Psychosocial Centre
International Federation
of Red Cross and Red Crescent Societies

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN EMERGENCIES

DELEGATE HANDBOOK

THE PSYCHOSOCIAL SUPPORT COMPONENT OF THE HEALTH EMERGENCY RESPONSE UNIT

August 2019

ERU
Emergency Response Unit

PSYCHOSOCIAL SUPPORT IN EMERGENCIES DELEGATE MANUAL
MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN EMERGENCIES
THE PSYCHOSOCIAL SUPPORT COMPONENT OF THE HEALTH EMERGENCY RESPONSE UNIT

A warm thanks to all organizations who have kindly allowed us to include their material in this handbook.

Content

Foreword

Among humanitarian actors it is recognized that armed conflicts and natural disasters cause significant psychological and social suffering to affected populations. Emergencies erode protective supports that are normally available, increase the risks of diverse problems and tend to amplify pre-existing problems.

The psychological and social impacts of emergencies may be acute in the short term and can undermine the long-term mental health and psychosocial well-being of the affected population, threaten peace, human rights and development. Previous emergencies have shown high numbers of patients presenting multiple somatic complaints; this group of patients places a heavy burden on the available health care delivery system.

The International Federation addressed this issue through the establishment of an optional and additional component to health emergency response units. This was developed in 2008 by the International Federation's Reference Centre for Psychosocial Support with the support of Norwegian Red Cross and for the first time used in the ERU responses in Haiti after the 2010 earthquakes. Lessons learned from deployments since then, have clearly proved the added value and importance of integrating psychosocial support into emergency response.

Emergencies create a wide range of challenges experienced at individual, family, community and societal levels. Emergencies tend to weaken formal and informal protective systems and increase the risks of new and pre-existing problems such as different types of violence.

ERU Psychosocial delegates work in chaotic circumstances, the National Society will often be overwhelmed, coordination and information sharing may be challenging, where there are many incoming actors. There will be many unforeseen situations where the psychosocial delegate will have to improvise to find the best solutions to challenges and problems.

This manual covers the initial phases of an emergency response. The manual provides psychosocial delegates with guidance on how to carry out psychosocial interventions both in Health Emergency Response Units, outreach functions or as a delegate in a broader emergency response.

Nana Wiedemann
Director, IFRC Reference Centre for Psychosocial Support

Abbreviations and acronyms

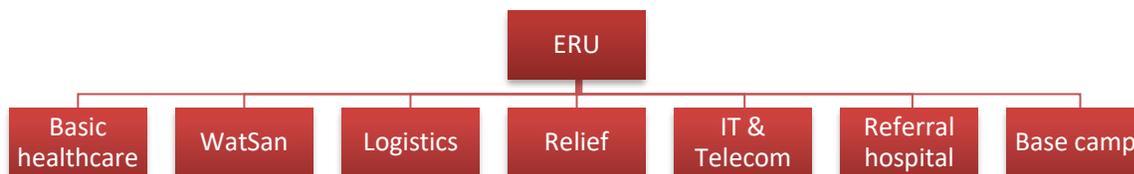|	
CEA	Community Engagement and Accountability
CP	Child Protection
DAPS	Dignity, Access, Participation and Safety, the key areas in the Minimum Standards for Gender and Diversity in Emergencies
ERU	Emergency Response Unit
FACT	First Assessment and Coordination Team
GBV	Gender-based Violence
IASC	Inter-agency Standing Committee
ICRC	International Committee of the Red Cross
IDP	Internally Displaced Person
IFRC	International Federation of Red Cross and Red Crescent Societies
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex persons
MCH	Mother and Child Health
MHPSS	Mental Health and Psychosocial Support
M&E	Monitoring and Evaluation
NS	National Society
OPD	Outpatient Department
PFA	Psychological First Aid
PHC	Primary Health Care
PHE	Public Health in Emergencies
PGI	Protection, Gender and Inclusion
PS delegate	Psychosocial Support Delegate
PSS	Psychosocial Support
PSSiE	Psychosocial Support in Emergencies
RDRT	Regional Disaster Response Team
RFL	Restoring Family Links
SGBV	Sexual and Gender-based Violence
VP	Violence Prevention
UaSM	Unaccompanied and Separated Child

IFRC ERU response system

Emergency Response Units (ERUs) are part of the IFRC global Disaster Response system deployed when assistance is needed to support a National Society in their emergency responses. An ERU is a vital part of the IFRC disaster response tools and consist of standardized and pre-packed sets of equipment with trained technical specialists, that are ready to be deployed at a short notice. ERUs are designed to be self-sufficient for one month and can operate for up to four months.

ERUs give immediate support to National Societies in disaster-affected countries and provide specific support or direct services when local facilities are overwhelmed, destroyed or do not exist. The need for assistance may continue beyond an ERU's four-month operational period, and if so, the service can be managed by an ongoing operation led by IFRC, the host National Society, local government or other organizations.

The Field Assessment Coordination Teams (FACT) will usually be the first IFRC response unit to arrive in country and they will advise on which types of ERUs are needed. Thus, the ERU system collaborates with FACT teams in the early stage of an emergency response.

The ERU system covers the following sectors:

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                                    ERU
   ┌─────────┬─────────┬──────────┬──────────┬──────────┬──────────┐
 Basic      WatSan   Logistics   Relief     IT &      Referral   Base camp
healthcare                                  Telecom   hospital
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Basic Health Care units, Referral Hospitals and Rapid Deployment Hospitals support disaster health needs. Besides focusing on medical care in acute emergency settings, sometimes replacing damaged or destroyed local facilities, health ERUs also address public and community health concerns. An added priority in emergencies is to protect and improve people's mental health and psychosocial well-being.

The term component covers all the psychosocial support activities, training of volunteers, community outreach, awareness-raising etc. led by the PS delegate in collaboration with a team of National Society as well as community volunteers. The overall aim is to improve psychosocial well-being, to protect and prevent further harm. The purpose in the ERU settings are to enable a positive, safe, social and physical environment where people of all ages and genders find opportunities for stimulation, skill building and restauration of well-being, through provision of relevant and culturally appropriate activities that respect dignity and local cultures. Integrating psychosocial support in the work of the ERU will enable vulnerable groups in affected communities to be reached, including those who suffer from mild to severe psychological distress, have experienced abuse, violence or are suffering from social distress. Some previous ERU deployments have shown high numbers of patients presenting multiple symptoms some of

which are psychosomatic and this group of patients places a heavy burden on the available health care system. The PSS component can often support caring for this type of patients.

The psychosocial component has a dual function, serving the Health ERU as well as the community and thus it has the potential to become a hub for engaging, informing and interacting with the surrounding community with the aim to support community cohesion. It is important to signal this dual function so that as many people as possible can access psychosocial support.

Psychosocial support is defined as any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent mental disorder. Within the International Federation, psychosocial support is seen a process of facilitating resilience within individuals, families and communities. This is done by implementing relevant and culturally appropriate activities that respect the independence, dignity and coping mechanisms of individuals and communities and enhance protection. In this way, psychosocial support promotes the restoration of social cohesion and infrastructure within communities that have lived through disasters or crisis situations.

A Health ERU may be established in an open or an enclosed area. Some Health ERUs are placed in the midst of a community or camp site where the PS team can support both patients coming to the health facility as the community itself. A Referral Hospital will sometimes be established in an enclosed area where only patients have access as in the case of an outbreak of epidemic diseases. In such cases the PS teams will cater for patients in the hospital itself, for relatives who may be in another enclosed area outside of the perimeter as well as for the community.

A timeline for the implementation of the ERU psychosocial support component is shown on page 25.

The host National Society
The host National Society at headquarter and branch level are involved in FACT and ERU mission as in the first place, the National Society will have requested assistance through IFRC to support from IFRC as well as other National Societies. Once arrived on the first rotation, the PS delegate will get in touch with the National Society as advised by the ERU team leader. The aims are to liaise with the counterpart in the National Society, if needed explain the purpose of the ERU psychosocial support component, how to collaborate, to get an overview of PSS services provided in National Society, to discuss which coordination and cluster meetings to attend and the allocation of volunteers to carry out the activities.

Psychosocial impact of emergencies

Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies weaken the protective support that is normally available to people and increase the risk of new problems arising as well as worsen pre-existing problems.

When protective systems weaken, violence will increase. While there are many variables that increase the risk of violence during an emergency, common underlying risk factors include:
- the collapse of protective systems;
- crowded and insecure environments;
- a stress-filled context;
- separation of family members;
- gender and age-based inequalities and discrimination;

- changing gender roles in households and at community level;
- social isolation and exclusion;
- harmful use of alcohol and other substances;
- income inequality;
- pre-existing vulnerabilities such as domestic violence, child abuse; and
- misuse of power.

Pre-existing problems and problems caused by the emergency and the humanitarian response are closely connected. The table below shows the kind of problems that affected populations may experience:[1]

	Social problems	Psychological problems
Pre-existing	Belonging to a group that is discriminated against or marginalised; political oppression; domestic violence	Severe mental disorder; depression, alcohol abuse, anxiety disorders
Caused by emergency	Family separation; disruption of social networks; destruction of livelihoods, community structures, resources and trust; violence	Grief, non-pathological distress; alcohol abuse; depression and anxiety disorders, including post-traumatic stress disorder (PTSD)
Caused by humanitarian response	Undermining of community structures or traditional support mechanisms; exclusion due to lack of access to services; misuse of power	Anxiety due to a lack of information about food distribution; aid dependency; helplessness

Functions of the psychosocial support component

The psychosocial components will usually have functions and activities, that the PS team will be responsible for:

- Provision of information, assistance or practical help to patients, their relatives, and community members
- Emotional and social support to individuals and groups
- Relevant activities with the aim of supporting the psychosocial well-being of individuals and groups
- Capacity building of staff and volunteers

Provision of information, assistance and practical assistance
The PS teams will provide information, practical and assistance help to those seeking assistance directly from the PS teams, and to those that are the health ERU. This assistance includes information about the emergency for instance through reading newspapers, or seeking information about possible reactions to crisis, asking about what other services are available and where, requesting practical help on issues of how to report protection concerns, help to contact family members and assistance to report missing

family members or read to get information. The support will also sometimes include emotional and social support as when someone needing information, assistance or practical help is in distress as described below.

Emotional and social support to individuals and groups

The emotional and social support can take many forms: individual and group psychoeducation, all kinds of activities run in a Safe Spaces for Children (e.g. often termed "Child friendly spaces") and Other Safe and Friendly Space, recreational and sports activities, community outreach as home visits just to name a few.

It is essential that Safe Spaces for Children are implemented following standards and do not pose harm to children. Children, parents and community leaders should be involved in the planning, implementation and monitoring of safe spaces. World Vision and IFRC PS Centre has published a tool-kit for Safe Space for Children that guides the establishing and running of the Safe Space with the *Minimum Standards for Child Protection in Humanitarian Action.*

Resources for Safe Spaces for Children

Operational Guidance for Child Friendly Spaces in Humanitarian Settings, Activity Catalogue for Child Friendly Spaces in Humanitarian Settings, Training for Implementers of Child Friendly Spaces in Humanitarian Settings by World Vision and IFRC PS Centre 2018) and Psychological First Aid for Children. Available on pscentre.org
Child Friendly Spaces in Humanitarian Settings available at
https://www.spherestandards.org/resources/minimum-standards-for-child-protection-in-humanitarian-action-cpms/

The Safe and Friendly Spaces are run offering e.g. psychological first aid, and information about local resources by volunteers who have been trained to provide this type of support. Information, Education and Communication (IEC)materials can be used in the ERUs for this type of support and a set of IEC leaflets and information sheets is also available from the IFRC PS Centre website for easy translation and adaptation.

