services/organisations that may be appropriate. Use the following case study and role play how you develop the collaborative treatment plan with everyone.

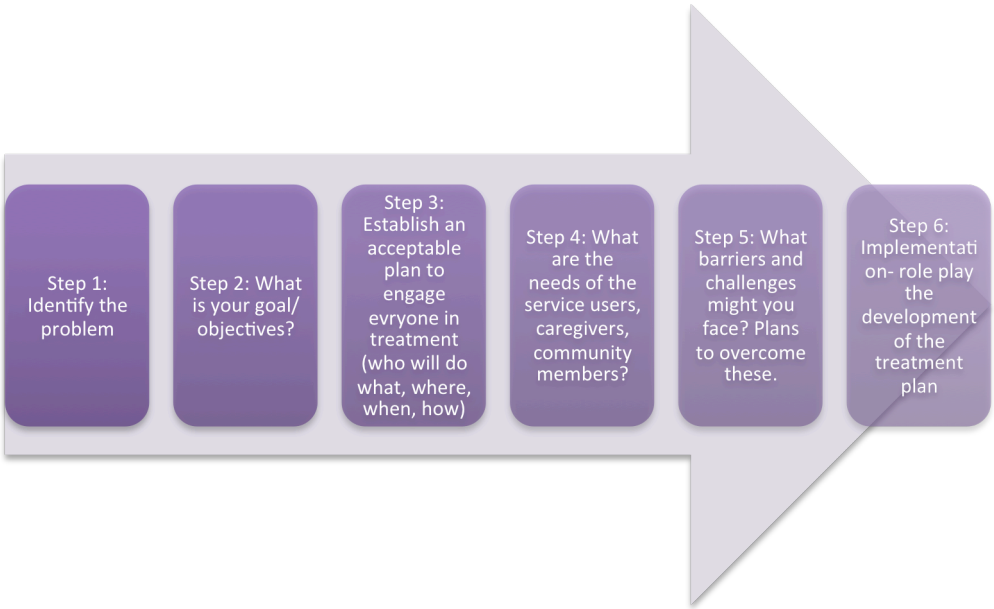
Case Study:

A man in is 40's, Robert, came in to the clinic when his small business of selling rice went bankrupt for the third time after declining prices and a difficult economic situation in Sierra Leone. Robert came complaining of insomnia, depressed mood, feelings of worthlessness and irritability. For the past year he has been feeling sad, unworthy of supporting his wife and three children, and lost interest in finding a job or farming. He hopes to cure this depression and go back to earning a living for his family but he feels lost in how to cope. He sees his depression as related to the difficulties associated with his business failure, which also left him feeling ashamed in the village.

Roles:

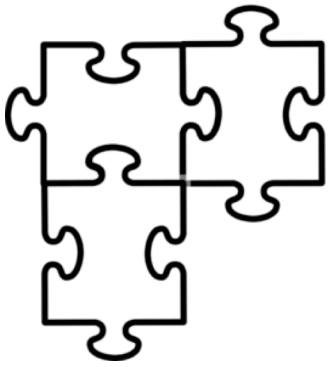
- Mental health nurse
- Service user
- Family members
- Religious leader
- Community member (e.g. colleague, fellow farmer)

Follow these steps in developing the role play:



Training Exercise Module 10

Aims: To put together the integral resources involved in a community through a visual puzzle.
Materials: multi-coloured puzzle pieces, pens



Community Mapping Puzzle

Thinking back to the personal social networks you created, next we're going to create a map of communities in Sierra Leone, using puzzle pieces to fit together the relevant assets and resources that are held within a community.

Split into five groups. Each group will take a set of puzzle pieces, which relate to one of the following assets of a community. Brainstorm whom and what organisations, services, spaces are key resources in the community, add to the puzzle pieces and we will post on the wall.

- **Group One:** Social services (e.g., education, health, politics/government)
- **Group Two:** Social spaces (e.g., markets, café, football pitch,)
- **Group Three:** Diversity resources (e.g., women, youth, age, groups and clubs, religious leaders/churches, mosques, tribal meetings)
- **Group Four:** People (e.g., individuals, families, neighbours, friends)
- **Group Five:** EVD response (e.g., isolation unit staff, burial teams, contact tracing teams, public health communications)

How does this relate to the Sababu Model? Where does this fit into the model and how might you use this tool in working with service users?

