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Training for impact

The International Training Programme on Development-orientated Psychosocial Care for communities affected by the Tsunami and other disasters

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The front cover photo shows Mr. M. Baskaran of the Centre for Social Education and Development (CSED) of Coimbatore, India participating in the first training programme in Sri Lanka.

The back cover photo shows Dian Marina of PULIH Aceh during the Indonesia training programme.

Preface

After a disaster the mental health (otherwise known as psychosocial well-being) of a population is affected due to the following reasons:

- Loss of lives, house, property, livelihoods and personal belongings
- Traumatic events such as near-death experiences and witnessing the impact on other people
- Physical injuries and illnesses
- The need for survivors to live in a temporary welfare centre

After the tsunami in 2004, BasicNeeds Sri Lanka was invited to support communities in their process of recovery. Through previous experience, practitioners in Sri Lanka knew that a focus on mental health would be essential to support communities, families and individuals in coping with the impact.

BasicNeeds formed the view that this model could be shared with individuals and organisations with a view to using it effectively in new locations. The International Training Programme on Development-oriented Psychosocial Care for Communities affected by the Tsunami and Other Disasters was formulated and conducted with the intention of sharing our experience.

This publication represents our learning in this area. It explains the two parts of the programme. The first module in the ten-day residential 'training of trainers' programme in which participants were provided with theoretical and practical training in community mental health and development in disaster settings. The second module was a twelve-month follow-up programme that enabled participants to gain from further skill development.

As a principal tutor of the International Training Programme, I have benefited immensely from the opportunity provided to share our experience with local and international participants. Publication of the story of this work will further enhance the capacity-building process.

Dr. Neil Fernando, Consultant Psychiatrist, National Institute of Mental Health, Angoda, Sri Lanka

Foreword

After the storm comes the quiet. I sat in the quiet office of our organisation in the UK waiting. Sadly only one day after Christmas and the festivities already forgotten I waited with my mobile phone pressed tightly in my hand. I was waiting for a sign that our colleagues were alive and that their families were well for this was 26th December 2004 and the Tsunami had devastated a substantial portion of the island of Sri Lanka as well as so many other countries. Our own Chintha Munasinghe, our own staff teams and many local volunteers went to work for the rescue effort alongside professionals such as Dr. Fernando who writes the preface to this book. We moved rapidly from general emotional help to a more substantive approach providing options for long term mental health support. We soon realised that we had a model of action which we wanted to offer others not only from Sri Lanka but also from all the countries in the Tsunami affected region.

Steve Fisher, the author and the leader of ITP, demonstrates the impact of this work on the final beneficiaries as well as the trainees who attended from organisations from across the region. He pays tribute to the team nature of such an enterprise and draws out the skills required to make this multinational training programme a success. After the storm comes the quiet. This is a thoughtful book which reflects on what can be done, and done successfully, to support the long term mental wellbeing of people affected by sudden and unexpected tragedy. In reading it we learn, we reflect and we remember.

Chris Underhill, Founder Director, BasicNeeds

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Introduction

Capacity-building has long been a mainstay of development programmes. However, training initiatives rarely grow from the actual practice of development during and after an emergency caused by a natural disaster. And trainers seldom feel the need to measure the results achieved by trainees after they complete the programme.

This publication describes the process by which BasicNeeds used its experience of establishing mental health services in tsunami-affected communities in Sri Lanka to create a training model which established new mental health initiatives in other affected locations. The story of the International Training Programme in Psychosocial Care for Tsunami-affected Communities has much to say about engaging development practitioners in new ideas, scaling up programmes and measuring impact across dispersed locations.

Meeting mental health needs after the tsunami in Sri Lanka

A massive earthquake occurred off the western coast of Sumatra on 26th December 2004. It was recorded as the fourth largest since 1900. The tidal waves generated from this earthquake swept across Indian Ocean causing devastating damage on the coasts of four countries and affecting ten others. Impact was greatest on Indonesia, Sri Lanka, India and Thailand, while Malaysia, Maldives, Myanmar, Bangladesh, Somalia, Tanzania, Seychelles, South Africa, Kenya and Yemen were also affected.

Basic Needs Sri Lanka (BNSL) responded to the needs of tsunami victims in Southern Sri Lanka immediately after the devastation. BNSL was requested by the Provincial Director of Mental Health to work directly with the most affected fifty-seven communities in southern Sri Lanka to address the mental health needs of local people. Rapid support from the UK Department for International Development (DFID) through its Conflict and Humanitarian Affairs Department (CHAD) enabled us to respond immediately to this request and for staff to work in the field from the first day of the emergency. BNSL could already count on trained community leaders and field workers of the partner organisations in their existing community mental health programme in the Southern Province and this also enabled a speedy and well-directed response. They set to work to train volunteers to work in five-member teams deployed to highly-affected communities. The work of the teams was supported closely through study days and reviews every month. In the first period of three months of work, a network of support to tsunami-affected communities was established providing support to several hundred families.

The emergence of a model of practice

In a situation of chaos and with time short and needs large, the people with whom BasicNeeds worked needed to rely on a structured approach to enable them to operate in an organised manner. In the early stages and without the luxury of spending much time developing and formalising the work, it was clear that a model of practice was emerging from the experience.

The work naturally divided into four components, summarised in the diagram below.

This approach is adapted from the Model for Mental Health and Development, which is more widely known and applied across the work of BasicNeeds and its partners. Due to the effectiveness of this model of operation, which we called the Development-orientated Psychosocial Care Model, it attracted interest from others. Support came from the World Health Organisation, the Institute of Psychiatrists of United Kingdom, the World Federation for Mental Health. It was featured by the BBC in its coverage of responses to the tsunami.

At the end of the first period of work with tsunami-affected communities, BasicNeeds formed the view that this model could be shared with others and used effectively in new locations. We did not have the capacity to work everywhere, but other organisations were already active in community mental health, social programs, rehabilitation projects and a range of other initiatives that followed the huge international response to the tsunami. Offering to share the experience with them and to conduct training programmes for their staff would enable more people with existing mental health problems or who were vulnerable to the psychological effects of the disaster to benefit from the work BasicNeeds had done in the Southern Province of Sri Lanka.

On this basis, Chris Underhill, Founder Director of BasicNeeds and Chintha Munasinghe, Country Programme Manager of BasicNeeds Sri Lanka, started to work out how an International Training Programme for practitioners working in tsunami-affected communities could be devised and implemented in practice.

Voices from tsunami-affected communities

In 2005, BasicNeeds conducted a study of tsunami-affected communities of Southern Sri Lanka. We gained insights on the situation that helped us plan for the training programme and would influence the character and content of the programme throughout its life. The key areas of learning from that study were:

- Underlying many of the problems that afflict people is a large and often unmet need for access to mental health services both among people traumatised by the tsunami and those individuals suffering from mental illness and unable to gain access to proper treatment and support.
- Part of the difficulty of providing these services lies in identifying problems which can manifest themselves in various ways that people do not necessarily associate with mental illness. For example, there were examples of fisher folk or farmers being unable to return to work due to treatable disorders such as depression. There are instances where families have fallen into conflict, where alcoholism has increased or where, quite simply, women have been unable to find the energy or commitment to look after their families in the way that they did before.
- The majority of these problems are attributable to mental disorders to which people affected by disasters are particularly vulnerable. These illnesses are mainly post-traumatic stress disorder or depression, but may include conditions such as anxiety disorder. Within families affected by disaster are groups that are themselves more vulnerable to mental illness, such as elderly people and people with physical disabilities.
- The appearance of mental health problems in a population that has been exposed to and experienced a severe abnormal event such as a disaster is a normal reaction. The tsunami itself can be seen as a stressor that triggered mental illness among affected people.
- Many organisations and individuals feel under-prepared to identify and respond to the mental health needs of affected populations.