A Safe Space for Children can be open at different times for different groups. It creates a sense of normality and provides a protective environment to play, learn and socialize. Activities with a psychosocial element will provide skills and tools to lessen the impact of the crisis. For children, play and recreational activities may have several functions as they offer direct support and care, while they wait for examination or treatment of themselves and/or parents or caregivers. Eventually these activities may transition into formal schooling, after-school recreational activities for school-age children, out-of-school activities for adolescents, and club activities or community social activities for people belonging to other age groups.

Activities for children, adolescents, pregnant and breastfeeding women, adults and elderly are facilitated in a space that is regarded as safe by users as e.g. children, as well as their parents or caregivers. Activities are organized regularly and include information sharing, games, drama, art activities, non-formal educational activities, psychoeducative sessions, newspaper reading, poetry, choir and musical sessions, and sports facilitated by volunteers. Different types of activities will appeal to different target groups. Therefore, it is recommended to offer structured, less structured, physical, quiet, indoor and outdoor activities.

Community outreach

The ERU psychosocial support component is potentially a hub for reaching out to the surrounding communities by organizing support groups and other outreach activities. Community outreach is usually carried out in collaboration with local resource organizations, such as local health authorities, the operating National Society, NGOs etc., CEA delegates and others identified during the initial assessment and mapping procedures.

Capacity building
Training, mentoring and supervision are important activities that build the capacity of the staff and volunteers with the aim for the National Society to take over and carry on activities when the ERU is handed over. An initial task is to recruit volunteers and train them in psychosocial support, basic protection and child protection, supportive listening and psychological first aid. Initial training is followed by continued supervision and refresher and/or training of newly recruited volunteers. When recruiting, it is key to ensure a gender and age balance in the group of volunteers. In some contexts it may be challenging to ensure gender balance, and a suggestion is to recruit sister and brother and husband and wife teams.

The PS delegate will also organize orientation sessions for ERU colleagues and other humanitarian staff working in the area as well as conduct awareness-raising sessions aimed at the general population or specific groups. The outline for a one-day training for new volunteers and an orientation session for ERU colleagues are to be found in the annexes.

Psychological first aid

Psychological first aid is a direct response and set of actions to help someone who is in distress. It is an approach of helping that is particularly well-suited for the Red Cross Red Crescent as it is also based on the fundamental principle of humanity and the intention to help prevent and alleviate human suffering. Psychological First Aid is recommended as the intervention of choice for the immediate psychosocial care for anyone affected by a crisis event.

Psychological first aid is a psychosocial support activity as it refers to actions that address both the emotional and social needs of individuals, with the aim to help people use their resources and to enhance resilience. Psychological first aid can be a stand-alone intervention in a crisis situation, or a component in a psychosocial support programme that includes other activities.

What is PFA?
Psychological first aid is a method of helping people in distress so they feel calm and supported to cope better with their challenges. It is a humane way of assisting someone to manage their situation and make informed decisions. The basis of psychological first aid is caring about the person in distress. It involves paying attention to the person's reactions, active listening and, if needed, practical assistance, such as problem solving or help to access basic needs.

All PS delegates will be expected to be able to plan, conduct and supervise training sessions in Psychological First Aid during their mission. The IFRC PS Centre has developed thee handbook *A Guide to Psychological First Aid for Red Cross and Red Crescent Societies* and several training modules that can be used to guide such trainings:

Introduction to PFA
A short four to five-hour training that introduces participants to basic psychological first aid skills. This training is suitable for all Red Cross Red Crescent staff and volunteers working in any sector.

Basic training in Psychological First Aid
The training introduces basic psychological first aid skills and presents a range of situations faced by adults, their reactions to crises and how helpers may respond appropriately.

Psychological First Aid for children
Focuses on children's reactions to stress and communicating with children and their parents or caregivers in situations of distress.

Psychological First Aid for groups – Support to teams
PFA for groups is a preventative and responsive form of support as it can be used to provide psycho-education and raise awareness of signs of distress, and as a method of assessing if anyone needs individual referral or other support.

Basic training on PFA skills

Training of psychosocial delegates and the PPSiE Competency Framework

PSS ERU delegates and PSSiE can be trained in National Societies, regional or international ERU or Psychosocial Support in International Emergencies (PSSiE) trainings. The IFRC PS Centre has developed a five-day PSSiE training for international deployments that are offered by the IFRC PS Centre and are announced on the PS Centre website at pscentre.org. The IFRC PS Centre can also recommend a PSSiE trainer, should National Societies of Regional offices wish to arrange an ERU or PSSiE training.

A PSSiE Competency Framework is developed in line with the ERU Health Competency Framework. It is approved by the ERU partners that deploy ERU PSS delegates. The PSSiE Competency Framework is to be found in the annexes.

All ERU PSS delegates on the National Society rosters are expected to keep updated and informed about developments in psychosocial support, be updated on best practices and new training materials from the IFRC and other relevant actors.

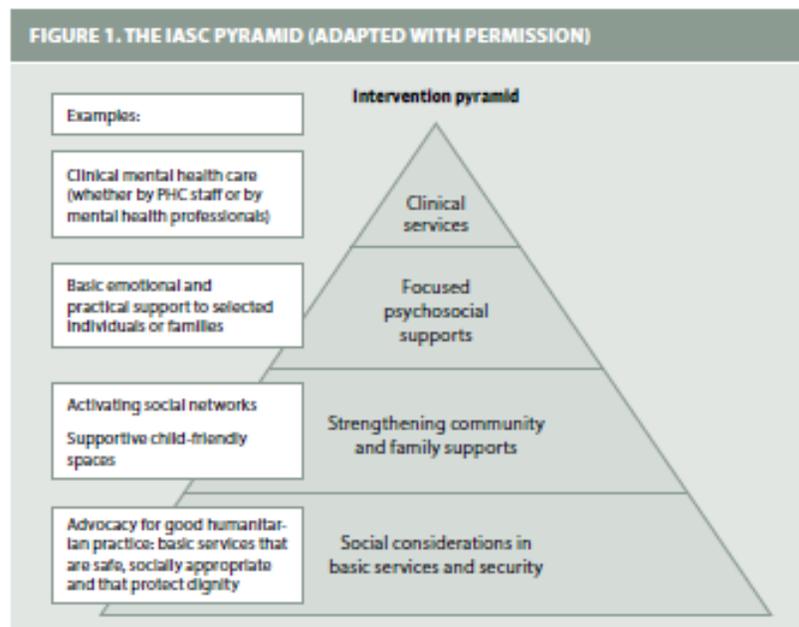## Community-based psychosocial support in an ERU

Multi-layered supports
In emergencies, people are affected in different ways and require different kinds of supports. A key to organizing mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups. Many people show resilience – the ability to cope relatively well in situations of adversity. Affected groups have resources that support mental health and psychosocial well-being and it is common mistake to ignore these resources and to focus on deficits as the weaknesses, suffering and pathology of the affected. Psychosocial support in the ERU is based on the principle that most acute stress problems during emergencies are best managed without medication, using the basic elements of psychological first aid. This involves non-intrusive emotional support, coverage

of basic needs, protection from further harm, and organization of social support and networks. Training materials on PFA for adults, children and also for groups of e.g. volunteers are available at pscentre.org

An enabling social, emotional, and physical environment will help increase the resilience and reduce the vulnerability in the affected population. It is important to identify the resource persons as formal and informal leaders including women group leaders, religious leaders, teachers, youth club leaders and support them in re-establishing social networks. Restoring social structures and providing stability allows people to cope with the effects of a disaster, and return to economic activities, family life, and supportive roles for each other.

The layered or tiered approach can be illustrated by a pyramid. All tiers of the pyramid are important and should ideally be implemented at the same time. The below pyramid is adapted in 2013 by UNHCR in *Operational Guidance Mental Health & Psychosocial Support Programming for Refugee Operations.*

FIGURE 1. THE IASC PYRAMID (ADAPTED WITH PERMISSION)

Intervention pyramid

Examples:

Clinical mental health care (whether by PHC staff or by mental health professionals) — Clinical services

Basic emotional and practical support to selected individuals or families — Focused psychosocial supports

Activating social networks / Supportive child-friendly spaces — Strengthening community and family supports

Advocacy for good humanitarian practice: basic services that are safe, socially appropriate and that protect dignity — Social considerations in basic services and security

The activities taking place in the ERU or a PSSiE operation will often relate to the three lower tiers of the pyramid as care for people requiring specialized services is usually pursued through interaction with local health authorities, local organizations or other resource groups involved in caring for people with severe mental disorders. However, these groups may still benefit from taking part in activities organized primarily for groups on a lower tier of the pyramid as those suffering from severe mental or disaster-induced distress can also gain from and should be included in community-based protection and psychosocial activities.

1. **Provision of basic services and security**
The well-being of all people should be protected through the (re) establishment of security, adequate governance and services that address basic physical needs (food, shelter, water and sanitation, basic

health care, control of communicable diseases) and do not negatively impact mental health and psychosocial well-being. Provision of basic services should be established in participatory, safe and socially appropriate ways that protect local people's dignity, strengthen local social supports and mobilize community networks. According to UNHRC, it may require advocacy from MHPSS professionals to ensure that these services are inclusive and safe for people with specific vulnerabilities. This could be people with mental disorders, survivors of SGBV and at the same time it should avoid targeting a single group as this can lead to discrimination, stigma and further distress. Furthermore, MHPSS professionals can advocate for all service delivery to survivors of SGBV to be survivor-centred.

2. **Strengthening community and family supports**
Supporting existing and helping (re)establish key community and family support systems will assist in maintaining mental health and psychosocial well-being. In most emergencies, there are significant disruptions of family and community networks due to loss, displacement, family separation, community fears and distrust. Useful responses in this layer include family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women's groups and youth clubs. It can be important to help survivors of different forms of violence to access key community and family supports. Community awareness raising and education to help inform and reduce stigma attached to vulnerable groups.

3. **Focused psychosocial supports**
A smaller number of people will require an additional more focused individual, family or group interventions and basic mental health care by primary health care workers. Providers will often be trained and supervised workers who can offer culturally appropriate counselling services
For example, survivors of sexual and gender-based violence might need a mixture of emotional and livelihood support from community workers delivering appropriate, accessible and high-quality services and assistance to support coping and recovery and other social or economic reintegration interventions
Case management for individualized service delivery and assistance
This layer also includes psychological first aid for individuals and groups and tailored livelihood.

4. **Clinical services**
A relatively small number will require additional support as they have severe symptoms and difficulties in basic daily functioning and their needs exceed the capacities of existing general health services. This assistance should include psychological or psychiatric supports for people with severe mental conditions whether per-existing or emergency-induced. People suffering from psychosis, drug abuse, severe depression, disabling anxiety symptoms would need clinical services and care.

