SUPERVISION AND TRAINING – ON –THE -JOB

GUIDE FOR MSF PSYCHOSOCIAL PROGRAMMES

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INTRODUCTION

Supervision is a key factor in mental health/psychosocial programmes. Usually we work with non experienced teams, recently being trained to become counsellors, community mental health workers, agents of community mobilisation, psychosocial assistants, social workers, etc who will need extensive supervision. Professional psychologists, psychiatrists and other mental health workers need also supervision in their daily practice[1].

Expat psychologists, psychiatrists and mental health officers in MSF might have experience in their own field of work, but not necessarily in coordination and supervision. Therefore, this guide could be very basic for some professionals and quite useful for others less experienced.

The levels of supervision are quite wide. In this document, we will address the field of clinical supervision as well as other monitoring methods in psychosocial programmes, for instance, evaluation of intervention approaches and results or individual assessment needs for team members.

OBJECTIVES OF SUPERVISION IN PSYCHOSOCIAL INTERVENTIONS

- Ensure quality of psychosocial interventions
- Monitor and adjust programme design and management
- Contribute to self-knowledge and self-understanding (personal growth) of team members
- Give the opportunity to the team members to reflect, analyse and share their practices.
- Analyse behaviours, attitudes, beliefs, knowledge, resources and expertise related to the practice of team members in order to define and properly manage operational and dynamic components of the work
- Encourage integration and learning process of experiences and theoretical contributions among the team
- Explore personal problems and find new ways of dealing with them. Prevent secondary traumatization, burn out and other psychological suffering among the team

TYPES OF SUPERVISION

1. Clinical Supervision during counselling session

Direct supervision during sessions with patients is needed in order to ensure the quality of the intervention. Sometimes unconscious attitudes and beliefs could jeopardize interventions and make them become even harmful. An external person with clinical eye present in the session together with the counsellor and the patient(s) can help improving the counselling.

Clinical Supervision during sessions can be put in place for:

- Complicated cases where the counsellor wish some support
- Cases where counsellors perceive difficulties to establish a suitable relationship with a specific patient.

And/or

- Systematically with each counsellor on a regular basis, as a routine part of the job.

It should be agreed in advance between the counsellor and the supervisor in which way the supervisor will behave during the session: silent observation, intervening in specific moments with

[1] Along this document, mental health actors are generically named “counsellors”.

short contributions, playing an active part in the session at the same level as the counsellor in charge, etc.
The patient should be informed of the supervisor's "visit" and give his consent beforehand.

In any case, the supervisor may take some notes during the session he observed to share them in a case discussion afterwards. Check-lists used for observers in role-plays can be helpful.

Unfortunately in the specific contexts where MSF works, language and culture barriers do not smooth the process of supervision. On the contrary, the fact that the expat supervisor is a foreigner and may need a translation will disrupt the natural dynamic between counsellor and patient and hinder the understanding of the usual development of the session. However, the only fact of being present without understanding the verbal language allows the supervisor to focus more on non-verbal reactions and to highlight those in the discussion with the counsellor afterwards.

2. Individual Case Discussion

The supervisor and the counsellor discuss a specific case together.

- When reviewing clinical files, and specifically when there is no coherence between reason for consultation – events – symptomatology – diagnosis / patient's situation – objectives and/or plan of intervention.
- When the counsellor has doubts on the way to proceed or requires support about the case for example when there is no improvement though it was expected, etc.

Or

- Systematically planned on a regular basis choosing difficult cases or specific criteria such as age group, sex, reason for consultation, problematic, etc.

Ideally the counsellor who presents the case should prepare in advance a summary of the situation of the patient with key information that will help the discussion, as well as questions and doubts.

It is important to clarify to the counsellor that the aim of these individual supervisions is not the evaluation of the person's capacity but to provide support for the improvement of the care.

3. Intervision and Clinical Team Supervision

Intervision is used when a group of psychosocial workers (not necessarily only MSF staff) establish working sessions with other colleagues in order to support each other and encourage mutual training and learning. Participants use case discussions as well as other tools to discuss about issues of common interest.[2]

Clinical Team Supervision is also organised in group but with the difference that there is a referent person with more experience and background who plays the role of facilitator and who will give specific explanations and clarifications when it is required.

Intervision or Clinical Team Supervision should be systematically organized on a regular basis in every psychosocial project. It is the standard tool to insure a continuous follow up of the professional growth of the counsellors and to improve the quality of the intervention.