The involvement of many community members and survivors of the tsunami as animators within BasicNeeds existing programmes refined and strengthened the programme design. An example of the views of Sriyani Dhammika, Deepa Dayani and D.P. Kumarasinghe, a group of animators, is included below in the form of their responses to questions about their experience:

How have you coped with the stress you have suffered following the tsunami?

I became ill after the tsunami, but because I have been trained in looking after mental health, I was able to handle my problems in a positive way. This has helped me to reach the point where I am now. I started doing animation while I was ill, but did it more after I recovered.

Can you tell us about the responses of people to your work in mental health? When you go to a new village, what happens when people ask for materials and other physical aid rather than emotional support?

There are many organisations that give materials and physical assistance but we are filling a gap in emotional support that has always been accepted by the people as being useful to them. We have the confidence that we have a role in, for example, working with children.

What system do you follow for assisting or treating people with mental illness?

In the tsunami-affected areas, we visit people's homes. It is not difficult to identify people with mental health problems. We refer them to clinics and to mental health camps where they can receive support, counselling and can stabilise themselves.

What is the first thing that crossed your mind when you were approached from BasicNeeds?

I met BasicNeeds, who asked me to write down all our problems. We set up a volunteer committee, which helped us organise ourselves. The only honest organisation in our area is BasicNeeds and so we trust them and work with them. Many people have been able to stabilise themselves now.

What specifically do people need to help them return to a normal life?

People often have social adjustment problems. The priority is to help them in this area so that they have confidence. That way they can see their own potential and can become involved in business development programmes, for example.

The right participants

The insights gained through the practical experience of implementing mental health and development programmes after the tsunami were the best possible practical basis for the training programme. Combined with the knowledge generated by talking with individuals, families and organisations during 2005, we started to put in place the building blocks of the programme that are summarised in the conclusion of this publication. But imagining a training programme that would extend the positive impact of existing work in Sri Lanka and actually achieving that aim are quite different things.

One particular challenge was to establish a system for selecting people to join the programme. We wanted to make sure that we found people who would participate in the training and then make a difference when they returned home. This set us thinking about three key factors that eventually determined the marketing of the programme to potential participants and the criteria for their selection:

The qualities of participants

In selecting participants, we looked for evidence that the individuals were motivated towards working in mental health. This often meant that they were already engaged in providing mental health services, either as clinicians or community workers. Or it could be that they were working in a field such as disaster rehabilitation or disability, where mental health issues are often apparent but responses are inadequate. Coupled with evidence of their motivation, we also looked for capacity in each person to gain maximum value from the training by understanding and being able to use the knowledge gained.

Activity of organisations

In achieving impact from the training, it was critical that practitioners returning from the course and entering the subsequent follow-up programme were in a position to make something positive happen within their organisations. At a basic level, this meant that they would be able to incorporate the knowledge and skills gained to the existing work with people who might be vulnerable to mental health problems. Or it could be that they would be able to start a new initiative through a consultation workshop, a training session for colleagues or the recruitment of volunteers to support community mental health work.

For this reason, selection of participants favoured those already active in programmes run by government or non-government organisations rather than people seeking work or operating as freelance staff or consultants.

Location

We targeted the training towards organisations working in disaster-affected or disaster-prone areas where community mental health services were limited and especially those in tsunami-affected areas of Asia. This aspect of the programme was central to the marketing of it and a central consideration in the selection process itself.

The importance of getting the selection of participants right became more apparent as we proceeded through the evaluations of completed courses and planning for the next. A small number of participants invited to the first two programmes turned out to be unprepared for the commitment required or had misunderstood its relevance to their work. In some cases, the level of English stated by participants on their application forms was not, in practice, high enough for them to properly understand the material without an interpreter.

These experiences, which were confined to a small number of people in the first two programmes, led BasicNeeds to strengthen the selection criteria for the programme. Marketing materials defined expectations of participants more clearly and we went to lengths to confirm the English language skills of participants applying to join programmes where interpretation was not provided. We did not approve applications from people who saw the opportunity only as professional development and did not demonstrate their ability to implement any mental health initiative when they returned home.

Participants undertaking an exercise on the impacts of disaster at the first programme in Sri Lanka.

Design of the training programmes

Objectives

From the outset, we saw the programme as an opportunity to share the knowledge gained in the Southern Province of Sri Lanka with people working in communities throughout the affected area of the country. But we also wanted to attract practitioners from other countries too. The Northern Rock Foundation and the One Foundation shared this vision and we planned the programme in this way, putting a strong emphasis on publicising it through web-based methods, such as existing networks, websites and an e-brochure.

Specifically, the programme set out to achieve the following:

1. To build capacity for designing and developing community-led psychosocial care programmes led by trained practitioners;

2. To prepare action plans for implementing psychosocial care programmes in areas from which participants came;

3. To support participants in the implementation of action plans in their own localities.

In order to maximise the potential for new initiatives to be established, we directed the programme towards participants from the following groups:

1. Community development practitioners or field workers.

2. Coordinators and managers of disaster management and reconstruction projects.

3. Psychosocial workers in tsunami-affected areas who are keen to implement the BasicNeeds Model of Mental Health and Development.

4. Those who are interested in community mental health and development and in a position to become a practitioner through their existing work.

Programme content

The programme comprised two parts. The first module was a ten-day residential 'Training of Trainers' programme in which participants were provided with theoretical and practical training in community mental health and development in disaster settings. In addition, participants experienced BasicNeeds programmes first hand and met with volunteers, psychiatrists, development workers and survivors of the tsunami. The chance for participants to learn from the communities in a structured and participatory way was central to the training programme.

The second module was a twelve-month follow-up programme that enabled issues arising to be discussed and addressed and participants to gain from further skill development over a twelve-month period. Overall, participants used their skills to develop programmes in their own countries, to integrate new approaches into their existing work and to train and support other staff in working with disaster-affected communities.

The content of the residential programmes was organised around the following modules:

A development approach to mental health

An introductory session on mental health viewed from a development perspective, with emphasis on exclusion, poverty, livelihoods and human rights. This session established the conceptual framework for the training programme, encouraging participants to view recovery from mental illness as a continuum of care in which increased community awareness, self-help groups, support to livelihoods and other developmental support all play an important role.

Mental health issues in relation to disasters

The purpose of this session was for participants to understand the mental health issues associated with disasters and identify resources and skills available at country level that could help address the needs identified. The story of the response of the Ministry of Health, BasicNeeds and other agencies to the trauma of the tsunami was central to this part of the programme.

Common mental disorders and related problems associated with trauma

The first clinical session within the course provided introductory material on the practical understanding and recognition of mental health problems associated with disasters. The subject was explored through practical examples and first-hand accounts of the aftermath of the tsunami in Sri Lanka, as well as a typology of mental health disorders and a discussion of the characteristics of each.