Vulnerable groups

To protect and support vulnerable groups it can be useful to look at which groups are more at risk than other groups:

Refugees, internally displaced persons (IDPs) and migrants in irregular situations	Unaccompanied and separated childrenASC), children living in the streets, children previously associated with armed forces or groups, trafficked men, women, boys and girls and those without identification papers and those in detention
People who have been exposed to extremely stressful events/trauma	People who have lost close family members or their entire livelihoods; survivors of sexual-and gender-based violence and torture survivors; witnesses of atrocities, etc.
People with disabilities or health conditions	People in the community with pre-existing, severe physical, neurological or mental disabilities, disorders or health conditions
People in institutions	Orphans; elderly people; people with neurological/mental disabilities or disorders
People experiencing severe social stigma	Non-gender conform persons; commercial sex workers; people with health status as HIV positive, those with severe mental disorders; survivors of sexual and gender-based violence, or indigenous populations
People at specific risk of human rights violations	Political activists; ethnic or linguistic minorities; people in institutions or detention; people already exposed to human rights violations; indigenous populations, and those who have been trafficked

A person with a disability may need adaptations such as alternative methods of communication or transportation. There may be great stress placed on family or other caregivers at the time of the disaster to protect the individual with a disability. In addition to persons with actual disabilities, caretakers are also vulnerable to the stress of the disaster.

For people with cognitive or intellectual disabilities remember to:
• Clearly introduce the team and explain why the team is there;
• Speak directly to the person;
• Speak slowly and clearly, using simple, direct language;
• Give extra time for the person to process what they are saying and to respond;
• Clarify the individual's emotions as well as the emotions of those around them to reduce anxiety or agitation, since the person may not understand social cues and may misinterpret others' actions or communications.

Outreach walk Improving protection and psychosocial support through outreach is a training manual on how to identify those needing support and how to do a psychosocial triage. pscentre.org

Principles for early mental health and psychosocial support interventions

Any early intervention approach should be based on an accurate and current assessment of needs prior to intervention. When conducting the assessment, follow the general principles for assessments and refer to IFRC PS Centre Monitoring and Evaluation Toolbox[1].

The interventions themselves should be culturally sensitive, related to a local formulation of problems and ways of coping. Early psychosocial support interventions focus on promoting stress-resistance and resilience and this represent a shift from an earlier focus on talking and emotional processing of events. The kinds of mental health and psychosocial interventions that focus on promotion of stress reduction and resilience building, are providing practical and social support and Psychological First Aid is one example of this approach. According to WHO, the development of mental disorders after a crisis event is rare, but stress reactions amongst survivors and relatives will be common. Early negative psychological reactions can be understood as signs of distress, fear, and helplessness without being signs that people need individual counselling or clinical treatment as most are most likely to need support and provision of resources to resume a balance in their lives. ERU staff and volunteers should therefore never ask intrusive questions or force individuals to talk about their experiences shortly after they have been exposed to severe stressors, as this may cause further distress. The added stress may disturb the natural healing process of body and mind at a point in time where it is essential to restore balance and calm down. Interventions in the acute phase of disasters that are not evidence-based may be harmful.

The researcher Stevan Hobfoll[2] and others identified five key principles to guide the kind of support which should be provided in the immediate and mid-term phases of potentially traumatic events affecting many people. Based on these principles, the ERU psychosocial interventions will be community-based aimed at reducing stress and strengthening social support for affected children and adults linked to restoring dignity and human rights[3].

The five guiding principles have been identified as promoting resilience following exposure to extreme stress in the immediate aftermath to several months after the event:

They are promoting a sense of:
1. Safety
2. Calming
3. Self- and community efficacy
4. Connectedness
5. Hope

When planning psychosocial interventions, it is helpful to keep these principles in mind and also to note, that these principles are inter-related.

Promoting a sense of safety
Crises changes what is physically safe and unsafe and what is perceived as safe and unsafe. It is essential that psychosocial interventions take place in spaces that are considered secure having safe access. Being able to access safe spaces as a Safe Space for Children and other Safe and Friendly Space, will support the release of high tension following crisis events. The spaces need to be objectively safe and located in a secure physical space that allows people to be protected from danger, and in an environment, that is perceived as safe for a sense of safety, trust, positive bonds and solidarity can develop. Promoting a sense

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[1] IFRC PS Centre – see pscentre.org
[2] Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence. Stevan Hobfoll and alii. Available at pscentre.org
[3] UN Convention of the Right of the Child.

of safety is essential to reduce psycho-physical reactions such as sleep difficulties, difficulties in concentrating and reduced mood levels, and to help individuals and communities to better cope with adversity. When safe, the affected can process information and use skills to evaluate and understand current and future threats in a positive and realistic manner. Supporting the development of coping skills and realistic ways of thinking can help enhance a sense of safety.

In the ERU this entails to:

- Set up the psychosocial component at an appropriate and safe site with secure access
- Inform about the crisis event and available assistance
- Conduct interventions following a regular routine to create a sense of normality
- Teach coping skills including bodily coping skills as grounding techniques
- Support restoration of family links
- Encourage individuals to limit intake of news media that cause distress
- Educate media to also cover safety and resilience rather than imminent threat

Promoting a sense of calming
Most will react with strong emotions to a crisis event and the level of arousal in the autonomous nervous system will be raised. Some may furthermore be anxious because of their own reactions and thus become even more distressed by fear of not understanding what is going on inside them. Awareness-raising about the normality of such reactions in the aftermath of an abnormal event is an important first step in assisting people to cope with their present situation. Helping the affected realize and acknowledge that certain stress reactions are common when exposed to extreme situations is a key intervention principle to promote calming. Listening is an important as when verbalizing reactions and emotions, it will be easier to understand the reactions and get a grip on the situation. Other activities that are useful to promote calming, include Psychological First Aid, meditation and relaxation, deep breathing, problem solving, positive self-talk, and physical activities.

In the ERU this entails to:

- Offer psychological first aid to those in distress
- Offer psychoeducation on crisis events and their impact
- Involve the affected in activities that help solving immediate practical needs and concerns
- Arrange stress-reducing interventions as meditation, relaxation, deep breathing, sports, games and expressive activities
- Provide information about possible reactions, self-help, and further support
- Provide opportunities for children and adults to engage in everyday physical activities, clean up, reconstruction, kitchen gardening etc.
- Liaise with local health authorities and others regarding psychosocial resources and support available/needed
- Inform ERU team members about psychosocial issues, stress reactions and coping

Promote a sense of self-efficacy and collective efficacy
Self-and collective efficacy is the belief of individuals and groups in their ability to act in a way that can help handle and improve the situation. Individual and group activities can assist the affected use their skills, regain some control, learn new skills and abilities. All this improves the self-esteem and by engaging

participants in activities, a step by step approach can lead to efficacy. When learning skills such as psychological first aid or positive parenting techniques, participants gain tools they can transfer into everyday life. Group discussions and reflections as a part of activities will stimulate the understanding of the new and changed life conditions participants live in, and this will also promote efficacy.

In the ERU this entails to:

- Plan activities for all to have a sense of success or accomplishment
- Include time for reflection and discussion in activities
- Create options for individual and team problem-solving
- Consult the community to enable it to take control of own lives
- Promote the individual and community as experts and focus on activities implemented by the community itself
- Identify and make resources available for a restoration of normality and dignity, e.g. school activities
- Involve people of all ages and genders in appropriate community activities
- Seek out those who do not participate in activities to find ways to engage them
- Collaborate with and awareness-raise on psychological reactions and resilience in other areas of disaster response

Promoting a sense of connectedness

After a crisis event, it is essential to promote social connection to rebuild the social systems as support networks may have collapsed as a consequence of a disaster or a protracted crisis and this is at the core of all psychosocial interventions. A common consequence of crisis events is that social connections are broken or weakened as many may be physically separated and others may not understand their own changed behaviours. All types of activities that bring people together, build and enhance bonds and reinforce support mechanisms. Interventions using sports, physical activities, theatre, ceremonies or other faith sensitive activities can be a platform for community cohesion. The community can engage in discussions of reconstruction and can have regular events to look forward to. Strongly interconnected communities are necessary for people to help and care for one another. Promoting connectedness is a priority in the PS in the ERU.

- Establish safe areas where people of all ages can play, interact, and engage in recreational activities
- Create activities for mixed groups of participants to enforce bonds between participants
- Create an appreciative environment that promotes positive interactions
- Assist patients and survivors connect with their loved ones
- Support community activities of all kinds, social groups, faith related or sports activities
- Identify and mobilize resources for Restoration of Family Links
- Promote support through community volunteers

Promoting a sense of hope

Hope are the positive feelings and beliefs that the situation can be adapted to and may work out well despite the adversity. It can also be understood as a positive and action-oriented expectation for the future. Being together with others, feeling cared for and loved, and experiencing good feelings facilitate hope. At a more concrete level hope can be encouraged by helping the affected individuals realize that they are not alone in their reactions and help them to feel less lonely, even while facing big problems and

adversities. Creating a trustful atmosphere in the group helps participants to feel that they belong and are included and will contribute to a hopeful state of mind. In addition, communicating that most people will gradually feel better is supportive as it helps participants to believe in a future where they once again will feel good.

- Involve and encourage the affected population to be active
- Highlight advances, positive moments and interactions
- Make long term plans known, and develop activities to suit needs as these develop over time and thus continue being stimulating and engaging
- Encourage making meaning of the new situation
- Advocating for and communicating appropriate interventions, including the power of human resilience and people´s right to have their dignity restored

Protection

The Inter-Agency Standing Committee's definition of protection is the most commonly accepted by humanitarian actors (including the Movement): "all activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and the spirit of the relevant bodies of law
(i.e. human rights law, international humanitarian law and refugee law)".

Protection and human rights approaches and activities are embedded in psychosocial support as defined by the IASC in their Guidelines on Mental Health and Psychosocial Support in Emergency Settings, which states : "Many of the defining features of emergencies – displacement, breakdown in family and social structures, lack of humanitarian access, erosion of traditional value systems, a culture of violence, weak governance absence of accountability and a lack of access to health services – entail violations of human rights." It is essential to deliver humanitarian aid and services in a dignified way that supports vulnerable people, restores their dignity and helps rebuild local networks. It is often seen that the most effective protection occurs when local people organize themselves to address threats, thereby creating a sense of empowerment and the possibility of sustainable protection mechanisms.

In emergencies, there is an intimate relation between the promotion of mental health and psychosocial well-being and the protection and promotion of human rights. Human rights violations and threats to the safety of individuals and communities have negative consequences on psychosocial well-being. Survivors often report that their greatest stress arises from threats, such as attack and persecution, forced displacement, violence, separation from or abduction of family members, exploitation and ill treatment. These kinds of protection issues cause immediate suffering and may interfere with the rebuilding of social networks and a sense of community, both of which support psychosocial well-being.

In ERU and outreach settings, protection issues can be addressed on several levels at the same time: There may be an immediate need to protect and care for individuals or groups whose safety has been compromised, while at the same time addressing protection issues at a higher level, e.g. by interacting with relevant authorities and advocating for the improvement of current conditions.

Emergency operations may have Protection, Gender and Inclusion (PGI) delegate/s that the PS delegate will collaborate with and consult on matters of protection, gender and inclusion for assessments, gender

and diversity analysis, protection service mapping and referrals. IFRC has a comprehensive set of standards on *Minimum standards for protection, gender and diversity in emergencies* that guide all sectors to ensure dignity, access, protection and security.