Ideally the counsellor who presents the case prepares a summary with key information that will help the process of discussion, as well as possible questions and doubts. After his/her presentation, the other members will ask questions to clarify some issues, and discussion will start to help the counsellor find alternatives to take care of this patient. A schematic procedure is explained below in Methods.

[2] See for detailed information: LAUMONT, B. et TADJET, A. « L´intervision: ou la fin de la solitude du travailleur psychosocial de fond ???", Alger, 2000, MSF-B.

As for individual supervision, it is important to clarify to counsellors that the aim of this type of supervision is not the evaluation of the job performance but the improvement of interventions and the self support in between team members.

Within MSF, it is often the responsible of the MH programme who will lead the individual or group supervision, but an external supervisor can be as well asked for, when available in the country.

4. Monitoring of the programme within the team

Very often monitoring methods are limited to data bases, quantitative indicators and maybe analyses of the general context related to the project. However, from time to time, better on a regular basis, organising a meeting among the team to discuss about the development of activities and the goal of the project, can help to redefine and drive more accurate strategies. In addition when members of the team feel involved in the discussion it helps to feel more engaged in the project.

For the closing of the project, when evaluation has to be done, it is also useful to organise discussions where different opinions can be collected, no only by coordinators and responsible persons in the project, but also the rest of the team and stakeholders.

5. Individual Supervision of the job performance

It is very important to count with a well-designed job description in order to be able to perform a proper individual supervision of the work of the counsellors. Standard evaluation forms in MSF projects present a way of supervision, but other tools can be used in addition.

The big difference with the previous types of supervision is related to the goals. In this case, the supervision aims at assessing the individual performance of team members according to their respective tasks and responsibilities, as well as identifying further training needs, individual support strategies to put in place, etc.

6. Assessment of Emotional Needs in the team

There has been many efforts within MSF Staff Health Policies to include mental health within the package of health services provided to MSF workers.
All MSF staff ideally should be able to ask for minimum psychological support, mostly when the suffering is a consequence of the work (ex., health staff working with patients in difficult situations, violence contexts, insecurity, etc.). Nevertheless a clear system for screening, offering services and referring is usually not established for mental health needs. In general, medical coordinators are responsible for mental as well as for physical health for expats and medical focal points for national staff. However local or regional resources are not always available. When mental health professionals are a part of the team, they are usually the ones giving emotional support to their colleagues, which is not always ideal, first because of their work relationship and second because workload and their own emotional needs do not always allow it.

Emotional needs are even clearer for psychosocial professionals who live usually in similar conditions as patients and also could suffer from secondary or vicarious traumatization and other psychological difficulties. Therefore, it should be an asset to always plan their support, when possible better externally.

The Stress Management Support unit (SMS) has been created to respond to staff emotional needs and is always available to give support in different circumstances, for instance in critical incidents.

Each situation is analysed to provide the best support possible, both in the field or from a distance. Resourceful documents are also available[3].

METHODS OF SUPERVISION AND INTERVISION

Different levels of supervision can be fulfilled through different ways and tools, according to objectives, availability of team members, planning, etc.

1. Clinical Observation

The supervisor attends to some sessions between counsellor and patient(s). The supervisor tries to understand and analyse the setting of the aid-relationship, as well as the coherence between the situation of the patient, his/her history and life events and the objectives, focus and strategies chosen by the counsellor and the progress made.

The supervisor will pay attention to the following:

- Relation counsellor-patient (welcome, during session and farewell, trust, empathy)
- Counsellor's language (including questioning and language adjusted to patient)
- Counsellor's non-verbal communication (respect, attentive listening, use of silence, empathy, etc.)
- Counsellor's capacity of encouraging the patient to express emotional feelings, thoughts, beliefs, etc.
- Counsellor's capacity to identify features and coherence between verbal and non-verbal communication of the patient
- Counsellor's capacity of identification, understanding and analyse of the patient's problems, current situation and coping mechanisms.
- Counsellor's capacity to define treatment objectives with the patient
- Counsellor's capacity of defining and setting up intervention strategies, to follow them up and adapt them if needed
- Counsellor's capacity to provide information to fulfil patient's needs

After direct observation, both counsellor and supervisor will discuss those issues observed in the session in order to give support and improve the quality of the counselling.
If it is not the first session with the patient, ideally a discussion should be held between the counsellor and the supervisor to present useful antecedents, previous starting the session with the patient. Additionally, a discussion about the expected improvements and prognostic will be useful.