Psychosocial interventions

This was the central component of the mental health part of the training programme. The purpose was to enable participants to understand the principles and practice of psychosocial interventions of value in emergency situations. Topics covered ranged from basic helping skills and relaxation therapies to group work and cognitive therapies. Most importantly, this part of the programme introduced participants to basic helping skills required in responding appropriately to mental health problems in disaster situations.

Caring for your own emotional health and well-being

Understanding the vulnerability to emotional problems that individuals face and using approaches to coping with them. This session was valuable in helping participants to empathise with people vulnerable to mental health problems caused by disasters. It enabled the use of group work and visual exercises to explore the pressures and support available to participants and to explore them through wider discussion.

Animation skills

The first session on development approaches to mental health, the purpose was to familiarise participants with social animation methods used by BasicNeeds to underpin the work of raising community awareness of mental health and build capacity and support for community-based responses. Theoretical understandings of community and culture were explored and examples of animation in practice were provided, included the video 'Power of the Voice'. Participants were invited to describe a community with which they were familiar and to conduct a role play exercise on animation.

Field visit

The field visit provided an opportunity to gain exposure of a community consultation workshop and to analyse and reflection on the experience. In Sri Lanka, visits were made to communities in the south of the country, particularly in Hambantota. In Indonesia, the field visit was made to a district of Jakarta that is affected by flooding every year, while in Bangladesh the group went to settlements that are prone to coastal cyclones. The field work was an opportunity to meet with community members and discuss their approaches to coping with the threat of disaster and, in Sri Lanka, recovery from the tsunami. A group exercise then explored the observations and key points of discussion arising from the day.

Process documentation, reporting and data collection

This session provided participants with an introduction to the techniques used to identify, develop and use an information and evidence base for a development-orientated psychosocial care programme. The underlying aim was to enable participants to appreciate how they could monitor and measure the impact of work undertaken by their own organisation.

Situation analysis for people affected by the tsunami

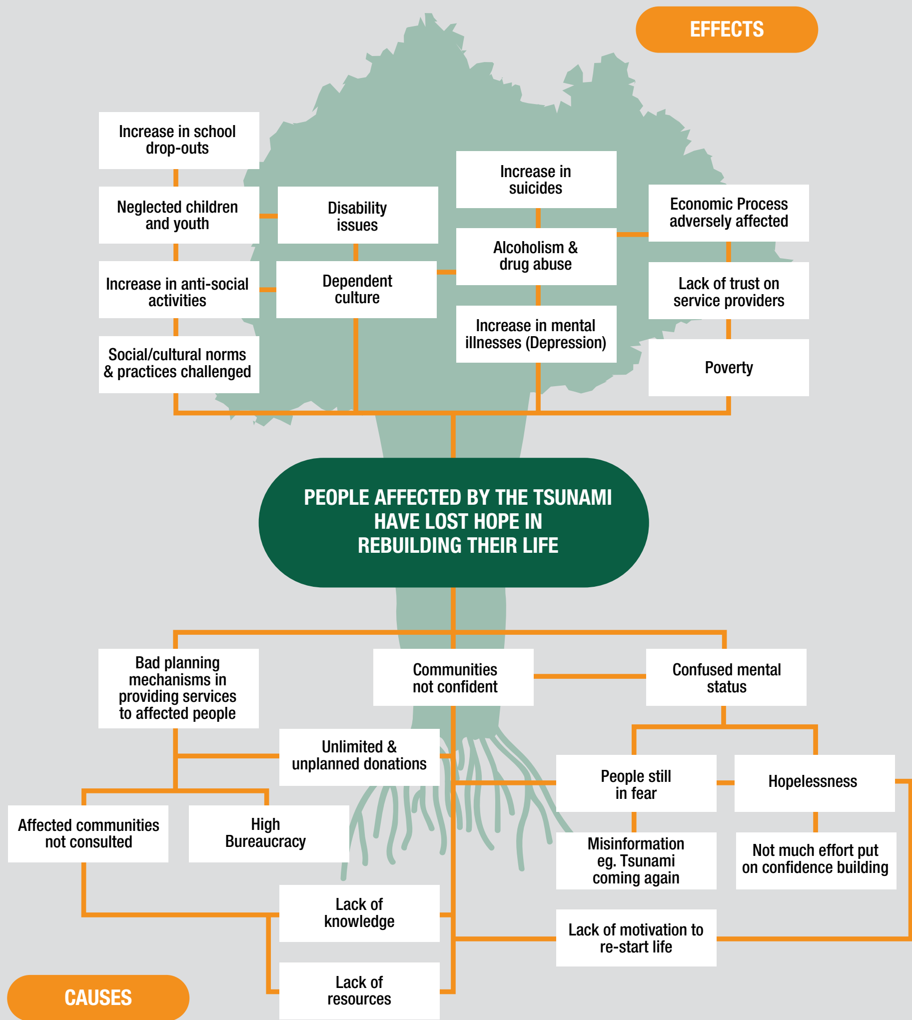
Entering the part of the course that started the planning of initiatives in mental health and development, the purpose was to analyse the situation faced by communities vulnerable to or affected by disaster. Examples of life stories collected by BasicNeeds were used to describe the challenges faced by individuals and families affected by mental illness.

Project development and planning

Participants developed the skills of project planning by conceptualising approaches to the addressing the problems and needs of people affected by the tsunami or other disasters in their countries. Problem and objective trees were used as a basis for analysis, leading on to logical framework planning for a typical project. Trainers encouraged critical feedback between groups to enable improvement of the plans as they developed.

Preparation and presentation of action plans

Completing the training programme, participants developed their own project and action plans with support from BasicNeeds and feedback from other members of the group. These plans provided a basis for the relationship between BasicNeeds and participants during the subsequent follow-up programme.



The problem tree is a tool that is commonly used for development programme and project planning. It is a method that helps to focus participants in a planning process on a central problem and map out the causes and effects that relate to it.

The problem tree was one of the analytical tools used in the course and proved to be a valuable way to support a transition from the mental health focus of the first half of the course to a development perspective in the second half. The problem tree, along with other techniques adopted by the resource team, also helped concentrate participants on the practical application of mental health and development in communities that they already knew well.

The version shown above was adapted for the programme by Chintha Munasinghe to illustrate an example from a tsunami-affected area.

Resource team

Underpinning our ambitions for the International Training Programme were the skills and commitment of the resource team of trainers brought together to lead the individual sessions and to support the follow-up programme. Reflecting the mental health and development aspects of the model used for the training programme, we established a pool of professionals from within the organisation and from partner organisations in Sri Lanka.

Dr. Neil Fernando and Dr. Mahesan Ganesan of the Ministry of Health, Sri Lanka, and Dr. N. Janardhan of BasicNeeds India provided leadership to the mental health sessions within the programme, bringing a clinical perspective to the material. For the development part of the programme, Chintha Munasinghe of BasicNeeds Sri Lanka, Mr. D.M Naidu of BasicNeeds India and Steve Fisher of BasicNeeds Australia were the lead individuals. Several other people made contributions throughout the programmes or in supporting roles.

The full group of individuals within the resource team is acknowledged in the conclusion of this publication. The number of trainers invited to lead a full programme ranged from between four and eight, depending on the budget available for each, the location and their availability.

Intensive lecture sessions were interspersed with group and visual exercises. This seemed to work well for a group that showed varying proficiency of English language skills between participants.

The field visit to Hambantota enabled the local community and self-help groups to demonstrate the techniques that they use for working together and planning. This photo shows a cooperative game to build teamwork skills.