Psychosocial action in emergencies can potentially cause harm because it deals with sensitive issues that are culturally specific. Humanitarian workers ideally should respect and adapt interventions to the culture, belief systems, established habits, attitudes, behaviour, and religion in the place where they work. They should possess the skills to communicate and work closely together with community leaders and representatives, as well as the skills to transfer knowledge and skills to community members or voluntary workers that are delivering many of the actual interventions.

The principle of 'do no harm' originated in medicine. It reminds healthcare providers that they must consider the possible harm that any intervention might do to a patient. In humanitarian aid, it most generally refers to avoiding the unintentional harm that may be caused to those who are supposed to benefit from an emergency intervention, as well as unintentional harmful consequences of aid on other nearby communities affected by the emergency intervention[4]. In the IFRC the "Better Programming Initiative" focuses on, a particular aspect of "do no harm" – ensuring a conflict-sensitive approach which does not exacerbate existing tensions between groups affected by conflict or disaster.

Humanitarian workers are crucial in their role of advocating for the rights and needs of the most vulnerable. It is the responsibility of humanitarian aid providers to identify and flag up harmful practices that may be acceptable in the local context.

Examples of reducing the risk of harm[5]:
- Participate in coordination groups to learn from others and to minimise duplication and gaps in response
- Design interventions on the basis of sufficient information
- Commit to evaluation, openness to scrutiny and external review
- Stay updated on what is considered best practice
- Develop an understanding of universal human rights, power relations between outsiders and the emergency- affected people, and the value of participatory approaches.

PS delegates should access information on relevant national laws to ensure they know the legaldefinition of rape and SGBV, laws on mandatory reporting (on sexual violence), termination of pregnancy, age of consent and homosexuality. They could also seek information on whether the Convention on the Rights of the Child and The Convention on the Elimination of all Forms of Discrimination Against Women, and the Convention on People with Disabilities has been signed and/or ratified.

It should also be noted that according to the IFRC Whistleblower Protection Policy there is a zero-tolerance approach to any form of retaliation against a person who either reports reasonably held suspicions of a breach of the IFRC Internal Rules or who cooperates in an audit or investigation process. IFRC's Anti-harassment Guidelines give guidance on how to analyze, report and resolve a harassment incident.

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[4] The IFRC Better Programming Initiative describes "do no harm" principles as *"The do no harm principle, derived from medical ethics, requires humanitarian and development actors to strive to minimize the harm they may do inadvertently by their presence and by providing assistance and services. Unintended negative consequences may be wide-ranging and extremely complex – for example, by inadvertently creating societal divisions or increasing corruption, if they are not based on strong conflict and wider context analysis and designed with appropriate safeguards."*

[5] Inter-Agency Guidelines for Mental Health and Psychosocial Support in Emergency Settings (IASC MHPSS). Geneva 2007. p. 10

Box close

Some examples of concrete actions in the ERU setting:

- Patients in an ERU health unit and in outreach activities may need information about their rights and how to access these rights
- Survivors of SGBV and other forms of violence need to have their information kept confidential and their choice of course of action respected, including the right to refuse treatment
- When interviewing for assessments and evaluations, suitable techniques that respect the dignity and consider psychological impact should be considered.
- Staff and volunteers need to be trained in, understand and sign the code of conduct

Sexual-and gender-based violence

IFRC defines sexual and gender-based violence (SGBV) [6] as "an umbrella term for any harmful act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to a man, woman, girl or boy on the basis of their gender. Gender-based violence is a result of gender inequality and abuse of power and usually increases during disasters and conflicts. The fact that disasters often occur in areas of conflict suggests that the intersections between GBV, conflict and disasters require more attention".

SGBV seriously impacts on survivors' sexual, physical and psychological health. Many effects can be hard to link to SGBV as they are not easily recognized by responders. It should be noted that in all emergencies, assume that SGBV takes place. Also note, that some are particularly at risk of SGBV during and after forced displacement, especially when they have been separated from or have otherwise lost the support of their relatives or communities. They include older persons, persons with disabilities, adolescent girls, children, LGBTI[7] persons, and female heads of household. Girls and boys are at risk of sexual exploitation, abuse or violence by persons who care for or have unhindered access to them, including in schools. Gender-based denial of resources or access to services can also amount to SGBV; for example, girls may be denied access to school because of their gender.

IFRC stresses that all actors should:

- Follow the Minimum Standards for Protection, Gender and Diversity in Emergencies
- Assume SGBV is taking place, even if no reliable data is available
- Explore collaboratively the intersections between GBV, disasters and conflict
- Increase awareness within organizations and communities that disasters can heighten the risk of GBV.
- Ensure that SGBV prevention and response and the safety of women and children and child protection are prioritized in all disaster preparedness and planning.

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[6] Inter-Agency Standing Committee Gender-based Violence (GBV) Guidelines 2015. https://gbvguidelines.org/en/home/
IFRC has several good training resources among these the IFRC PS Centre training manual Sexual-and Gender-based violence for psychosocial volunteers. pscentre.org
[7] LGBTI: Lesbian, Gay, Bisexual, Transgender and Intersex persons

- Conduct a situation analysis with use of secondary data and look for information on social and cultural norms, laws, types of SGBV, specific at-risk groups and services available that can inform programming.
- Involve communities in efforts to prevent and address SGBV.

Community engagement and accountability

Community engagement refers to efforts made from both inside and outside the community to involve its members (groups of people, families, relatives, peers, neighbours or others who have a common interest) in all discussions, decisions and actions that affect them and their future. The ERU psychosocial support component can play an important role, both in supporting community members in coping with the crisis situation that they have lived through and by initiating and organizing activities that will help communities reassume their normal lives.

Some operations will have Community Engagement and Accountability (CEA) delegate/s that the PS delegate will collaborate with and consult on matters of community engagement and accountability. IFRC has a CEA toolkit that is useful to engage in the best ways with communities.

As people become more involved, they are likely to become increasingly hopeful, better able to cope and more active in rebuilding their own lives and communities. At every step, relief efforts should support participation, build on what local people are already doing to help themselves and avoid doing for local people what they can do for themselves.

Communities tend to include multiple sub-groups with different needs that often compete for influence and power. Facilitating genuine community participation requires an understanding of local power relations, patterns of community interaction and potential conflict, working with different sub-groups and avoiding the privileging of particular groups. Before beginning outreach work, the community should be consulted if at all possible, it should be engaged in the process and feed-back mechanisms established to be used in improving services, and communities should be informed about findings. During an assessment, it is important to be aware of individuals or groups within a community who may not speak up or even be visible at a first glance. Such marginalized groups may be among the neediest, and so it is the responsibility of humanitarian actors to ensure that their needs are included in the emergency response.

When interacting with local communities, it is crucial to understand the local social, cultural and religious/spiritual factors that influence the way people experience an emergency. There is a delicate balance of respecting a culture or religious values that one does not share or even agree with, while at the same time being aware of potentially harmful practices that may be culturally acceptable in the local setting. Examples of such harmful practices are corporal punishment of children, child marriage and female genital mutilation. If a volunteer or staff member becomes aware that such practices are taking place, he or she has a responsibility to immediately act, take necessary measures and inform relevant authorities according to local laws and referral pathways. Culture can never be an excuse for harmful, hurtful behaviours.

Some examples of concrete actions in the ERU setting:

- Engaging with the community leaders including faith leaders on which kind of support they find relevant and needed, ensuring representatives and needs of all age and gender diverse groups are included
- Discuss how the community may help at-risk groups identified in the assessment as needing protection and support
- Discuss with the community how information on different kinds of support can be disseminated
- Support communities in re-establishing normal cultural and religious events
- Support communal healing practices
- Ensure a complaint mechanism is established in the PS component
- Staff and volunteers need to understand the need for respectful engagement with the community

Psychosocial support and restoring family links (RFL)

Restoring Family Links is the term used to describe various activities that aim to prevent separation and disappearance, restore and maintain contact between family members, reunite families and clarify the fate of persons reported missing. These activities are often connected to the psychological, legal and material support provided to the families and persons affected, resettlement and reintegration programmes and social welfare services.

The restoration of family links is a priority in all emergency situations. Not knowing the fate of family members and loved ones causes great suffering to a large number of people throughout the world. Not knowing the fate of one's family can ultimately lead to years of anguish. In emergencies, the need to know where and how relatives are – if they have survived, if they need help – is important. Beyond the immediate needs in the acute phase of an emergency, the psychological, physical and social recovery of individuals and communities depends heavily on the family. For the majority of the affected, belonging to a caring family is perhaps the most essential coping mechanism of all.

Some operations will have Restoring Family Links delegate/s that the PS delegate will collaborate with and consult on matters of tracing of missing persons and family reunification – restoring family links.

The psychosocial teams will often be faced with people in dire need of support, because they have been separated from their families. Providing them with psychosocial support is crucial and helping them to restore contact or finding out the whereabouts of their family members will contribute immensely to their psychological well-being. RFL colleagues will deal with RFL cases, trying to restore contact and reuniting loved ones. Providing psychosocial support to these families will help them deal with the agonizing pain of not knowing the fate of their relatives.

Some examples of actions in the ERU:

- Establish contact with the RFL team and identify referral pathways
- Ensure ERU colleagues and volunteers are aware of restoring family links aspects
- Identify RFL needs among persons assisted by asking if they have lost contact with family members paying particular attention to children as unaccompanied or separated children
- Ensure that such evacuations and transfers are registered and families duly notified as medical evacuations and transfers can lead to separations between the injured and their families,
- Ensure the RFL team refer the most vulnerable individuals to the psychosocial team for support and follow-up.

Setting up the PS component

In most cases the psychosocial component of the ERU serves both the ERU and the community. Regardless of its location, the psychosocial support component has the potential to become a hub for interacting with the surrounding community and a place from which to organize outreach activities. It is important to signal this dual function so that as many people as possible can access psychosocial support.

An initial action is to identify a suitable site for setting up the psychosocial support component often in one or two tents or structures where most activities are coordinated and carried out. As part of the health ERU, this may either be in the immediate vicinity of the Basic Health Care Unit or Referral Hospital. There may be settings where the only space available for the psychosocial activities is outside the ERU compound, or where the best location is e.g. in a camp for internally displaced persons (IDPs). If the psychosocial support component is based in an IDP camp, it may function as an area for social interaction and support for camp residents.

When identifying the best setting many factors needs to be taken into consideration: security, ensuring a sense of safety and dignity for all ages and genders. Some activities call for a quiet space for private, one-on-one communication whereas other activities, such as support groups, awareness-raising sessions and sports, require more space and are noisier. If the psychosocial support component is set up in the immediate vicinity of the Health ERU, those waiting for treatment of themselves or relatives, can join. Patients in the ERU need to be made aware that they can access information and supportive activities in the psychosocial support component.

The PS space may have the following uses:

- Information point with a notice board with timetable for PSS activities in writing and in symbols for those with difficulties reading
- Inclusive activities for all ages and genders
- Information and supportive activities for individual or groups
- Health sensitization sessions run by ERU health staff or volunteers
- Supervision and training venue for volunteers
- Meeting and recreational area for the PS volunteers
- Meeting space for the ERU psychosocial delegate, staff and volunteers

Responsibilities of the psychosocial delegate
The ERU team leader and delegates agree on how the psychosocial support component and its activities will be coordinated with the rest of the ERU. The ERU team may decide on a certain flow of patients through the clinic and the criteria for consultations with the PS team. The criteria can be that patients are not talkative, are depressed, anxious, have many symptoms, etc.