XI. Module Eleven—Training-of-Trainers

Session Aim: To provide feedback on the training and take learning to next step by brainstorming ways that this can be taken back to DMHUs and used to address needs and gaps in service provision.
Session Tasks:
1. Overview of ToT concepts and why it's useful
2. ToT workshop for nurses to develop their own training programme

Session Duration: 90 minutes
Materials: Flipchart paper, pens

Most people, when presented with new information, do not automatically assimilate and apply it to their own world. Learning is about understanding new information, linking it to current and past experiences and adapting it to one's own life or work situation. Often, people learn best when they are asked to teach new skills to someone else. This is why ToT workshops are so effective at helping people to building on their experiences and put learning into effect immediately. Participants have now completed the training course. Explain that the purpose of this activity is to brainstorm and identify what steps need to be taken next back in the DMHUs to apply this new knowledge and train others in the Sababu Model.

Training-of-Trainers Workshop

20 minutes - Ascertain how each of the individuals feels about the intervention. Discussion about any points of confusion as to how it works, how it fits into their own existing practice/will fit into the existing practice of a team in the DMHU.

10 minutes - Individually, write down or think about what you understand the Sababu Intervention to be about. Remember to include as many aspects of the intervention model as possible. Don't look at the workbook; this should be the first reflection that comes to mind (10 mins)

10 minutes - In pairs, find a quiet space and one at a time tell the other person what the Sababu Intervention is all about. Use the notes you made earlier to help you. Try to describe it in as much detail as you can. Try not to refer to the workbook – do as much as you can from memory. When you have both had a chance to do this, look at the workbook and discuss which areas of the model you were unclear about or could not think about what to say. Talk about what aspects of the workbook you would like to see in a training session.

20 minutes - Design a training session/day for other staff / new staff. Do this as a whole group workshop, but supported by trainers.

1. How and when will the training programme occur?
2. After the initial presentation and feedback on the model, what would be useful to cover?
1. Discussion topics?
2. Any activities that you completed during this training that could be useful?
3. What are the likely gaps in knowledge and how can you help to cover them?
4. What resources will you need?

By the end of this process individuals should be really clear on how they are going to train people, when they are going to do it, and what materials they will need.
15 minutes – action points. Each member of the group should have one action point that they will carry out in a set amount of time.

Refresher Training Activity

Aims: To share cases with peers that reflect "success stories" and barriers to practicing Sababu. Group feedback. Create action plans.
Materials: Sababu Workbook, flip chart paper, notecards

Case studies: "success stories"

Get into groups of three. Person number **ONE** starts by sharing a case with person number **TWO**, s/he is to listen and ask questions; person number **THREE** is to listen and observe (a silent role!).

Person number **ONE**: The case should be a person whom you worked with recently (past 3 months, since April) in which you used some aspect of the Sababu model. For example, maybe you discussed their assets and support networks with the individual, you involved their family or community members in their recovery, or you linked the service user with a group or organisation to support their recovery.

Person number **TWO**: Ask your peer questions about the case to better understand how s/he worked with the service user. Try to get as much information as possible about the case, what the main issues were, how your peer helped this person and what the next steps might be in treatment.

Person number **THREE**: Observe and listen, your role is to remain silent but to assess the interaction between your peers and reflect upon how this case fits in the Sababu Intervention Model. *Write down on the notecard:* 1 way in which the case maps onto the Sababu model, 1 thing your peer did well in treatment, and 1 suggestion for improvement in dealing with this case.

For each case, take five minutes for person **ONE** and **TWO** to discuss the case, five minutes for person **THREE** to feedback. Switch so that each person in the group has a turn sharing a case. Feedback to the wider group.

Individually write down three action points from our discussion that you have for yourself. How can you improve your practice? What might you do differently in the future?

1)_____

_____

2)_____

_____

3)_____

_____

XII. Module Twelve— Final session, wrapping-up

Evaluating the Training

The training programme will initially be evaluated by asking participants for feedback with suggestions to further improve future training programmes.