Group analysis of issues in mental health was central to the training methodology.

Dr. Fernando of Angoda Hospital, Colombo.

The training programmes in practice

The process of turning an idea for training into an international programme for which a multinational group of people register is an exciting one. After a period of intensive preparatory, planning and assessment of needs during 2005, the training itself commenced in early 2006. The level of anticipation that everyone associated with BasicNeeds Sri Lanka felt during the lead-up to the first programme was palpable. As participants arrived from each of eight countries and made their way to the venue in the Southern Province, so we felt that this was the start of a challenging process. By the end of it, over two years later, we had conducted six programmes in all, with the twelve-month follow-up programme for the final programme coming to a close in May 2009. The overall cost of the International Training Programme was £300,000.

The first International Training Programme in Development-orientated Psychosocial Care for communities affected by the Tsunami and other Disasters was held in February 2006 at the Emerald Bay Hotel, Induruwa, Sri Lanka. Twenty-eight participants from six countries came to the programme. It was endorsed by Dr. Hiranthi De Silva, Director of Mental Health Services in Sri Lanka, Dr. S.W. Pathinayake, Provincial Director of Health Services South, Mr. C.L. Rathnayake, Chief Inspector of Special Task Force and Dr. Palitha Abeykone, Consultant Advisor to the World Health Organisation, Colombo, who attended in person at the opening or closing ceremonies.

A community consultation workshop held during the first training programme in southern Sri Lanka.

At this time, Sri Lanka was still recovering from the tsunami. The physical signs of disaster were obvious everywhere in the broken bridges and roads, the signposts to reconstruction projects and livelihoods initiatives and the ubiquitous blue tarpaulins covering temporary shelters or replacements for lost roofs. Many people along the road from Colombo to the Southern Province were living in camps for internally displaced persons. The mental health consequences on the population were apparent for anyone visiting the area. The Emerald Bay Hotel itself had been damaged by the tsunami and renovation works had only recently been completed.

Role play and group exercises were a key part of the course.

The training methodology was one of participatory learning with participants encouraged to engage in work in pairs and groups and to work in role plays, discussions and active exercises designed to develop and put into practice their learning. A number of tools and techniques were used, drawn from the field work experience of BasicNeeds Sri Lanka and with contributions from BasicNeeds India, especially for the social animation sections of the programme. This was the first time we had used participatory approaches in an international training course. We spent time evaluating the experience.

Participatory exercises were popular with participants as they enabled people to share experiences from their own countries and communities.

Another key feature pioneered during the first programme and which subsequently became central to the methodology was the field visit described in the previous section. This overnight trip enabled participants to see a 'real-life' consultation workshop in progress as part of a mental health and development programme. In particular, the skills and techniques of the animators could be observed and the reactions and involvement of the community members noted by participants. A highlight was the subsequent discussion of the observations of participants, which we organised as a stop on the return journey to the training venue. This was a facilitated session using cards for participants to identify aspects of the community workshops that impressed them, which features they particularly noticed and those that puzzled or concerned them.

After two programmes in February and July 2006, we started to see the emergence of a network and 'community of practice' in mental health and development for disaster-affected areas. No less than seven participants came to the course from three small NGOs in Aceh, plus two influential individuals from Bangladesh and Thailand respectively. As usual, there was a strong representation from South India; six people from six separate organisations. These participants took steps to maintain contact with each other after the programme.

A particular interest of participants was the opportunity to learn about approaches to caring for their own social and emotional well-being. This would then enable them to advise tsunami-affected people facing the stresses and pressures of recovery from the disaster, often over an extended period. After two programmes, we strengthened this section of the course and made it a regular feature to which participants responded well as it lined up with the overall philosophy of mental health and development programmes in taking a holistic, empathetic view of the challenges facing individuals and families.

Over time, the range of exercises and role plays within the programme was enhanced by the ideas and contributions of participants themselves. We introduced more demanding processes that required participants to offer a critique of the work of other groups. This was a response to the concern of the resource team that participatory training approaches can make the mistake of substituting enjoyment for learning value if mechanisms are not built in to challenge the work that is done in groups. In addition, the parallel process of conducting follow-ups with previous participants started to have a bearing on the training itself.

Specifically, it enabled us to anticipate challenges faced by participants and talk about them during the training course. This helped participants to prepare better for the work of implementing an initiative in mental health.

During the two training programmes conducted in Sri Lanka during November 2006 and July 2007, it became apparent that the benefits of running a similar course in Indonesia would be considerable. Not only were most participants from Indonesia, especially Aceh, but their commitment to the BasicNeeds approach was very strong. In fact, at least four organisations in Indonesia urged us to hold the programme there and to present it in Indonesian, as well as English, so as to be able to reach a larger number of suitable participants. We chose to hold the programme in Jakarta for the same reason; we felt that more people from tsunami and other disaster-affected areas would be able to come to Jakarta than Aceh.

The programme in Indonesia was presented during November 2007 in association with the PULIH Foundation, a local NGO which provides psychosocial care services and had sent participants to a previous programme in Sri Lanka. Overall, we welcomed 25 participants who met the selection criteria for the programme. It was interesting to note that the range of backgrounds of participants' organisations and the disciplines represented in the group, was wider than we had experienced before. This is a feature of Indonesia, which has a population approaching 200 million and is diverse geographically and economically. But it also indicates an increasing interest in community-based mental health initiatives outside those professional disciplines that usually relate to mental health.

Participants visited new housing developments community workshops in the tsunami-affected region of Sri Lanka and met with trained animators and community mental health volunteers, often in their own homes.

The sixth and final disaster-related training programme held in Bangladesh in May 2008 was very effective in achieving its immediate goals, mainly due to the strength of our main partner, Social Assistance and Rehabilitation for the Physically Vulnerable (SARPV), but also through the overall level of energy and engagement of participants. The programme was held in Cox's Bazar, on the south-east coast of the country.

Taking part in community workshop processes in Sri Lanka was a central element of the training experience for all participants.

Evaluations by participants

Participants in the training programmes completed daily evaluations covering four aspects of the programme; knowledge gained from the session, handouts, clarity of presentation and methodology used. The overall aggregated evaluations of the 120 participants across the six ten-day training programmes are summarised in the table below:

	Very good	Good	Average	Needs improvement	Cannot say/ no comments
Knowledge gained from the sessions	49%	40%	10%	1%	0
Handouts	42%	43%	11%	1%	3%
Quality of presentation	44%	43%	12%	1%	0
Methodology used	45%	44%	9%	1%	1%

The field visit to Kampung Melayu was a chance to discuss at first hand the challenges of community mental health in a disaster-affected settlement.

The evaluations show that between 85% and 89% of the responses of participants rated the knowledge gained, handouts, quality of presentation and methodology used as either good or very good. Only 1% considered each of these aspects in need of improvement. It is notable that slightly higher ratings were achieved for the knowledge gained and methodology, confirming that participants responded well to the participatory approach that BasicNeeds took to the material and that they considered the learning value to be high.

Meetings with people in Chakaria offered insights into ways in which they care for their own mental health and cope with the threat of disaster. There are specific issues that have come from previous experience of cyclones, such as the lack of good bridges on some evacuation routes, as shown in the photo on the left.

In addition, nearly all participants offered comments on the overall assessment of the programme.