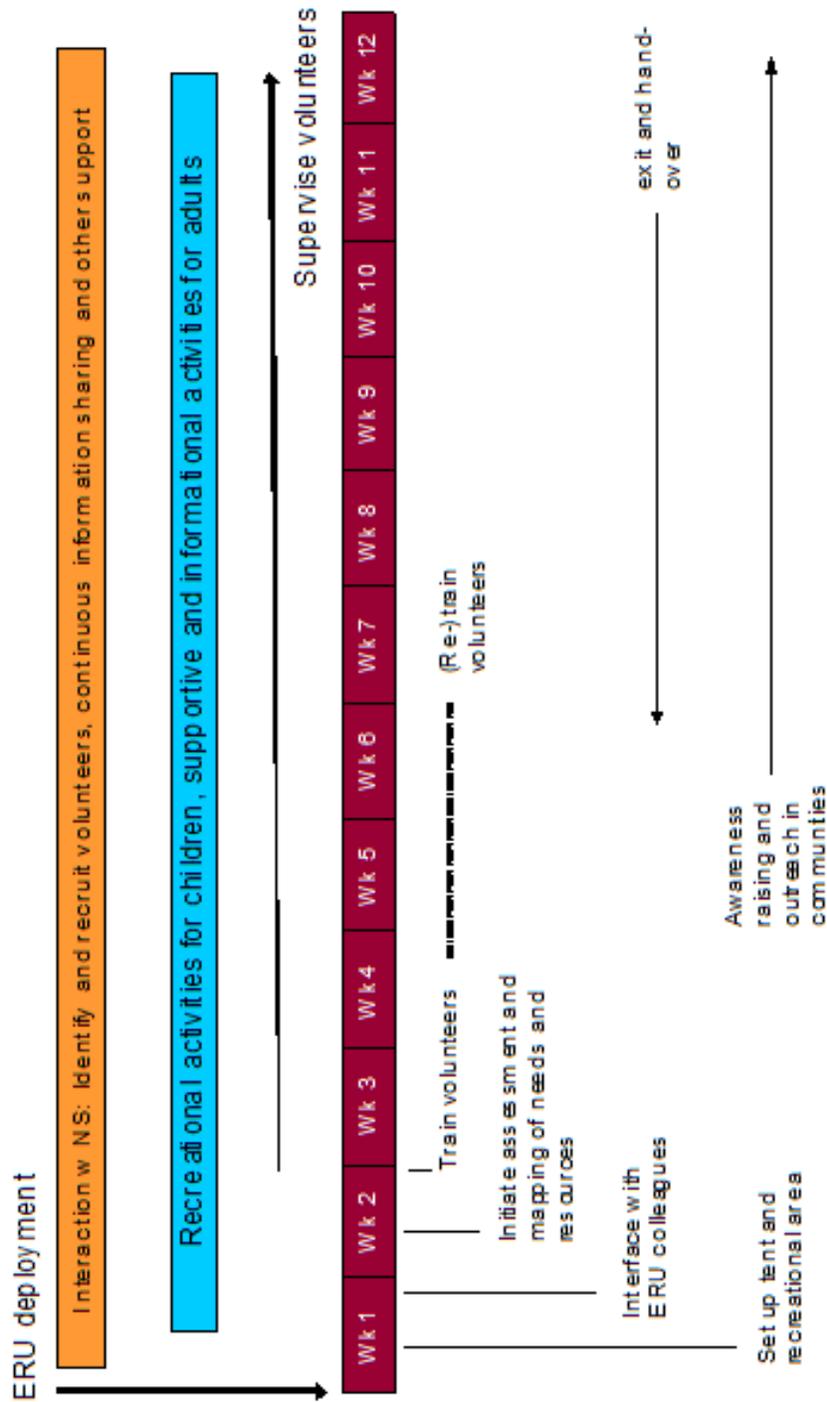The PS delegate will plan, establish and oversee the running of psychosocial activities as part of the work taking place in the ERU and as outreach with the ERU teams, host National Society and/or local health authorities. When planning activities, existing resources must be taken into account and a budget for psychosocial activities, materials, snacks and meals, transport, etc., for volunteers attending trainings.

As tasks change during the different rotations, therefore consulting the PSSiE Competency Framework at pscentre.org is important.

The tasks of the PS delegate on the first rotation:

- Set up a safe space with secure access for psychosocial activities where possible and appropriate
- Agree on modes of collaboration and flow of patients
- Establish the line of command and the reporting requirements
- Discuss the budget for psychosocial activities
- Take part in health assessment activities with specific focus on violence prevention and psychosocial issues, identifying vulnerable groups, mapping of local resources and identification of gaps using the IFRC M&E framework
- Assess existing mental health and psychosocial resources, link up, and establish referral pathways
- Interact with the National Society to identify psychosocial volunteers following screening policies and procedures
- Facilitate training of volunteers in support to affected groups and individuals, including creating safe environments and handling of disclosures of e.g. SGBV
- Instruct volunteers on how to organize games and activities for children and other groups of affected
- Create a safety plan for the psychosocial components linked to the overall safety plan of the ERU
- Launch psychosocial activities in the ERU
- Organize outreach activities, e.g. community-awareness raising sessions and support groups
- Continuously assess, monitor and evaluate needs and activities, follow up when necessary
- Inform ERU team members about psychosocial issues, including psychosomatic reactions, grief and extreme stress reactions
- Liaise with local health authorities, WHO, UNICEF and others regarding psychosocial interventions and mental health care at cluster meetings
- Conduct awareness-raising trainings on the need for psychosocial support and safe environments free of violence to people in leadership positions, for example in emergency response organizations, with camp committees or military personnel assisting the ERU
- Plan outreach as home visits to follow up on discharges patients and their families

Timeline for the psychosocial component of the Health ERU

ERU deployment

Interaction w NS: Identify and recruit volunteers, continuous information sharing and other support

Recreational activities for children, supportive and informational activities for adults

Supervise volunteers

Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10	Wk 11	Wk 12

Train volunteers

(Re-)train volunteers

Initiate assessment and mapping of needs and resources

Awareness raising and outreach in communities

exit and hand-over

Interface with ERU colleagues

Set up tent and recreational area

Needs assessment

Needs and context should be assessed either in connection with the health assessment or as a separate activity through focus group discussions, key informant interviews, observations and site visits. As part of the initial assessment of psychosocial needs and resources, the PS assessment team will identify people and groups that will be helpful in providing information on community resources and thus in facilitating psychosocial activities. Examples of such resources are community leaders including government officials, significant elders, religious leaders or groups, local health practitioners, traditional healers, teachers, social workers, youth and women's groups, neighbourhood groups. A useful strategy in locating resources is to ask which community member people - either themselves or others - normally turn to for support in times of crisis. Statistical information, e.g. existing data about health systems, is helpful to complete the picture. To begin a needs assessment, first collect and review existing sources of secondary data about the situation, needs and resources. Next, conduct interviews with groups and individuals using quantitative and/or qualitative methods. The information gathered should be informed by and validated against those of local key informants and humanitarian stakeholders.

When conducting needs assessments, the IFRC PGI Toolkit has information on how to do a gender and diversity analysis, that can inform interventions.

The *Rapid PSS and violence prevention assessment* from the *Monitoring and Evaluation Framework Toolbox* is to be found in the annex and on pscentre.org with the training tool *Outreach walk Improving protection and psychosocial support through outreach*.

Box opens
A high quality needs assessment aims to:
• Link to rapid provision of effective support and services
• Collect information on how local people understand and experience their situation and how they are able to cope with it
• Analyze how psychosocial impacts and access vary according to gender, age, ethnicity and other stratifications
• Realize not only what the programme may bring but the local resources available and how groups (e.g. women's or youth groups) may contribute to programme delivery and support
• Analyze the situation and programme approach on an on-going basis
• Map local power structures and gender relations, and identify the most vulnerable, invisible groups and those not included in regular community discussions.
• Recognize that Western concepts and tools may not apply in the local context and that especially spirituality may be a significant factor to be considered.
Box close

In most emergencies different groups, such as government departments, UN organizations and NGOs, will collect information on psychosocial and mental health issues. Psychosocial action must always be coordinated as much as possible with other entities.

The IFRC PS Centre has developed a comprehensive Monitoring and Evaluation Framework for Psychosocial Support Interventions that consists of three parts: M&E Framework Guidance Note, an Indicator guide and a Toolbox.

The IFRC PS Centre M&E materials complement the IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergencies.

Psychosocial triage in the ERU

When providing psychosocial support in an ERU setting, it is necessary to identify and prioritize the needs. The PS delegate and volunteers will conduct individual psychological triage and mental health surveillance of community needs. The triage involves a rapid assessment and matching resources to people in need based on limited information as quickly as possible. It is a method of identifying the most critical supportive and protection cases in an emergency assessment and management of the needs of people can include the nature and severity of a person's situation, available resources, knowledge of their own coping abilities and the available time to assist. As mentioned, the *Outreach walk. Improving protection and psychosocial support through outreach,* an IFRC PS Centre training tool, can be used to train volunteers in psychosocial triage.

For psychosocial triage, prioritize those that:
- are unaccompanied or separated minors,
- poses danger to him- or herself or others,
- feels or expresses extreme panic or fear,
- experiences threat to life, self or family members,
- has witnessed death or dramatic injury to others,
- has family members missing or
- has a prior history of mental health issues[8].

In case anyone has several of the above risk factors the case will be prioritized.

Recruiting and engaging volunteers

Local volunteers, community volunteers and staff will facilitate PS activities and interact with vulnerable people. All volunteers will be working with therefore it is a strong advocacy point vis a vis the national society to ensure the do no harm principle is respected and that volunteers are screened and trained. Facilitating community psychosocial support requires sensitivity and critical thinking, as communities often include diverse and competing sub-groups with different agendas and levels of power. When assessing, planning and implementing activities, it is essential to avoid strengthening particular sub-groups at the cost of others, and to promote the inclusion of people who are usually invisible or left out of activities or discussions.

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[8] Adapted from the American Red Cross manual: Disaster Mental Health Handbook. Disaster Services.

The PS delegate is responsible for training and supervising volunteers and as volunteers become familiar with facilitating activities and interacting with community members, there will be time for other activities, such as organizing outreach activities in neighbouring communities, doing follow-up training for volunteers, linking up with local organizations and initiatives and gradually preparing for exit and handover.

The training of volunteer usually takes place several times during the period of ERU deployment. Volunteer teams may change and as the exposure to MHPSS increases there will be a need for more training. In the annexes there is an example of a one-day training programme, other resources as the eCBHFA (http://ifrc-ecbhfa.org/) on MHPSS launched in 2018 is another, and on the PS Centre website there are many other manuals for training of staff and volunteers. The PS Centre Monitoring and Evaluation Tool box has a template for a training report to be found at pscentre.org.

It is not possible to make a general recommendation for the number of volunteers that will be needed; it depends on both the capacity of the National Society as well as the nature of the emergency. Many volunteers may already be involved in relief activities or dispatched to assist other teams. However, when liaising with the National Society, there will usually be five to 20 volunteers depending upon the size of the operation.

The IFRC PS Centre has developed information and training materials on Caring for volunteers including an ERU information leaflet describing the responsibilities of the National Society in creating a supportive safe work environment for volunteers and the kinds of support mechanisms that should be in place. The materials are useful when advocating on behalf of volunteers with the National Society.