2. Case Discussion

As mentioned before, this method can be run with the presence of a supervisor or among field work members alone (intervision).

One of the counsellors (or more) will be asked to present a patient's case he wants to discuss with his colleagues to receive support. He will have to prepare a description of the case so as to give the relevant information for the others to understand the situation.

Example of a frame to prepare a case discussion:

- Key personal data about the patient (it is better not to use a real name for the sake of respect of confidentiality): age, sex, key social data, education/occupation, family key facts, current living status, etc.
- Reason for consultation

[3] The booklet "I feel good. I feel healthy" published in MSF-OCB is a good example to provide information about prevention, coping mechanisms and who and how to ask for help.

- Key life events
- Main problems perceived by the patient and by the counsellor
- Symptoms and category of major problem (and diagnosis if pertinent)
- Severity of problems and functionality
- Resources and coping mechanisms
- Objectives of counselling
- Intervention plan / strategies / techniques
- Understanding of the case as a whole picture
- Counsellor's feelings and perception about counselling and relation with patient
- Difficulties and doubts found
- Questions and requests for support

After the presentation, a turn of questions will be asked to clarify some issues before starting the clinical discussion.
The participants, through their own experience, will give ideas, suggestions, analyses, in a constructive way respecting confidentiality and avoiding personal judgements to support the counsellor in his management of the case.

All key points listed for the Clinical Observation can be also useful to address here.

It is advisable that after some period of time, the same counsellor gives feedback to the group on the evolution of the follow- up of the patient presented in a previous case discussion.

3. Role-plays

Role-playing is a very useful method to observe and practice communication and counselling skills, and to empathise with both patient and counsellor situations. It is a very valid method especially for beginner counsellors, who are learning and developing their skills. Usually cases are made up for this purpose (see Annex 4 for examples), trying to exemplify the type of cases commonly seen in the programme. Among the team members, a person will play the role of a counsellor, another one the patient (and sometimes a relative who attends also the counselling session) an the rest of the team will be observers.

Role-plays can be used also to practice sensitization or psycho-education activities, in order to improve abilities and skills as well as knowledge and clearness of the information offered.

Observers can use a checklist to evaluate and write comments about the scene. Sometimes it is useful to choose different observers to focus on the counsellor and on the patient(s). (See annex: Making and using checklists for role-plays)

After the activity, a discussion will take place in order to identify good practices and those ones which could be improve. Practical propositions from all team members involved are desirable.

4. Psychodrama[4] and Sociodrama

They are useful methods to exemplify events, situations and problems usually lived by individuals (psychodrama) or in the community (sociodrama) with whom we are working. We often use these methods in psychotherapy where the patient is playing a real situation in his/her life, relevant for the therapeutic process, but it can be also used in supervision.

As for role-plays, instructions about the case can be given to participants, but also the context of the scene can be chosen by the "actors" who are playing. Afterwards a discussion will be opened.

[4] Conceived and developed by Jacob L. Moreno, MD.

The difference between role-playing and psychodrama/sociodrama is mostly about the type of situation represented. During role-plays, the situations acted are activities of the programme (mainly counselling) but psychodrama/sociodrama exemplifies real or imaginary situations of the population (for instance, a traumatic event). Whereas psychodrama focuses on an individual's personal concerns, sociodrama addresses the group's issue.

These methods employ guided dramatic action to examine problems, concerns or issues raised by an individual or a population. Using experiential methods, sociometry, role theory, and group dynamics, drama facilitates insight, personal growth, and integration on cognitive, affective, and behavioural levels. It clarifies issues, increases physical and emotional well being, enhances learning and develops new skills. Used as a supervision method the aim for the team is based on realising the experiences that the population who is assisted and accompanied is living. Group members participate in the drama as significant others and share how they personally relate to and can learn from the presenting issue at the end of the session

Ethical requirements are not absent for role-plays and psychodrama activities. As well as for psychotherapy and other psychological practices we should take into account responsibility, competence, welfare, confidentiality, therapeutic relationships and values[5].