We will have a Question and Comments box in the room. At the end of each training day we will ask participants to place written comments and questions in the Questions and Comments box. We will use the comments that have been received during the final evaluation.

The implementation of training into practice will be evaluated over a six month period, the conceptual framework of which was adapted from Kirkpatrick's (1996) four-level evaluation model: reaction, learning, behaviour, results. This will include repeated quantitative measures linked to each of the training modules, qualitative semi-structured interviews, a fidelity checklist, and researcher observations.

Level 1: Reaction = participants' satisfaction, trainees' reactions, perceived relevance to work
Level 2: Learning = participants' knowledge acquisition, improved skills or changes in attitude
Level 3: Behaviour = changes in participants' on-the-job behaviour
Level 4: Results = overall results in terms of production and performance

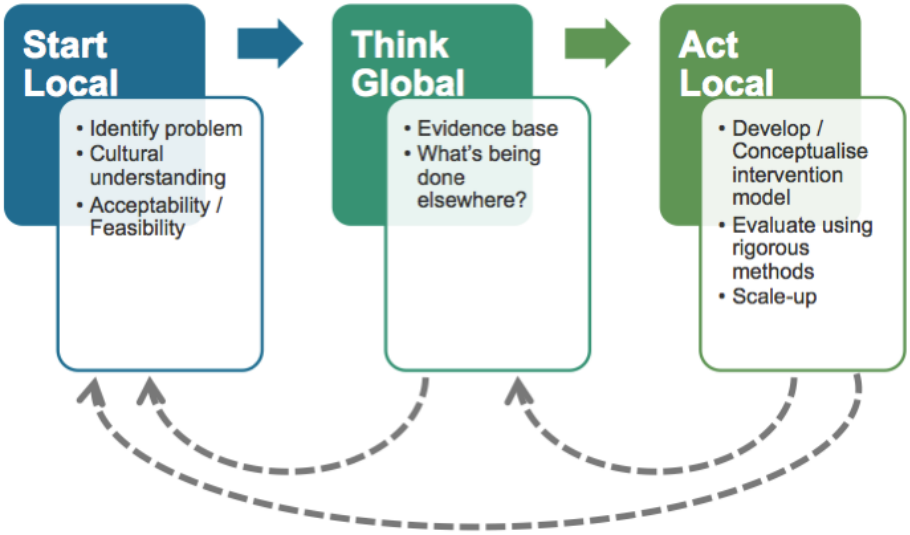
What have we learned?

Ask the participants to think of something they have learnt across the course of the training that they are willing to share with the larger group i.e., what new knowledge or understanding do they have now that they did not have at the beginning of the training? Allow 3 minutes for this reflection, and then ask each of

them to share their particular learning with the rest of the group, one by one. Challenge them to not repeat from what others have said!

Supervision and Refresher Courses

Capacity building is not sustainable unless training is followed up with an integrated and consistent supervision system as part of the longer-term strategy for mental health systems development. EAMH are responsible for nurse supervision and will lead on the follow-up from this training. MN will also be in touch with the nurses on a regular basis and visit again in six months to conduct follow-up assessments and observations. If nurses are able to implement the learning from this training into practice and it is found to benefit the service users and communities with whom they work, there is scope to scale-up this training with CHOs, social workers, and other healthcare professionals involved in the EVD response.



THANK YOU!

The course will end with a small presentation ceremony that acknowledges participants' efforts by thanking and presenting them with Certificates of Attendance.

Additional Resources

Sababu Training materials are published online, open access:
http://www.york.ac.uk/spsw/research/icmhsr

Please use the following citation: Fendt-Newlin, M. & Webber, M. (2015). *Sababu Training Manual: Mental Health Capacity Building in Sierra Leone*. International Centre for Mental Health Social Research (ICMHSR), University of York: United Kingdom.

Connecting People Study training materials, available online: http://connectingpeoplestudy.net/training/

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Psychological First Aid (PFA) during Ebola virus disease outbreaks, Geneva: World Health Organization; 2014. Available from: http://apps.who.int/iris/bitstream/10665/131682/1/9789241548847_eng.pdf

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