I work specially with children and adults who were affected by the tsunami disaster. There are a large number of children who lost their parents and family members. Most of them live in temporary shelters. They still feel sorry and anxiety about their past. When I work with these children I observed that they have psychosocial needs as well as biological needs. Therefore, as a psychosocial worker, we must have the knowledge about psychosocial needs of people.

Roshan, ECSAT Sri Lanka

The training is useful and attractive because we haven't had that kind of training available to us before.

Kyaw Lin Oo, Coordinator, Grassroots Development Committee, Thailand

Many times the role of religious leaders in supporting families affected by mental health was pointed out by participants.

Anibal and Florentino, the two participants from Timor Leste, brought their own perspective on disasters and mental health.

The BasicNeeds Training Programme is very useful because it is easy to implement, to adapt and to communicate with people. It is a programme that should not be neglected or overlooked.

Ulya Fasrini, CEO, Comunitas Siaga Tsunami, Aceh, Indonesia

I have been working for the tsunami-affected people to enable them to rebuild their lives with dignity through empowerment and holistic social approach thus bringing them into the normalcy of life. The training of trainers programme will benefit me to enhance my knowledge and skill so as to impart them successfully in the communities. It will enable me to cater to the psychosocial care and needs of the tsunami-affected people in the communities.

Mary Jasmine, Church of South India, Kerala

The flexibility and patience of the facilitators was the most positive thing that I noticed here. The programme was excellent and beyond my expectations in terms of knowledge gained. I've attended many trainings but this one was quite different and perhaps the best.

Nosheen Waqar, BEST, Pakistan

This programme explains many aspects of psychosocial care and it gives opportunities for participants to share their experiences

Harya Bhimasena, Ibu4Aceh

These comments offer some insight into the motivations and backgrounds of participants. Many were from local or national NGOs that are, in many ways, overwhelmed by the scale of the problems that they are trying to address and where mental health is an issue that seems all-pervasive. In other words, where they are principally focussing on women and violence, then mental health problems are present too. Where organisations are working with disabled people, then the vulnerability of their client group to mental health disorders is higher than the general population.

Groups of participants conducted role plays of situations faced by NGO staff seeking to talk to families about mental health issues. Each play was discussed and analysed by the rest of the participants as a means of gaining learning value from it.

Dr. Ganesan of Batticaloa Training Hospital ran sessions on identifying symptoms of mental illness and designing interventions. The exercise shown here involved confronting and coping with fears. Melisa Yunisafina of Ibu4Aceh is pictured in this image.

Group discussion following the field visit in Jakarta.

The follow-up programme

As described earlier, we considered follow-up contact with participants to be critical in supporting them to achieve their aims after completing the residential programme. We formalised this idea into a twelve-month programme that became a central part of our commitment to improving access of people affected by mental illness to appropriate support and services. Basically, this was a key element of the strategy for achieving impact from the training courses themselves.

The follow-up programme had two objectives:

1. To reinforce and strengthen the learning of participants gained through the course itself.

2. To support the practical application of psychosocial care programmes in communities in which participants work.

The approach that BasicNeeds adopted was to enable structured contact between participants and the resource team at intervals over a twelve-month period. This involved the following:

- Reports provided by participants on the work that they are doing, with comments and advice sent back to them by BasicNeeds;
- Visits by members of the programme resource team to participants in their own organisations to discuss work in person;
- Participation in review meetings held in South India, Sri Lanka, Thailand, Indonesia and Bangladesh;
- Contact through email, letter, telephone or Skype (voice or text over internet).

Our commitment to participants was that they could expect access to a follow-up programme that met their aspirations while being manageable for BasicNeeds. In return, our expectation was that participants made a commitment to applying their knowledge and skills in practice and that they report to us on the progress that they made. If this was not possible for any reason, they we expected them to advise us and negotiate any changes to their participation in the follow-up programme.

During the period of the training programme as a whole, review meetings were conducted by members of the BasicNeeds resource team in the following locations:

- Kaolak, southern Thailand in April 2006.
- Meulaboh, Aceh Province, Indonesia in November 2007.
- Banda Aceh, Indonesia in November 2007.
- Trichy, India in May and November 2006, July 2007 and November 2007.
- Polonnarumwa and Colombo, Sri Lanka in May 2005 and February 2007.
- Bangalore, India in February 2008 and September 2008
- Jakarta, Indonesia, November 2008
- Dhaka, Bangladesh, December 2008

The progress of participants in the Maldives, the Nicobar and Andaman Islands and Pakistan was supported through e-mails and using Skype internet-based telephone technology.

Not all reviews required a formal meeting or workshop. In two cases, Meulaboh and Kaolak, there was a small number of participants and so we visited and spent time with them discussing the implementation of their work, the particular challenges that participants faced and providing information drawn from the experience of BasicNeeds. Like Banda Aceh, Meulaboh was badly affected by the tsunami and a number of organisations were active in providing mental health services during the period following the emergency. Many sent participants to subsequent BasicNeeds training programmes.

Aarthy Balakrishnan and Mary Jasmine using a card-based exercise to analyse the situation facing tsunami-affected communities in South India.

But the other reviews were conducted as one- or two-day workshops for which we established a pattern that enabled the greatest value to be gained for participants and was largely defined by their needs and expectations. In some cases, participants were able to attend more than one review. Despite the meetings being held in the regions that they were based, many still had to travel long distances on public transport to attend, so it was important that the time was used to the maximum.

An exercise on giving and receiving Feedback, conducted as part of the section of the programme on social and emotional well-being.

The structure of a typical workshop included four parts:

1. A report on progress by each participant. Given that many review meetings were held at least six months after the end of the training programme, this was a good opportunity for sharing of experience between participants. BasicNeeds staff identified issues for discussion, drawing out common elements.

2. Discussion of common themes. A structured discussion around the issues arising from the presentations enabled collective effort to be directed towards working out how to adapt the learning from the training programme to the challenges of the local context. The key issues are described below.

3. Further training. Through the preceding discussion or from suggestions by participants themselves, each review included a session that either reinforced parts of the training programme or tackled new areas of interest.

4. Planning the future activities of participants, especially through discussing options, exploring through collaboration between organisations and providing feedback on ideas.

Themes that arose during the review meetings and became subjects of discussion or further training included:

- Self-help groups, especially ways to establish and support groups without creating dependence on an external facilitator.
- Approaching communities about mental health, especially making the first interaction effective and then how best to talk about mental health and to spend productive time with local people.
- Working with communities that may be suspicious of outsiders or consider NGOs solely as sources of material assistance, especially in cases where basic services are not currently met.
- Project management, including logical framework planning and systems for managing resources.
- Basic helping skills for working with people vulnerable to or affected by mental health problems.
- Ways to tackle stigma, a major barrier for many participants.
- Identifying mental health problems.
- Gaining access to clinical support, especially in districts where there is no psychiatrist.
- Developing information materials on mental health.
- Models for integrating mental health into existing programmes.
- Attracting resources for new work, especially through developing high-quality proposals for potential funding.
- Effective ways to increase the importance of mental health more generally in society and specifically within local organisations, who often are unable to prioritise it above other concerns.

Participants from Tamil Nadu use a role play to illustrate ways in which local people cope with bereavement.

In many ways, the value of the follow-up programme is found in this list of issues and the discussion that ensued. Of course, in most cases there is no standard answer to the subjects that arose. The building of capacity in organisations and the development of mental health initiatives is a long-term process requiring determined work. But the meetings enabled people working in often isolated ways, sometimes even within their own organisations, to feel part of a community of practice of people facing similar challenges.