Checklist for recruiting and engaging volunteers
- Draw up an initial plan for psychosocial activities in the ERU facilities and as outreach and discuss the plan with the ERU team leader and the National Society
- Recruit and screen volunteers
- Brief volunteers on the IFRC Code of Conduct and ensure volunteer sign it
- Conduct an induction training on psychological first aid - also for children - and activities in psychosocial support
- Train volunteers on protection and the IFRC Child Protection policy
- Establish a daily routine, roll call, working hours, meetings etc.
- Set up procedures as a buddy system for inclusion of new volunteers
- Establish a daily routine, roll call, working hours, meetings etc.
- If needed organize a support group if, in large-scale crisis, volunteers have suffered many losses themselves e.g. after working hours. This can give them an opportunity to address their own situation and enable them to continue supporting others.

In most cases, volunteers get an incentive or a per diem, an amount to cover daily expenses, for instance when travelling to and from the ERU. Volunteers may also not have any income in the emergency phase of a crisis situation and in such contexts, payment of expenses is important to enable people to volunteer. Usually there is a roll call every day to register those present and payment is made at the end of the week.

Launching psychosocial activities

Each crisis is personal, and responses following crisis are normal reactions to abnormal events. The reactions will depend upon previous experiences, and what an affected person says may differ from what they are experiencing inside. Acknowledgement can relieve built up anxiety, it provides an opportunity to establish a supportive relationship, enables people to start helping themselves and they may start answering some of their own questions by telling their story.

When interacting with people do consider and acknowledge the needs of every person and group. For example:

- Age as children may need their caregivers and simpler language
- Gender e.g. women may prefer to talk to women and men to men
- Culture e.g. some groups may prefer not to hold eye contact
- Religion e.g. when people need to pray or what they can eat
- Needs and disabilities e.g. assistance may be required
- Language e.g. interpreters may be needed

People of all ages and genders come to play, socialize, seek information and assistance about the emergency and possibilities for further assistance. They will also receive emotional and social support in dealing with the distress or grief they are experiencing. Some community members will come only once, and the intention is that they benefit from their visit, by being informed, being made aware of their own reactions or simply by having a pleasant time while playing or talking. Other community members will become part of a group of regulars and activities must be designed in a way that meets their needs as well. Based upon the assessed needs, activities will be arranged and depending on the context in which the ERU operates, the psychosocial support component may operate anywhere on a continuum, as shown below:

Activities for children

Newborn, infants and younger children[9]

It may be a task for the psychosocial team to assist in reducing children´s stress in health care settings

- For newborn and infants it may be important to share information with caregivers on the importance of close contact between children and their caregivers, when children are hospitalized.
- For newborns skin-to-skin contact is of great importance and should be encouraged whenever possible.
- Share information and bring attention to children´s need of stress-reducing interventions and prevention of additional stress, e.g. children´s need for adequate pain relief including infants and very young children and age-appropriate information.
- Reduce stress in the hospital environment by arranging as much routine and predictability as possible.
- Make the hospital environment friendly by for example decorating with drawings.

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[9] Please also consult IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Action Sheet 5.4 Facilitate support for young children (0-8 years) and their care-givers

- Provide recreational activities such as arranging music and singing in the hospital setting for children and their caregivers.
- Support caregivers of hospitalized children, providing them with information on common reactions, giving practical assistance and emotional support.

Play

Play is an important aspect of children's well-being and stimulation and opportunities to play and education will often be interrupted during crises and emergency situations. Play and recreational activities enable a positive social and physical environment where children find opportunities for stimulation, skills-building and socialisation. Once children are safe, they should be encouraged to play as they develop their understanding of the world around them through play. They realise their potential and develop physically, intellectually, emotionally and socially. Early childhood activities should provide stimulation, enable protection and promote bonding between children and their caregivers.[2]

Skills development falls within several categories as listed in the table below:

Skills	Description
Cognitive skills	Involve mental processes in learning, understanding, reasoning, decision making, remembering and problem solving
Sensory skills	Encompass hearing (auditory skills), seeing (visual skills), touching (tactile skills), tasting, smelling and sensing body/muscles and balance (kinaesthetic skills).
Hand-eye coordination skills	Refer to the control of eye movement and hand movements as well as the processing of visual input to guide bodily movement. Training of hand-eye coordination happens in e.g. handwriting, drawing, games and sports activities.
Social and language skills	Deal with the interaction of children with other people through communication and cooperation. Encompass the ability to express and respond to feelings in a respectful way, to engage in relationships, to cooperate and solve conflicts. Language skills include understanding what others say, as well as developing a differentiated language through expansion of the vocabulary.
Motor skills	Gross motor skills deal with large muscle movements, i.e. using the large muscle groups through physical movement i.e. when jumping, running or kicking. Fine motor skills deal with small muscle movement when using the mouth, hands or fingers i.e. when sewing, eating with utensils or writing.

Children are a particularly vulnerable group during and after emergencies. Children's well-being can be affected if their parents or caregivers are overwhelmed or exhausted or depressed, and therefore physically or emotionally unable to provide care, routine and support. In setting up Safe Spaces for Children, it is critical to provide a safe and protective environment. Staff and volunteers need to know best standards and practices as described in the *Operational Guidance for Child Friendly Spaces in Humanitarian Settings* and *Minimum Standards for Child Protection in Humanitarian Action*.

The communities should be engaged in the child protection activities as can be done through some of the following activities:

- Support initiatives Such as protection, stress management, how and where to access support for children, having systems in place for UASC, etc.as community patrols, that walk through the area every day to assist and monitor what is going on in children's lives
- Conduct sessions for communities on topics as violence prevention, children's reactions to stress, positive parenting etc.
- Include children in community healing practices as ceremonies or memorial meetings
- Community child protection committees can be formed to help identify at-risk children, monitor risks, intervene when possible and refer cases to protection authorities or community services, when required by law or appropriate
- Discuss with the community, how to organize structured and monitored foster care or other appropriate alternative care solutions rather than orphanages for separated children, whenever possible

Activities for adults

Social support for groups and communities

Groups of people with similar problems or life situations benefit from meeting together. In the context of the ERU, establishing a support group may be an effective way of empowering participants, helping them to support one another. Volunteers with solid training in psychosocial support can assist in facilitating support groups. Activities should include marginalized groups, unaccompanied or separated children, adolescents, youth, widows, widowers, elderly people, people with mental disorders or disabilities or those without social networks. Activities should promote non-violent handling of conflict as discussions, drama and songs, joint activities by members of opposing sides, etc. psychoeducation.

Youth

Pregnant women, mothers with infants and young children

Children are affected by the well-being of their caretakers. Mothers of infants or young children bear responsibility for the well-being of not only themselves but also of their children. In the ERU setting, children may be engaged in activities in the while their mothers attend sessions on positive parenting, health promotion or attend support groups where they have a chance to 'discuss the past, present and future, share problem-solving and support one another in caring effectively for their children'.[10]

It is also possible for caregivers to come and play with their children, using the toys and play items in a Safe Space for Children. Volunteers may be role models for mothers of young children, demonstrating positive interaction and stimulation.

Men

In societies where men traditionally are the main providers for the households, a disaster may lead to men losing their position, socially and emotionally. In armed conflicts, men are also at greater risk of being exposed to violence, of being abducted or of being stigmatized in the local community because they may be ex-combatants. These factors add to the personal distress that a disaster may entail. It is common for men to be involved in clean-up or reconstruction activities, and psychosocial awareness raising sessions can be added to such activities, giving men a chance to express their needs and share their experiences.

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[10] IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Action Sheet 5.4 Facilitate support for young children (0-8 years) and their care-givers.

Groups where men learn about the emotional reactions of children and adults to crisis events, are introduced to positive parenting skills and learn to identify harmful responses to children's stress, learn problem solving techniques, read and discuss news from newspapers or radio broadcasts, construct children's toys or tools, that are needed in the community, are but a few examples.

Older people
Older people are particularly vulnerable and face specific threats in emergencies due to restricted mobility, increased vulnerability, lack of food, inadequate healthcare, isolation and loss of livelihoods with limited access to micro-credit or pensions. It is important to keep in mind, that older people also contribute to their families and communities in various roles. Engaging older people in activities as support groups, reading, sewing or knitting circles, kitchen gardening teachers and, or as story tellers, teachers, trainers of traditional skills, peer supporters or as community grandparents, where they conduct daily outreach walks.

Outreach activities
Different outreach activities will be established depending upon the context. In some cases, there will be visits to support the communities to engage in the reconstruction of the community and initiate psychosocial support activities, and in rarer cases, outreach activities will be limited to household visits to patients who have been treated in the ERU facilities.

Outreach to communities will normally in the first phase take place to liaise with community leaders to support the re-establishment of social networks and activities. Communities include sub-groups that differ in interests and power, and these different sub-groups should be considered in all phases of community mobilisation. It may be appropriate to meet separately with sub-groups defined along lines of religion or ethnicity, political affinity, gender and age, or caste and socio-economic class.
It will be important to explain the need to begin informal educational activities should schools not be functioning, to establish clean-up activities, to ensure chains of information on distributions and other events are disseminated etc. Consulting with faith-based leaders to support re-establishment of normal cultural and faith-based events, communal healing practices are important[3][11]. More mundane activities as sports and games including tournaments will also be important activities as markers of normal life for the communities.
Safe Space for Children and Other Safe and Friendly Spaces or Community Centres will be established, where community members can meet for different activities and mutual support. It is important to secure access for people of all ages, genders and capacities so they may all find opportunities for stimulation, skill building and restauration of well-being, through provision of relevant and culturally appropriate activities that respect dignity and local cultures

Household visits
Households visits may take place to follow up on patients seen at the ERU health facilities and to households having been identified as needing extra support.

When training volunteers in conducting household visits, the following may serve as the sequence in which the visit is conducted:

1. Great the members of the household and introduce the team members

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[11] IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Action Sheet 5.3. Faciliate conditions for appropriate communal cultural, spiritual and religious healing practices.

2. Request permission to enter and talk
3. Explain the purpose of the visit
4. When talking to household members, listen actively by:
    - accepting and understanding emotions expressed
    - using key psychosocial phrases
    - remaining non-judgemental
5. Ask what the focal person/s experience/s
6. Validate, rephrase, reflect, review facts and emotions
7. Encourage and stimulate hope
8. Convey key sensitization messages
9. Refer to the appropriate service required; eg. to health facilities and faith leaders
10. Schedule a second visit if necessary
11. Offer condolences if appropriate
12. Thank and acknowledge efforts made by the household member/s

Administrative tasks, dealing with the media

Daily and weekly reporting requirements
In the first weeks of an ERU deployment, there are daily verbal and written reporting requirements, and daily ERU team meetings to coordinate, plan and report, where all unit will report about activities and number of age and gender segregated data on participants.

The format for the written documentation in the form of statistics and situational reports (Sitrep) will be supplied by the ERU. A weekly narrative report with statistics is done using the form in Annex 3.

Other reports might be requested depending on the context. It may be the local hospital administration, requesting an update on the psychosocial activities or the National Society gathering information on all psychosocial activities in the area.

A few weeks into deployment, situational reports usually cover a period of two to three days and by the end of deployment, they will probably only be required once a week.