The leader/supervisor explains the aim of the activity, and asks a group of participants to voluntary play a situation usually lived by beneficiaries. During the drama, s/he and the other colleagues who are participating will take notes about feelings, behaviours and attitudes showed. After the representation an open discussion will take place to discuss about the experience of the “actors”, the perception of the observers, and the similarities with the reality of the assisted people.

5. Review of Clinical Files and Diagnosis

On a regular basis it is important to review clinical files of patients from all counsellors in order to assess the quality of the identification of the patient’s problem(s), the support provided, to identify points that need to be reinforced amongst the counsellors and to get a general overview about the cases treated.

Standard methods of diagnosis such as DSM-IVTR (APA) or CIE-10 (WHO) which provide specific criteria to establish a diagnostic are normally only used by clinical psychologists and psychiatrists. DSM-IVTR provides a very useful diagnostic decision tree. In any case, it is advisable when using these categories to write the CIE-10 code (in addition to the DSM code) which makes comprehension easier amongst professionals who are not necessarily trained in the same system.

According to the technical level of counsellors, as well as the choice of psychological approach, many programmes do not pretend to identify more than symptoms or subjective sense of suffering/problems by the patient and therefore don’t implement a strict diagnostic system. Nevertheless, the supervision process needs to address the capacity of the counsellor to identify rightly the problem(s) of the patient so as to be able to provide the adapted support.

A basic way of categorising the problems of patients is the one described by GUUS VAN DER VEER (2001), without being a clinical diagnosis:

- Counselling a person about a practical problem or a difficult situation.
- Counselling a person about a lack of skills.
- Counselling a person with symptoms, complaints and problematic behaviour related to traumatic experiences.
- Counselling a person suffering from overwhelming feelings.
- Counselling a person about an inner conflict.

[5] KELLERMAN, “Ethical concerns in psychodrama”, Journal of the British Psychodrama Association, 14, 1/2, 3-19

Another way to categorise simply the major complaints of the patients is the one proposed by MSF-OCB in the clinical files: General symptoms, Symptoms of Anxiety, Symptoms of PTSD, Symptoms of Depression, Symptoms of Psychosis, Psychosomatic symptoms and Behavioural problems:

<table>
<tr><th>1. General Symptoms</th><th>2.Symptoms of Anxiety</th><th>3. Symptoms of PTSD</th><th>4.Symptoms of Depression</th><th>5. Symptoms of Psychosis</th></tr>
<tr><td>o Insomnia
o ↘ concentration
o Loss appetite
o Sexual Problem
o Low energy/weak
o Irritable/angry
o Enuresis</td><td rowspan="2">o Panic
o Phobia
o Constant worry/anxiety
o Restlessness
o Fear
o Heart beating fast
o Pain in chest/heart
o Breathing fast/difficult
o Trembling
o Always fearing the worst</td><td rowspan="2">o Intrusive thoughts of event
o Flashbacks of event
o Nightmares of Event
o Body react 2 reminder
o Avoiding reminders
o Overwhelming fear when reminded
o On Guard
o Easily startled, jumpy
o Repetitive games of event</td><td rowspan="2">o Sadness
o Loss of interest
o Hopeless
o No future plans
o Guilt
o Crying easily
o Suicidal thoughts
o Absent feeling
o Feeling worthless
o Thoughts of death</td><td>o Delusions
o Hallucinations
o Bizarre behaviour
o Disorganized thoughts
o Disorganized speech</td></tr>
<tr><td>6.Psycho Soma
o Headache
o Gastritis/stomach
o Pain in body</td><td>7.BehaviourProblem
o Substance abuse
o Aggressive behaviour
o Delinquent Behaviour
o Hyperactivity
o Withdrawal
o Regression in development</td></tr>
</table>

Counsellors have to choose the major category of symptoms according to the most present symptoms as well as the severity of that group.
When the counsellor has doubts, it is up to the supervisor to help him to analyse deeper the patient clinical history in order to help him make a differential analysis.

It is important not to play a "police officer" role, but to highlight well completed clinical files while verifying that key data are recorded and that there is coherence in the objectives set up and the progression of the support provided to the patients. Language used in the file may be simple but need to be comprehensive and clear enough for other colleagues to understand. We should not forget that a well prepared clinical file is useful also when a counsellor (for what ever reasons) needs to hand over a patient to another counsellor who will have to quickly get an idea about the case and the stage of the support process in order to do a proper follow up, even if a new therapeutic alliance between him and the patient should be established.