In some cases, participants have maintained contact after the programme and so the sharing of experience has continued. The forum group in Bangladesh is one example that brings together organisations with a commitment to improving access to psychosocial support for communities vulnerable to disasters.

Achievements of the training programme

The impact of the training programme flows from its measureable results or outputs. We categorised those outputs as numbers of participants, materials produced, changed awareness of community mental health and development, collaboration between organisations and new initiatives produced as a result.

This represents a continuum that commences with the training itself and leads on to a combination of measureable achievements such as the number of volunteers involved in new mental health programmes and less tangible results, such as raised awareness.

A further level of analysis, one that was not possible in this programme due to the intensive effort and cost involved, would be to monitor the work of trained volunteers and the quality and impact of their work on the lives of people with whom they worked. We can therefore trace our training for its impact up to a certain point only.

Participants

The target quantifiable outputs for the programme and achievements against each target up to 31st May 2009 are summarised in the table below. The residential programmes themselves are denoted by the first row in the table, with the second row indicating numbers of participants. Training programme participants came from 75 organisations in 11 countries: Australia, Bangladesh, East Timor, India, Indonesia, Laos, Maldives, Pakistan, Thailand, Sri Lanka and the USA. Over 90% were from tsunami-affected countries.

	2006		2007			2008	Total
	Feb	Jul	Feb	Jul	Nov	May	
No. of training programmes	1	1	1	1	1	1	6
No. of participants	24	16	18	13	25	24	120
No. of consultation workshops conducted by participants	34	4	27	7	0	1	73
No. of local people that have attended the workshops	1066	415	2227	848	0	50	4606
No. of volunteers identified by participants' organisations as a result of the workshops	84	22	121	10	0	2	239

Each participant in the training programme was asked to run at least one consultation workshop or a similar activity on mental health and development after they returned home and to report back on it through the follow-up programme.

The numbers of workshops, people attending them and subsequent numbers of people who offered to work as village or community mental health volunteers are described in the last three rows of the table.

Materials

BasicNeeds tested and implemented a training model that is novel and achieved good results across language and cultural divides. We have developed, refined and tested course materials that have received positive evaluations from between 85% and 89% of participants across the six programmes. These materials are available for use in future programmes.

BasicNeeds published full proceedings of the first programme in 2006 and produced a DVD 'Beyond the Third Wave', to both document and publicise the programme. The DVD is also available as a 28-minute extended version with a brief narration of the 10-day programme. Updates on the progress of the programme have featured regularly on the BasicNeeds website since 2005.

Awareness

It is notoriously difficult to measure the change in perceptions of people through their exposure to the work of an NGO. However, we can define a range within which the awareness of the subject has been changed.

At the very least, the 120 practitioners from 75 organisations are now better informed and able to respond more effectively to mental health issues in the work that they already do. It is certainly the case that 4,606 participants in events, workshops and training courses run by these practitioners have received basic training and induction on the subject. The impact of these people, although impossible for us to extrapolate, is likely to range from simply sharing of knowledge on mental health with family and community members, to their active participation in mental health initiatives in the ways that are described in the case studies that follow.

The higher end of the scale of impact on awareness that we can project comes from the work of people as volunteers and through the continuing mental health programmes that some participants have started. Nothing builds awareness of mental health more effectively than real programmes. This has occurred in Aceh, in parts of South India and in Sri Lanka, all of which have benefitted from a 'critical mass' of participants returning home from our programme and becoming active locally.

In the Maldives and the Nicobar and Andaman Islands, the presence of a small number of participants with the skills to be effective advocates will also have had an impact on awareness. For example, Bikash Chandra Manna from Nicobar has maintained contact with BasicNeeds and expressed a long-term commitment to working entirely in the field of community mental health. He attributes this shift in his priorities largely to the experience he gained on the training programme.

Collaboration

The lexicon of collaboration includes words that can be empty when applied to situations where development professionals talk to each other, they network and share knowledge, but ultimately little change takes place in the field and even less to the lives of poor or vulnerable people. Being rigorous about impact implies giving careful attention to the quality and nature of collaborative work emerging from the training.

Although the concept of 'partnership' is one of growing importance in development and is fundamental to BasicNeeds, the collaborative relationships that have emerged from the training programme need to be seen in different ways than simply variations on partnership. We categorise these relationships in three ways:

1. **Relationships that will lead to ongoing contact over a long-term period**
   Some participants consider their relationship with BasicNeeds to be one that will enable them to gain advice, support and materials from time-to-time as they develop their work. For small NGOs and their staff who are constantly looking out for new opportunities, then the chance to be part of a wider consortium that could be funded to work on mental health and development is also attractive. Between 25-30 of the participants in the programme could be said to fall into this group.

2. **Partnerships to develop new programmes**
   For established organisations with mature programmes, often there are opportunities for mental health to feature and grow within their work. Working with BasicNeeds provides a basis for new programmes to be developed that bring together strong local knowledge with international experience and skills. Organisations such as AHED, ADD, SARPV, CBDN, Creative Action and PULIH are of this type and some initiatives we have taken with them are described in the next section.

3. **Course 'alumni'**
Most of the participants in the course do not expect further contact with BasicNeeds beyond the end of the follow-up programme. However, they remain part of a group of alumni; practitioners who have been trained in community mental health and development and that are likely to be interested in further contact should be visit their region or invite them to a subsequent workshop or similar initiative on the subject.

There is great scope to make more of the network that has been established through the programme. BasicNeeds is doing so through its existing offices, but there is much greater need for further work on mental health and development for disaster-affected communities in Asia and other continents. This will ultimately depend on projects being developed and funding secured.

New initiatives

In this context, an initiative is a new project or activity that focuses on meeting needs for services in mental health and development. Some of the most important initiatives achieved by participants are described later in this publication and stand as one of the most significant achievements. But the training work also led directly to two new programmes:

Promoting mental health in tsunami-affected communities in Sri Lanka

Encouraged by the response of participant organisations to the International Training Programme, BasicNeeds developed a three-year initiative to combine training with direct interventions for 5,000 families vulnerable to mental disorders. Submitted for consideration by the Big Lottery Fund and citing the experience and impact of the International Training Programme, the work was successfully funded and commenced in September 2007. It will complete the involvement of BasicNeeds with tsunami-affected communities in Sri Lanka.

A pilot project in mental health and development in Bangladesh

As a partnership with Action on Disability and Development (ADD), this initiative was approved for funding by Cordaid in early 2009. Importantly, its development followed the May 2008 training programme in which several staff and partners of ADD were participants. In this sense, the local capacity developed will have an immediate application through the pilot programme that will support coastal communities in Bangladesh.

In Colombia, Laos and the African countries in which BasicNeeds is operational, training is also an established means of mobilising resources to meet local needs in mental health. The experience of the International Training Programme informs the work in those locations too.

The stories of coastal communities in Bangladesh made clear the need for further work on mental health and development programmes.

Case studies of the work of programme participants

Reaching out to tsunami-affected people in Tamil Nadu, India

Joseph Eye Hospital is a strong supporter of the International Training Programme. Ms. Aarthy Balakrishnan, participant in the programme and member of staff at the hospital recognised that many patients with physical conditions are also vulnerable to mental health problems and this was the main reason that she joined the programme. Following her attendance at the training programme, she organised local initiatives relating to mental health during May and July 2006 in which 1,320 people participated. The images below come from the various meetings and workshops that were included in her programme.

This work included nine consultation workshops on mental illness and mental health for the people at Vanagiri, Koolaiyar, Toduvai, Pudukuppam, Madathukuppum, Nayakakuppum, Kutiyandiyur, Kesavanpalayam, Vellakoil. On average, fifteen people participated in each village. Fifteen volunteers were identified through the nine consultation workshops and training programme on counselling was conducted for them. A psychiatry consultation camp was conducted for people identified through a survey of mental health needs. A psychiatrist from Trichy attended and provided counselling and other support to participants. Follow-up assistance for people receiving medicines was organised through the Government hospital.

Aarthy also directed some of the activities towards meeting the needs of children and young people who are vulnerable to mental health problems. A rangoli (pavement art) event was held at Perumalpettai for twenty children, with a similar number participating in a drawing session at Kooliayar and Vanagiri. A consultation workshop on mental health was held for 12th grade students and in which three volunteers participated in the running of workshop with the presence of the coordinators.

Finally, the programme supported clients recovering from mental disorders to participate in a chalk-making unit at Marthampatinam. This enabled them to work with a team setting and in a structured work environment.

Activities of course participants in the north and east of Sri Lanka

Francis Nehru and his colleagues from the Professional Psychological Counselling Centre held a one-day psychosocial programme at Thirukkovil on 25th April 2006. Fifty two people participated. Francis described the day:

'The programme started with two minutes' silence in memory of those who lost their lives in the tsunami. The first session of the programme participants introduced themselves to each other through the "Thirukkovil market game", an ice-breaker exercise.'

'The participants shared in groups about the problems faced at the village level, how these problems arise and how these could be solved. The groups were asked to make presentations. Group leaders were identified and problems were shared.'

In his area, volunteers are more commonly known as accompaniers, a work that described their role in befriending and supporting others. He describes how these individuals work in practice:

'At the end of the workshop a committee of seven members from the community was formed and explained what they have to do for the development of their village. I explained how they should help our accompaniers in identifying the mentally depressed people from their community. We decided that our accompaniers attached to Thirukkovil area and I visit the community to identify the mentally depressed people and to find out their needs and fulfil the same. The accompaniers would visit them once a week and I will visit them once a month. Already the members of the group that we formed helped us to identify many mentally depressed people.'

A second programme was held on 25th May 2006 and sponsored by Social Welfare Organisation of Ampara District (SWOAD), a local NGO. Three officers from SWOAD and twenty eight women from Kalmunai Aiyana Kovilady village participated in this programme. SWOAD was appreciative of the opportunity to be involved and made a commitment to conduct more programmes in their areas in the future.

The third programme was held on 20th June 2006 and was sponsored by Christian Life Community in Kalkudah where thirty six local people participated. Some of them were war widows and others had lost their husbands during the tsunami. We were able to identify those in need of counselling under the psychosocial programme.

A fourth programme was conducted on 25th July 2006 at Kiran. Forty-two people participated in this programme, most of which were the field officers of a local NGO called THADAGAM and the others were field workers attached to some other organisations functioning at village level. The members of the group helped to identify many people suffering from depression. All participants were satisfied with the programme and they asked for more programmes to be held in the future. They further stated that this programme gave them a chance 'to know who they were'.

Consultation workshops in Indonesia

Dr. Ulya Fasrini joined the programme when she was working in Aceh, the region worst-affected by the tsunami and an area to which she has strong professional ties and commitment. She has deployed her skills beyond the tsunami-affected area, especially in a mental health consultation workshop that she led that was based on the BasicNeeds training model and designed for communities affected by the earthquake in Jogjakarta. The workshop took place on 18th to 20th June 2006. There were, at various times, 80-120 participants, some of whom feature in the images below.

Around 80% of participants were survivors of the disaster and the rest were local volunteers. They were highly motivated to improve their lives. After working on a problem tree exercise and situational analysis, they went on to explore options for addressing the personal and psychosocial problems which are prevalent in their community.

A similar consultation workshop was conducted at Caben village a day after. In both cases, Dr. Fasrini was available for follow-up support to participants.

Working with tsunami-affected people in Aceh

Linda Sianturi participated in the training programme in February 2007 and she immediately started to use the skills she developed in her work with Peu Woe Seumangat, a development organisation already working with people affected by the tsunami in the devastated city of Banda Aceh, Indonesia.

Linda described the work she did. 'On my return we held a training session at Lambaro Neujit, a coastal village which was one of the worst affected by the tsunami. It was attended by twenty-seven women, most of whom have mental health problems. I applied some of the techniques I learnt at the programme in Sri Lanka and adjusted it to suit the community here'. The images below come from that workshop.

The training that Linda received also helped her to tackle some difficult issues in the community. She explains. 'We also held a session about women and child abuse and found some cases of child abuse in this village. Tackling this problem needs time, though, and a very careful approach because this is a very sensitive matter among the Acehnese people.'

Analysis of the experience

BasicNeeds learned much from the experience of the International Training Programme for tsunami-affected communities. The immediacy of bringing together practitioners from different disciplines, cultures and language backgrounds for a period of ten days is a good way of testing out ideas and methods. The challenge of doing that in the context of a subject as demanding as mental health only added to the focus of all those involved in the residential part of the training programme. And the qualities of participants helped enormously in working out what was effective in the programme and which elements needed to be improved.

Participatory approaches

As commented earlier, participants almost universally praised and supported the participatory training techniques used in the programme. In fact, the more of these approaches that trainers used, the more participants asked for. It is a truism in training that once people overcome their initial reservations about being asked to be actively involved in the process rather than passive recipients of information, then their appetite increases. There seem no limit to the number of role plays, energisers, group work, panel feedback exercises and flipchart drawings that were needed to meet demand.

Although there is no doubt that participatory training techniques are effective and will continue to be central to the BasicNeeds training philosophy, they have weaknesses. One shortcoming is that they can create a perception of learning which may not necessarily stand up to scrutiny. Just because people are watching each other do role plays and they feel stimulated and challenged as a result, does not in itself mean that they have extracted the greatest learning value from the experience.

In this sense, the role of the trainers is critical and they need to constantly be involved themselves and to demonstrate the skill of bringing new insights to the participatory process. In practical terms, this means always commenting on role plays and group work outcomes, being prepared to challenge the ideas of participants and showing leadership in directing the process fully and appropriately. In the programme, we set high standards in this regard, but it is not clear that we consistently met them.

Follow-up programme and implementation of action plans of participants

Our ambitions for the follow-up programme had to be revised downwards after around the second training course. The reason was that it soon became apparent that only some participants were willing or able to play a full part in it. The character of the follow-up process is that it depends on demand. If demand is not strong, then the need to service it is less than anticipated.

Put another way, the performance of participants in implementing their action plans was variable. Some achieved much more than expected and others achieved much less or very little, in some cases due to factors that are reasonable and understandable. Similarly, some participants and their organisations sought close association with BasicNeeds and for a longer period than the twelve months originally envisaged, whereas others gained all that they needed from the training and follow-up programme.

Of course, trained practitioners always face barriers in implementing their work. These range from the upsurge in armed conflict in northern and eastern Sri Lanka during 2007 and 2008, to cultural obstacles to people talking about their mental health, disputes within resettled communities and sometimes negative attitudes towards the work of NGOs. For a few participants, they discovered that management support for mental health was not as strong as they had hoped or that resources were unavailable. So they returned home full of commitment only to be met by more pressing demands or colleagues who had not had the same experience. Despite this, reports from them show that good progress was possible for many participants.

Dr. Ganesan conducting a session during the follow-up workshop in Dhaka.

Community of practice

BasicNeeds has established a 'community of practice' in mental health and development for disaster-affected communities. This means that there are country-based groups of alumni of the programme who know each other and some of them exchange knowledge and experience on their subsequent work.

This is particularly the case in Aceh, where the monthly psychosocial coordination meetings provided a vehicle for these exchanges, and Bangladesh, where participants have already shown a high level of willingness to collaborate. But in India and Sri Lanka there are also instances of ongoing contact between participants, especially where they have found that joining forces enables them to achieve a greater impact than they would if they were working alone.

To BasicNeeds, this community of practice is not formalised into a network or association since resources would be required and the value of a formal group not necessarily justified by the cost. But in the context of reflecting on the experience, we would have liked to achieve a genuine alliance of practitioners and their organisations working in mental health and development for emergency situations.

Language

Although BasicNeeds was able to overcome language barriers in each of the countries affected by the tsunami, for Thailand we were much less successful, despite a visit to that country by the International Training Programme Manager in 2006.

The reason was that it was difficult to attract response to our marketing materials from Thailand and the difficulty we experienced in finding a person who could translate to Thai. If we had achieved this, then we ourselves would have not been able to respond to enquiries in Thai and would have found presentation of the course in Thai to be too great a challenge. The fact that we managed it in Indonesian and Tamil was due to the basic English language ability of nearly all participants in this programmes.

We conclude that greater efforts to overcome the language barrier in relation to Thailand would have been worthwhile and could have attracted a larger number than the three people who came to the programme from that country.

Counselling

At times during the programmes, participants expressed a desire for more opportunities to learn about and practice techniques of counselling. Every programme included a short session on the subject, but we were reluctant to try to teach counselling in a programme that could only introduce the principles and for which specialist professional training and preparation is essential.

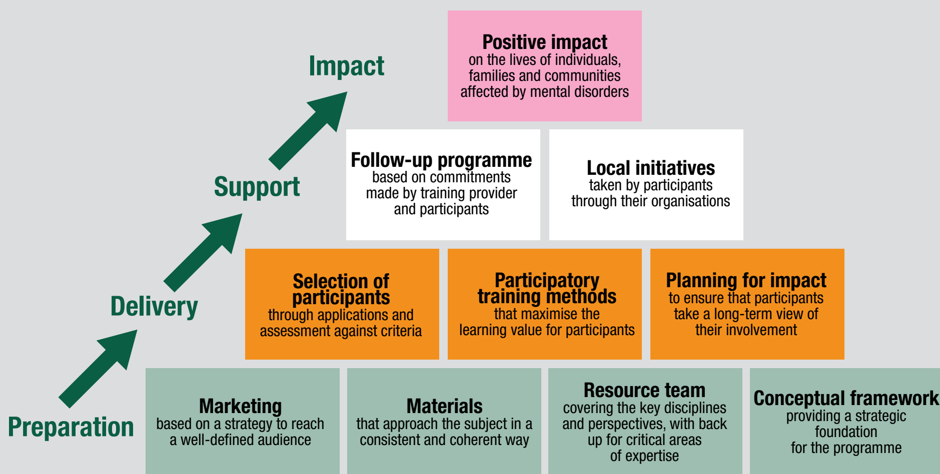
It is certainly the case that the role plays in counselling that were used in two programmes were largely effective. And in the Indonesia and Bangladesh programmes the use of the more manageable concept of 'basic helping skills' as a training topic made more sense than trying to introduce counselling. But a point of consideration for the future is how best we could make more headway on training in counselling to build the confidence and understanding of participants but without pretending that we are able to develop the competencies of participants in such a short time.

Members of the group relax on the last evening of the programme in Indonesia.

The building blocks of a training programme

The experience described in this publication has taught us how to design and deliver a training programme that leads to measureable results across a large number of organisations and locations. We can now define the elements of an effective training programme and the way that they inter-relate in sequence through the process of preparation, delivering the training and supporting participants.

The diagram below illustrates these building blocks.



Our experience has been that each block has a critical part to play in the effectiveness of the programme as a whole and particularly its ability to achieve the desired positive impact for people who often have limited access to community mental health services.

Conclusion

Awareness of the mental health impacts of disasters is growing internationally. This includes greater knowledge of the effects on people with pre-existing conditions and on those for whom the losses that a disaster causes include family bereavement, damage to property and loss of livelihood. The work of the World Health Organisation to analyse the experience of recovery from the tsunami and their recommendations on appropriate responses to the mental health effects have brought the subject into sharp focus. More recently, earthquakes in Pakistan and China as well as the aftermath of Hurricane Katrina have further illustrated the need for attention to mental health services in recovery and rehabilitation programmes for disaster-affected areas.

This publication has described the results of an innovative approach to mobilising support at the community level for people whose mental health was affected by the tsunami and other disasters. I wish to acknowledge the contributions of a number of people who have been involved in the programme. Chris Underhill and Chintha Munasinghe worked on the original concept. Udaya Madugalle worked with Heloise de Lima to undertake preparatory work, manage and deliver the early programmes. Heloise de Lima continued this work throughout, notably as Programme Coordinator from September 2006.

BasicNeeds established a pool of trainers from which we could draw to conduct each programme. This became the resource team for the programme. The members were:

- Dr. Mahesan Ganesan, Batticoloa Training Hospital
- Dr. Neil Fernando, Angoda Psychiatric Hospital
- D.M. Naidu, BasicNeeds India
- Dr. N. Janardhan, BasicNeeds India
- Mr. Herath, Angoda Psychiatric Hospital
- Udaya Madugalle, BasicNeeds Sri Lanka
- Steve Fisher, BasicNeeds Australia

In addition, for some parts of the programmes, we invited the following individuals to work as trainers:

- Chintha Munasinghe, BasicNeeds Sri Lanka (and later, Laymen's Den)
- Dr. M. Kurruppu, BasicNeeds Sri Lanka
- Thushara Senaratne, BasicNeeds Sri Lanka
- Malkanthi Gamage, BasicNeeds Sri Lanka
- Buddhika Indatissa, BasicNeeds Sri Lanka
- Dr. T. Gadambanathan, Ratnapura Hospital
- Dr. S. Sivathas, Angoda Psychiatric Hospital
- Dr. Jayan Mendis, Angoda Psychiatric Hospital
- Dr. T. Prabhath, Angoda Psychiatric Hospital
- Dr. Ruwan Jayatunge, Psychotherapist

Staff of BasicNeeds Tangalle office organised the field visits in Sri Lanka, including after the point when some members of the team formed a partner organisation of BasicNeeds called Creative Action.

Thanks are also due to the One Foundation and the Northern Rock Foundation, whose support for the programme was chiefly financial, but whose staff maintained a close interest in the work and thoughtful encouragement of our efforts. I wish to offer my thanks to everyone who has contributed to the special combination of skill and inspiration that led to the results described in this report and which I believe has made a difference to the lives of people affected by the tsunami event of 2004.

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