Checklist of reports

- Daily verbal reports to the ERU team leader or at staff meetings
- Daily situational report with age and gender segregated data to the team leader
- Weekly reports and statistics to the team leader
- Occasional requests for reports to National Society, local administration or cluster meetings

Monitoring
The PS delegate is responsible for monitoring the ERU psychosocial support component. This entails:

- Monitoring and supervising volunteers
- Monitoring PSS activities
- Monitoring the on-going needs of ERU patients and the community

The monitoring form in Annex 3 can be used to monitor activities and numbers of people assisted on a daily and weekly basis. The psychosocial delegate should integrate their reporting of psychosocial action with reporting of other activities within the ERU, as agreed with the ERU team leader.

Visibility and the media
Journalists are usually keen to report about the impact of relief operations in emergencies. Psychosocial activities provide excellent photo opportunities and the media is generally interested in psychosocial support. Exposure is essential in mobilizing attention and in raising fund for the relief operation. It is an opportunity to explain the need for psychosocial support and can give the world an insight into the work in the ERU.
The influx of reporters may get in the way of the work and may overwhelm the beneficiaries. The PS delegate must secure the approval of the ERU team leader for interviews and if beneficiaries are portrayed, they need to give informed consent to interviews as well as photos.

Checklist for contact with the media

- Ensure permission from the ERU team leader for all contacts with the media
- Secure informed consent from volunteers or beneficiaries for contact with the media
- Follow IFRC guidelines for taking and using pictures of children

Social and communicative PSS activities

Different target groups may enjoy social and communicative activities as:
Storytelling, poetry recitation, singing in a choir, book and newspaper reading groups, knitting and sewing circles, discussion groups, kitchen and communal gardening and psychoeducational activities.

These activities help express and clarify thoughts and feelings. Stimulates reflections and allows for discussion of important issues. Helps participants understand what happened in their lives and promotes self-and collective efficacy. Activities should build on and appreciate local culture and tradition.

Facilitators will guide participants with relevant topics and themes for the activities using simple ideas as beginning a story with one sentence and ask participants to continue (add on) to the story. Use a story to start a discussion. Facilitate discussions with groups following their areas of interest and /or guiding them through a theme, such as one of the risks they or their peers face. Groups can discuss and develop key messages for others in the community, authorities.

Different target groups may enjoy quiet individual or group activities as:
Puzzles, LEGO and other building blocks activities, board games, sodukos or the like, drawing and painting, clay activities and production of toys and educational materials and tools for livelihood activities.
These activities improve problem-solving skills and concentration. Builds social skills as cooperation, turn taking and identifying and working with others to tackle challenges.
Facilitators will guide participants on rules of games and forming teams and arranging tournaments. Some activities will require a quiet area.

Different target groups may enjoy bodily and physical activities as:
Relaxation, yoga, meditation, dance, drama, choir and role plays, sports and games sports – football, volleyball, frisbee or hand ball, outdoor team games and local traditional games.

These activities develop motor skills, muscles, coordination, stimulates senses and body awareness. Develops self-confidence, builds relationships and teamwork skills – interaction with peers, rules, and cooperation Furthers calming and the ability to regulate the level of arousal. Are fun, promote team spirit, and active participation.

Facilitators will establish a safe area to conduct outdoor activities, sports and games. They will guide participants by developing a time schedule for different teams thus ensuring all groups have access to activities, create a rotation system for the uses of equipment, form teams, and arrange tournaments.

After the initial phase

ERU deployments all differ, and the timeline will vary according to the circumstances. Even if it is easy for PS delegates to get caught up in the running of the day-to-day activities, it is important to build the capacity of National Society to sustain psychosocial activities once the ERU mission is ending. Each rotation will adjust the programme to the actual needs, however it is important not to begin with yet another in-depth assessment in each rotation and that the directions set by previous teams are respected. No matter at which phase of the ERU deployment it is important that to keep a strategic view, and at the same time to respond to the needs of the emergency in collaboration with the National Society to enable the National Society to move into a recovery and development-oriented response. Well ahead of time the PS team will discuss the relevance of recovery and/or long-term development programmes to prevent further harm and promote resilience and psychosocial well-being.

PSS programmes can be stand-alone or integrated into programmes. A stand-alone PSS programme will usually have a separate budget and management and be implemented independently. If integrated, it will be part of a bigger, sectorial programme (such as health, social support, education, livelihood or life-skills programmes) and managed and implemented in conjunction with these activities.

Ending the ERU mission

An ERU mission usually lasts up to three months, though sometimes this period may be extended depending on the nature of the emergency. The PS delegate will write the handover (see a template in the annex) the ERU team leader and to organize the practical handover The formal handover is a good time to celebrate the efforts of the volunteers are celebrated in a formal farewell ceremony.

ANNEXES

Psychosocial kits

Some PS delegates will deploy with a pre-packed PS kit in a backpack or suitcase. The content of the kit will help initiate activities until local procurement can be done for locally made toys and game materials. Activities should be adapted to the local culture and volunteers will assist in identifying song, dance and play activities that are known and accepted locally.

Starter kit
Based on what National Societies have developed for national emergencies the PS Centre propose the following to be in the portable PS starter kit:

- 1 bar of soap
- note books
- 2 packages of pencils
- 1 pencil sharpener
- 1 pair of scissors
- 1 clothes line
- 1 package of clothes pegs
- 1 package of coloured crayons
- 1 colouring book
- 1 clown nose
- 1 foot ball, wolley ball
- net for ball games
- 2 soap bubbles
- 6 tennis balls
- 1 bat
- 1 frisbee
- roll of paper
- 2 finger puppets
- 1 hand puppet
- 1 memory game
- 1 package of balloons
- 1 roll of wool
- 1 set of dice
- 1 set of playing cards
- 2 soft inflatable balls

Additional kits to be purchased locally
The following sets of materials are recommendations for what could be purchased locally.

- Paper
- Carton
- Rolls of paper

- Paper pads
- Pencils
- Pens
- Colour pencils
- Crayons, jumbo and normal
- Erasers
- Sharpeners
- Scissors, round and sharp edged
- Clip board
- Glue
- Blue tack
- Clothes pegs
- Adhesive tape
- Chalk sticks

The toys and games and equipment should be made by materials that make them easy to clean to avoid spreading of diseases.

Overview of generic PS Centre IEC materials

Volunteers will be trained so that those seeking support are comforted, informed, made aware of own reactions or simply benefit from having talked to and interacted with someone. A set of printed materials is available and can be used in the training as well as to provide information on a number of different topics to humanitarian workers, parents, teachers etc.:

No	Title	Type	Target group	Content
1	**Coping with stress and crisis**	Brochure	Beneficiaries and patients	Helps adults to understand their reactions to extreme events and what they can to help themselves and others
2	**Children's stress and how to support**	Brochure	Beneficiaries: parents, teachers and adults in general	Provides information on children's reactions to crisis situations and how adult may help them cope
3	**Working in stressful situations**	Brochure	Red Cross Red Crescent volunteers, ERU staff and humanitarian staff in general	Provides information on work-related stress and useful action for how to deal with stress
4	**Psychological first aid**	Brochure	Red Cross Red Crescent volunteers, ERU staff and humanitarian staff in general	Provides information on the benefits of psychological first aid and describes basic elements
5	**Supporting volunteers**	Information sheet	Operating National Society	Informs National Societies on how to support and care for their volunteers, and how to keep them safe
6	**Common reaction of persons affected by disasters**	Information sheet	ERU staff and other humanitarian staff	Information on common reactions of persons affected by disasters
7	**All children deserve to be safe**	Information sheet	Volunteers, ERU and humanitarian staff, parents, teachers	One-page information sheet with pictures about violence against children

Brochures number 1 and 2 will be especially helpful in explaining the kind of normal reactions of adults or children can expect to crisis events and what can be done to get through a difficult time. It is recommended you spend time during the training with the volunteers going through these materials and making sure that volunteers are comfortable with this information.

Training and briefing sessions for volunteers and peers

The PS delegate will be responsible for different trainings and this manual contains suggestions for:
- A one-day training for volunteers in the ERU psychosocial support component
- A short 30 minute to one-hour session for ERU colleagues on psychosocial needs and support

One day training curriculum for volunteers

As soon as a group of volunteers has been identified and screened, the initial training is planned and carried out.

Box open
When planning the training, the following needs to be considered in liaison with local brach:
- Branch chairperson (or other official) to hold opening speech/welcome
- A safe and secure training venue
- Selection of participants to ensure equal representation among genders
- Issue culturally accepted invitations
- Per diem or remuneration for volunteers
- Transportation, if necessary
- Curfew, if relevant
- Interpreter, if needed
- Branch chairperson (or other official) to hold opening speech/welcome
- Lunch and snacks during breaks
- Materials for training
Box close

The training day for volunteers provides a brief and basic introduction to psychosocial support and to the tasks that the volunteers will carry out.

After the training, participants will:
- Understand the function of the health ERU
- Know the importance of setting up safe environments
- Know which kind of activities that will take place in the psychosocial component
- Understand the basic concepts of psychological first aid

Participants are likely to come from a variety of backgrounds and will not necessarily have experience in health, mental health or social welfare. The training is practical and participatory to engage volunteers. The training days are often short as there may be curfews, check points or travel time for volunteers to arrive and leave on time.

Training materials: note books and pens for participants, a medium size ball, flip chart paper and markers, sticky tape to fasten paper to surfaces as tent walls, trees or walls and masking tape for name tags. Participants are welcomed when they arrive, asked to write their name on a piece of masking tape and to sit in a circle. The programme on a flip chart or a piece of paper and hung for all to see.

The ERU folders *Stress and coping* and *Children's stress and how to support,* and *Psychological first aid* can be used as reference materials by the participants during the training sessions.

9.00 – 9.10   Welcome

The training is opened by a Red Cross Red Crescent representative, ERU team leader or PS delegate.

9.10 – 9.30   Introductions

Participants pair up and are instructed to spend a few minutes talking about one or two of the following questions:
- Tell your partner about a favourite activity you liked to do as a child.
- What is your motivation for engaging in psychosocial support?
- Do you have a hidden talent that you can use in psychosocial support?

Next, the group is gathered in a circle and participants are asked present themselves or their partner talking about the questions above. If time allows ask participants to think about what they learned from their favourite childhood activity. This presentation can later be linked to which activities are useful when working when children.

09.30 – 9.45   Rules of engagement

Tell participants that when working together as a group it is a good idea to have a set of rules as the same way as there are traffic rules. Ask participants to think for a moment about which rules would be good to follow that would make them feel safe and help them learn.

Next ask for a scribe to note the rules on a flip chart or other piece of paper and have participants call out their suggestions one at a time.

The facilitator ensures the rules have a positive wording and seem realistic given the situation and environment. Ensure confidentiality and rules about mobiles are mentioned.

09.45 – 09.55 The training programme

The trainer gathers participants around the programme and describes what will happen during the day. It should be mentioned that if, at the end of the day, anyone thinks psychosocial support is not for them, this is perfectly fine and they are welcome to discuss this with the trainer.

09.55-10.00   Energizer

Ask participants to stand in a circle. Explain that you will throw the ball to a participant who will throw it on and that the task is to ensure all has the ball once! Reverse the order when the ball throw functions well or add one and then two more balls to follow the first order of catches.