The most important information to be analysed in the Clinical files is the coherence between:

- Life events, problems and "diagnosis"
- Current state of the patient and definition of objectives and intervention strategies
- Follow up, adjustments and progresses

6. Set up and review of Inclusion criteria and Patients' flowchart

Inclusion criteria should be known and understood by all team members. Clinical criteria should be comprehensive for psychosocial workers, counsellors, and the medical team.
Other external factors such as being displaced/refugee, being victim of violence determine also inclusion criteria.
Therefore, everyone in the programme, even guards should acknowledge them in order to facilitate clear information and access for beneficiaries and the local population.

A visual flowchart with the circuit to be followed by a patient in the project is very helpful for everyone. Posting it around MSF offices and health centres, as well as explaining it to all team members will prevent misunderstanding and provide clear information to the population (see an example in Annex 4).

The patient flow should include referrals and counter-referrals in between the different professionals of the health structure, from and to physical health services, psychological service, social services if available, and external organisation for other type of support.

Inclusion criteria and patient flowchart should be elaborated at the beginning of the programme, regularly reviewed and modified along the way if needed.

7. Intervention's Objectives and Strategies Discussion

From time to time, it is also useful to review, with the whole team, the objectives, strategies and activities put in place in the mental health programme to ensure the best adaptation possible to the context's changing realities.

Using the problem tree and Logical Framework methodology, is a useful tool to define all possible intervention objectives and strategies with activities as well as a monitoring tool in order to improve and readjust projects.

Meetings and workshops with the team can help defining programmes in a participatory way. They are also useful for monitoring and evaluation.

Proposal of a scheme to discuss the programme in the team:

1. Strategy, coordination and team dynamic:
    a. Mental health / Psychosocial Strategy: communitarian, clinic, prevention and promotion, mix, etc.
    b. Coordination between the different components in the project: PHC, watsan, log, psychosocial, nut, etc.
    c. Coordination with other actors: aid agencies, authorities, associations, etc.
    d. Team composition
    e. Team dynamic

2. Technical evaluation:
    a. Needs evaluation
    b. Access to population
    c. Intervention coverage
    d. Activities: list all activities, describe and discuss Achievements and Difficulties for each one.
    e. Means and tools
    f. Adjustment of the intervention to the specific identified needs

3. Current situation of the population: For each age group (children, adolescents, adults, elderly people) and if relevant other population groups (displaced, refugees, children soldiers, handicapped people, HIV patients, etc.)
    a. Current situation
    b. Recommendations for the future intervention

4. Evaluation of results in the intervention (it could be mid-term evaluation). For example:
    a. Individual and community level
    b. Empowerment of individual and social resources
    c. Leadership empowerment
    d. Information coverage and awareness
    e. Strong and Weak points of MSF intervention:

5. Lessons learned:
    a. To review
    b. To replicate

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ANNEXES

ANNEX 1: RECOMMENDATIONS FOR ROLE PLAYS, PSYCHODRAMA AND SUPERVISION/INTERVISION TEAM CASE DISCUSSIONS

(Based on Manual for Counselling Interviewing –p.7,23,57; with adjustments)

Some interesting rules and agreements:

- You might want to agree that no one in the team judges another. We have all made mistakes, and in bad times people do the best they can. No one has to talk on an issue if they do not want to, and no one should put pressure on another.
- Show respect constantly towards the other colleagues.
- You might want to promise each other that anything said in the group is kept confidential. This would allow everyone to be franker about their own ideas and experiences.

For role-plays and psychodramas:

- You might suggest that it is fine for people to turn their own stories into fiction, or to tell stories as if they happened to someone else. You might even tell someone else's story as if it happened to you. This way, if someone wants to talk about a really bad experience like having to kill, or having to earn money through sex, it is never clear whether it is fact or fiction.
- You might want a group leader or you might want to take this role in turns. But make the choice at the beginning. It might also be a good idea to choose one group member for the following job: there are many role-plays for you to work through, and sometimes when someone plays the bad guy then afterwards they still feel like the bad guy, or feel like the others see them as the bad guy. So the job is to keep peoples' feet on the ground, to remind them it was only a role and that they are great people.

Making and Using a check-list for role-plays:

- On the next annex you will find a check-list to use when groups do role-plays of psychosocial individual interviews (counselling, orientation, etc.). It is not restrictive, so add other information or adjust it to your specific context, according to the behaviours that you want to look for. Make sure that you write it so that a "yes" answer is always positive. For example, write: "Did the counsellor use simple language?" where yes is good (and not "Did the counsellor use language that was too complicated?" where yes is bad). If you use check-list questions like this, then when it is filled in you will see the overall picture very clearly.
- Define case examples for the role-plays or use real examples from your project. Have at least two of the team members play it out (according to the situation). Then the rest of the team can together fill in the check-list.
- If you copy the check-list you can then split into groups of three, in which one person plays the counsellor, one the patient and one listens and fills in the check-list (observer). Then you could change over. You can practice as often as you feel you need to.
- If one of the team does poorly, please do not make him/her feel bad. Skills need practice. Many excellent cooks burnt the food when they first started.
- You will find that this kind of simple check-list can be used in many situations where you want someone to do a job better. It is a very handy tool. For instance, it could be used with a whole team working in a health centre to practice skills for receptionists, registrars, nurses, medical doctors, etc., and not only psychosocial teams.
- Depending on the type of activities in the project, only the first part (basic) of the check-list will be used. For role-plays about basic psychosocial interviews, for instance a community mental health worker who meets someone in the population in order to give some orientation. On the contrary when the activity consists on counselling or psychological consultation, use also the second part (advanced)

ANNEX 2: A CHECK-LIST TO EVALUATE PSYCHOSOCIAL INTERVIEWING SKILLS

Did the interviewer do the following?

PART I: BASIC SKILLS

CATEGORY OF SKILLS	SKILL	YES, A LITTLE, NO	COMMENTS
WELCOME	Welcome the person politely		
	Choose and adequate place and moment		
	Encourage an ambience of security and confidence		
BASIC COMMUNICATION SKILLS	Open attitude		
	Attentive listening (gestures, eye contact, position, etc.)		
	Ask good questions		
	Encourage to talk		
	Use clear language		
	Give feedback		
	Show respect		
IDENTIFICATION OF GENERAL PROBLEMS	Help to identify specific problems (food, water, shelter, health care, events, etc.)		
	Help to sort priorities (immediate needs…)		
GIVING INFORMATION	Give good and proper information (resources available for the community…)		
	Be clear about who does what and where; and do referrals if needed.		
CLOSING THE SESSION	Summarize the session		
	Make a further appointment		
	Say goodbye nicely		
OTHER	Explain confidentiality		

PART II: ADVANCED SKILLS

CATEGORY OF SKILLS	SKILL	YES, A LITTLE, NO	COMMENTS
IDENTIFYING PSYCHOSOCIAL PROBLEMS	Help the person to let out emotional issues		
	Detect signs and symptoms		
	Detect other psychosocial difficulties (family, social life, etc.)		
IDENTIFYING RESOURCES	Take appropriate steps with other family members and other resourceful persons		
	Find previous resources not used currently		
	Highlight strengths and improvements		
HELPING TO EXPLORE ALTERNATIVES AND TO MAKE CHOICES	Help the person to identify appropriate tactics for his/her problems		
	Help to choose concrete solutions		
ADVANCED COMMUNICATION SKILLS	Establish a good working relationship		
	Verify comprehension		
	Make silence possible		
	Make summaries		
	Make agreements		
	Help to think		
	Smile		
	Use physical contact when appropriate		
	Keep a clear record with all important information		
	Explain symptoms (normalisation)		
OTHER			

ANNEX 3: EVALUATION OF BASIC COUNSELLING SKILLS

(Based on Manual for Counselling Interviewing –p.25; 59)

A good counsellor does two things:
— identifies the client's situation and problems;
— helps the client make his own good choices.

Every counsellor needs to do these two things systematically.

Here is one way – with one check-list:

1 What can you learn from a good look at the patient – dress, posture, face?

2 Think and learn about events in the recent past – whether the client has had very bad recent experiences. Have they been part of violence, been told that they are sick (perhaps with AIDS), lost someone they love, and if so . . .

If they have been eating badly for some time . . .

If sleeping badly for some time . . .

If badly stressed for some time . . .

3 Think about their immediate needs. Do they need:

- somewhere to live?
- somewhere to live which is safe?
- access to food?
- access to water?

Do we know if there are resources available for the community for these needs?

Did the counsellor verify if the patient knows about these resources?

Did the counsellor give orientation?

4 When these needs are met, will they want/need:

- health care?
- schooling?
- paid work?
- the chance to show emotion?
- support from people like themselves?
- to take part in rituals and ceremonies?
- to find ways of being useful

Could the counsellor do a referral or give advice for these needs?

5 Do they belong to particular groups?

Children . . .

The elderly . . .

6 Do they have particular problems?

Over-using cigarettes/alcohol/khat . . .

Post-Traumatic Stress Disorder?

TO THINK ABOUT:

Are you looking at the patient in a systematic way?

Are you setting some goals for yourself and them?

Do you have a time frame in your mind?

ANNEX 4: EXAMPLES OF ROLE-PLAYS

(Based on Manual for Counselling Interviewing –p.55; 56)

1. man of 19
   "Since the fighting I have lost my house and my job. I have gone back to stay with my mother. I sleep all the time and have trouble getting out of bed, and my head is full of sad thoughts. What should I do?"

2. man of 35
   "Since the war, I manage to survive here with a small job. My wife and children are in the capital with my father. I think I have an ulcer because my stomach hurts all the time. And I sleep very badly. I have not seen my family for over a year – if I go on a visit I would have to bring expensive presents, so that they will respect me. What should I do?"

3. married woman of 18
   "My only child died four months ago and I am sad all the time. My husband wants me to have another baby but I hate the idea. I am becoming a bad wife."

4. married woman of 35
   "We have five children and I do not want to get pregnant again. In fact the idea makes me very tense. I had a very bad time in labour with my last child. I want contraception but my husband has forbidden it. I tell him I am not well enough to have another child. I am tired and have headaches all the time, especially in the evenings."

5. widow of 30
   "My husband was killed by the rebels so we ran away. I have just arrived here with my three children because I thought my uncle was here. But he isn't. We slept in a woodshed last night but we have no money and no food and the kids are sick and what can I do?" (starts to cry)

6. wife of 32
   "My husband has been told he is HIV positive; they tested me and I am OK. They said we should use a condom but my husband says he doesn't want to know; he will never have sex again. He is still healthy but very moody. Is there anything I could do?"

7. widow of 65
   "My husband was killed in the war, and my only child is now married in Europe. She sends me a little money so I can just live, but I only want to die. I have painful arthritis in all my joints. There is nothing in life to give pleasure or purpose."

8. boy of 15
   "I was separated from my family four years ago in the fighting. The Red Cross are looking for them. They thought they had found them over the border but yesterday they told me it was not my family. I wish I still had my rifle."

9. widow of 35
   "My husband and children were killed in the fighting. I live with my brother and his family. The eldest niece is 15 and looks exactly like my own dead daughter. Every time I see her it is a knife twisting in my heart."

10. Widow of 25.
    "I arrived in the town this morning with my two children. My husband died of AIDS last week and it is the custom in my ethnic group for widows to be married quickly to their brother-in-law. I don't want this because perhaps I am not infected and I am sure he is. He runs around with prostitutes. (Also I don't like his wife who would be in charge of me but I would not say that). Now I have nowhere to stay and the 8-month-old baby has a fever (I am also pregnant but I don't want to say that because the gap between the baby and the pregnancy is so short. I

have stopped breast-feeding the baby and he is looking thin). And I loved my husband and want to pray for him but I am missing the funeral and if I am not careful my relatives will find me and take me back and Oh Dear I don't know what to do."

11. Man of 23.
"I an HIV positive and have had one episode of pneumonia, so I guess I now have AIDS. I was infected by my girlfriend. She told me she had only had one lover, but later I heard she had many. She must have suspected that she was infected when we met. I am so angry with her. I manage daily life by wearing a mask of control because it would be very bad to admit my fear and anger."

12. Widower of 26
"I came to this town with my two sons when my wife died. I thought I would find family here but they have left. So I am bringing up my children on my own. I get a bit of money from my brother overseas most months. I can make porridge so I do that every evening, and I keep some for breakfast. Then I buy snacks and biscuits for the kids when they are hungry, if I have the money. Yes, I can see they are skinny. Yes I buy cigarettes and the odd beer. But how else can I get by?

ANNEX 5: EXAMPLE OF A PATIENT'S FLOWCHART

(Based on Referral Criteria Medical Staff, February 2007, annex 2–p.5, Mental Health IWG- MSF)