10.00-11.00   Introduction to the Health ERU

The facilitator gives a description of what an Emergency Response Unit is, what is happening in the Health ERU, who can access its services and for how long it will be deployed. It is a good idea to give concrete examples and not to use technical language.

Invite participants to walk through the ERU explaining what each unit is used for and give examples of the psychosocial support activities that can take place for patients and

relatives. When back from the walk, ask participants to talk to their partner from the presentation if anything surprised them and if they have questions. Answer these and end by reminding participants of the rules of confidentiality.

11.00 – 11.45 Introduction to psychosocial support

How does crises events impact the affected and what their needs are.

Ask participants to discuss in groups of three how a crisis event as the current crisis impacts those affected. Each group is assigned a target group: boys, girls, adolescent boys and girls, women, men and older women and men, gender-diverse people, those living with disabilities or other target groups.

Next to discuss what the affected need to feel well again.

Plenary discussion of what needs are and how to support the affected.

11.45 – 13.00 Introduction to psychological first aid (PFA) and active listening

Helpful actions when someone is in distress:

Facilitator asks participants to stand in a line ordering themselves after height, age, birth date, next to pair up and find a place to stand or sit while they discuss: If a friend has some troubles and is affected by the troubles, so the friend is in distress, what actions could they think could help the friend?

After some minutes of discussion, call the group together and ask participants to share what can help. Pairs take turn saying one action that can help till everything helpful for someone in distress has been mentioned.

Introduce three flipcharts or pieces of paper, each with the heading Look, Listen or link. Introduce the PFA principles of Look, listen and link principles from PFA. Next ask participants to discuss where their example of a helpful action belongs and ask them to note the action on the corresponding paper. Add anything important that is missing from the poster/papers.

Explain that PFA is a humane, supportive response to a fellow human being who is suffering and who may need support (IASC) and is a caring response that addresses practical needs and concerns. PFA is something everyone can learn and should be trained in. Providers of PFA do not ask intrusive questions about feelings and the event, but stresses listening in a non-judgmental manner, identifying and assisting with practical needs, discouraging negative ways of coping and linking people with their loved ones and others who can provide needed social support.

Explain that for the PFA volunteers will be offering in the ERU they will learn to:
- Calm and listen to someone in distress
- Understand and help clarify the needs
- Help with information
- Protect the distressed from further harm

Bad listening skills:

Ask for a three questions and answer these in a way that shows bad listening skills. Discuss with participants what they observed and why the shown listening behaviours are bad.

Active listening exercise:

Ask participants to pair with a new partner, someone they haven't talked to yet.

Ask them to decide who will be listened to first. They have three minutes to talk about an everyday story that does not affect them too much. The listener will listen, by giving their attention to the speaker and using non-verbal prompts as encouraging nods.

After three minutes, ask participants to notice how they felt as speaker or listener. Then change roles. Ask the same question and next ask participants to talk about how it was to be listened to and to listen.

Plenary discussion: how was the exercise? Was it easier to listen or talk or did both roles feel comfortable?

Role-play:

End the session with a role-play in front of group to ensure the learning outcomes.

Ask for two to play the role of a person in distress and the other the role of a psychosocial volunteer. Decide on an imagined case, not a real case, of a friend who is in distress. The helper is to focus only on the look and listen principles in this role play. End the role play after some time and facilitate a discussion first with the role players and next with the group on what went well and what can be added given more time in a real life situation. Give feedback on the good listening behaviours.

13.00 – 13.30 Lunch break

13.30-14.15   Vulnerable groups and protection needs

Begin the session by asking participants how the rules of engagement work. Are they followed? If not, why and should rules be adapted?

Form new groups of four to five participants.

Ask the groups to discuss: who are the vulnerable groups that are in and will come to the ERU?

This should take five minutes followed by a short plenary discussion.

Next ask groups to discuss the protection needs of children.

This should take five minutes followed by a short plenary discussion.

End the session by showing the *ERU information sheet 7*: *All children deserve to be safe*, to recap the need to protect children after crisis events and what can be done if someone suspects that a child is suffering from a protection threat as abuse or maltreatment and go over the rules for volunteers when interacting with children.

14.15 – 14.20 Energizer

Ask participants if they can suggest and lead a local game or suggest a song.

14.20 – 15.00 Activities in the ERU

Participants are divided in groups that will list ideas for what activities that will make patients feel safe, calm them and help them cope with their situation as well as the need for materials used.

The target groups chosen will depend upon the context, and could be: children whether patients and accompanying caregivers or relatives, patients in wards, pregnant and lactating women, adolescents etc.

Plenary discussion of how to initiate activities beginning from tomorrow. Link the discussion of what activities to do to what participants said in the morning when they talked about what they learned from being engaged in their favourite activity as a child.

15.00-15.15   Ending the training day

Ask participants to pair up with their partner from the morning introduction exercise and discuss how the day has been for a few minutes. Next to form a circle and conduct a round of what each appreciated about the day, or what they learned or what they are looking forward to.

Briefing session on psychosocial issues for ERU colleagues and staff

This section outlines a briefing session for ERU colleagues and other humanitarian staff working in the same area that lasts 30 minutes to 45 minutes. The briefing session presented here lasts 45 minutes but can be changed to fit a 30-minute time slot.
The overall objective is to raise awareness about the psychosocial impacts on those affected by the emergency.

It may be quite important as humanitarian workers may not think that armed conflicts, violence or natural disasters cause psychological and social suffering. They may not realize that psychosocial actions may significantly influence the abilities to adopt positive coping mechanisms to handle the situation for those affected. Humanitarian staff involved in general health care, camp management or water and sanitation, for example, may also need to sensitized to their contribution to support the resilience and coping mechanisms of people affected by disasters or crisis situations.

Introduction - 5 minutes

Introduce the function of the PS delegate, the tasks and responsibilities as well as the overall support the PS team can offer.
Ask participants what they'd like to know more about and if they have any concrete questions about psychosocial support.

Mental Health and Psychosocial support - 10 minutes

The term psychosocial support covers Mental Health and Psychosocial Support, a composite term, and is an integral part of the IFRC's emergency responses. It aims to help individuals and communities to heal the psychological wounds and rebuild social structures after an emergency. The key objective is to ensure early and adequate help to prevent distress and suffering from developing into something more severe and help people better cope. Health care settings, such as the health ERU, are often entry points for supporting people with mental health and psychosocial problems. Health care providers frequently encounter psychosocial issues when treating diseases and injuries. For example, they invariably will be treating injuries from some type of violence. The strong connections between social, mental and physical aspects of health are commonly ignored in the rush to organize and provide health services.

Introduce the Hobfoll principles and give concrete example of how they are transformed into practice in the current ERU setting.

Briefly mention the IASC Guidelines for MHPSS in Emergencies that were developed in order for humanitarian actors to plan, establish and coordinate a set of minimum multi-sectorial responses to protect and improve people´s mental health and psychosocial wellbeing in the midst of an emergency.

Psychological first aid - 15 minutes

Explain resilience and how resilience can be furthered by being understood and listened to, having practical needs met as tracing missing family members, having access to social support and being actively engaged in own recovery. Stress the importance of meeting and treating affected people with respect for their dignity and provide basic information about the mental health and psychosocial impact of crisis events, violence and situations.

Explain the Look, Listen, Link principles of Psychological first aid using one or two of the short exercises from the IFRC PS Centre PFA training manual.

Introduce the IEC materials chosen in the concrete ERU setting.

As the health ERU is the entry point for many, there will be a range of patients suffering from normal psychosocial distress and those with mental disorders requiring clinical treatment or referral. With this understanding, colleagues may avoid inappropriate medical treatment. You can also explain your role in assisting with information on local referral mechanisms for people with mental disorders and indicate that, patients with mental disorders may also benefit from taking part in the activities organized in the ERU psychosocial support component.

Assesment findings, local resources and referrals – 10 minutes

Present the findings of the initial psychosocial assessment, indicate where local resources are and what social support and protection structures are in place, as these may be helpful in the overall implementation of ERU activities.

Outline the referral pathways and how to refer to identified actors in the area. If initial stress reactions are diminishing, the affected person is likely to heal without any need for professional psychological support. However, if reactions are persisting, increasing or hindering in everyday life, it is likely that the person may need further review and/or referral to professional (psychological or medical) help.

Explain that even though PTSD is the most widely recognized post-traumatic disorder, it is not the only one. Other negative post trauma reactions include depression, anxiety, incident-specific fears, somatization, traumatic grief, sleep disturbances and substance abuse. Reactions may also be due to the increase in inter-personal violence after disasters[4].

Questions and answers – 5 minutes

PS delegate hand over template

This hand over document covers x rotation in the ERU mission to xx country in 20xx from xx xxxx 20xx to xx xxxx 20xx

In the verbal handover to the incoming PSS delegate/s introduce to the ERU team, the National Society, other PNS and key i/NGO partners. Here I will add some more… what??

PSS delegates during this period was/were: name and emails,
Handed/sent to: xxxx ERU team leader, health delegate, incoming PSS delegate, xx in deploying National Society, counterpart in NS and xxx
Written by xxxxx xxxxx the xx xxx 20xx

Names and contact info of key ERU partners
Name and contact info of other PSS delegates
Names and contact info of National Society partners
Names and contact info of IFRC key partners

Internal coordination
Please describe the internal coordination meetings as scheduled meetings with line manager, head nurse, deputy team leader or team leader:

External coordination
Please describe how the ERU PSS is placed in the coordination mechanisms, which coordination, cluster or Technical Working Group meetings attended (including if NS counterpart is attending):

Assessments, monitoring and evaluation
Please outline the assessment (incl. where to locate soft copies) or how the work was continued/adjusted based on previous assessments:

Daily and weekly reports to ERU TL and NS

Security
Describe the security situation during the rotation, eventual security incidents, how access to communities were during the rotation and include security plans on site:

Also describe what has been arranged with regards to visibility for volunteers (procurement of caps, vests, ID etc)

Capacity building of National Society volunteers and community volunteers
Please describe capacity building initiatives, on the job training, and trainings carried out (including topics, materials used and gender disaggregated data on participants):

IEC materials
Please describe PSS or other IEC materials used or translated during the rotation or materials that could be developed:

Caring for staff and volunteers
Please describe caring for staff and volunteers' activities, support meetings, mentoring or supervision carried out, letters of appreciation etc.:

PSS activities
Please insert or describe daily and weekly schedules incl. working hours and days off:

Achievements, unexpected outcomes and challenges
Please describe results, what did you not expect but good or disappointing outcomes and what challenges were encountered:

Community Engagement and Accountability in the PSS

Reports
Recommended reports etc. for the incoming delegate to read:

Cultural sensitivity and social context
Please brief on the culture, sensitive issues and the social context in the environment:

Practical issues
Please introduce to reporting requirements (daily/weekly/bi-weekly reports), attendance sheets used etc., to remuneration for volunteers and community volunteers and to translators used:

Coordination with other PSS entities

Procurement
Please describe procurement procedures if changed from previous rotations as well as which requisition forms are to be used:

Recommendations for directions ahead
Please give recommendations for short and long term plans as trainings that staff/volunteers need including refresher trainings, the willingness and capacity of National Society to engage:

Referrals and pathways
Please describe how referrals are done using the IASC referral guide and note, visits carried out to service providers to ensure quality and security of referrals, and where to find the pathways identified in the operation:

Contacts lists
Please add relevant contact lists: