

# **“Community Based Mental Health”**

*A Practical Methodological Guide Based on Experiences of two  
Multidisciplinary Mental Health Teams in Working with Children and  
Families in Palestinian Camps.*

**2010 - 2016**



*We would like to thank every child and parent who trusted us and helped us along the way. Every mother and father is a true specialist regarding their own child and we have benefitted and learned a lot from them. Moreover, their commitment and faith in us have been instrumental in allowing us to design, develop, and improve our community-based mental health services. Each and every one of the children and parents has added to our collective experience and has contributed to improving the quality of the services we provide.*

*We would like to thank all our team members, especially the community workers, who are working relentlessly to challenge stereotypes of mental health services and who are converting the relationship with the community from being service recipients to becoming partners and true participants throughout the action plan cycle.*

*Through this guide we hope to transfer our success as a “model” for other communities with limited access to specialist mental health services.*

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## **FOREWORD**

Since 2010, Handicap international has decided to improve access to mental health rehabilitation services to children living in the Palestinian camps and surroundings in North and Tyre areas. Within the framework of the Mental Health project, Handicap International has targeted persons who have been refugees for more than 68 years living in Lebanon in extremely difficult conditions, confronted on a daily basis with high poverty, hopelessness, volatile security, violence, poor health, low education standards, poor housing and infrastructures and overcrowding. Moreover, what made the situation even more difficult is the arrival of more than 45,000 Palestinians Refugees from Syria since 2012 to the camps in Lebanon seeking security.

Full of desire to improve the situation and to contribute to the improvement of the psychological well being of children living in the Camps, Handicap international hand in hand with two local partners, FGC and CBRA, have decided to overcome all the barriers and to benefit from the technical approaches that go along with the existing context and lead to long term results.

Based on the child rights and starting from the user him/her self, the mental health needs of the targeted children were addressed through a multidisciplinary comprehensive intervention. This intervention has tackled the main factors contributing to the mental health problems, rather than focusing only on the consequences, and considered the child as a whole addressing all components having any link with his/her mental well-being through referral, coordination and collaboration (support, training, sharing of information, etc.), and seeking for equal opportunities and on promoting inclusive services.

The setting of emergency within another emergency is a fertile source of mental health problems factors, and working in such context required very special interventions to make use of the available resources and to avoid negative consequences of poorly implemented approaches.

Handicap International has put all its experiences related to providing mental health rehabilitation services in this guide to help other stakeholders to respond to the mental health needs in similar context.



## ACKNOWLEDGMENTS

This guide was produced by Handicap International with the collaboration of the Family Guidance Center – Al Buss team and the Community Based Rehabilitation Association team in the framework of the program: “Touching Minds, Raising Dignity” funded by the Agence Française pour le Développement.

### **\*\* Handicap International (HI).**

Handicap International has been working in Lebanon since 1992 with the Lebanese civil society supporting people with disabilities, providing mental health and psycho-social support services to children living in Palestinian refugee camps and surroundings, strengthening local Disability People’s Organizations across Lebanon, providing rehabilitation and psychosocial services for refugees coming from Syria and carrying out humanitarian mine and cluster bombs clearance.

HI has been supporting mental health promotion, awareness and care services in Palestinian camps since 2004.

*Please refer to Annex 1 for more information about Handicap International*

### **\*\* The Community-Based Rehabilitation Association (CBRA).**

The Community Based Rehabilitation Association (CBRA) is a non-profit development association located in North Lebanon working in the field of disability and rehabilitation with the Palestinian communities living in refugee camps in North Lebanon as well as with the surrounding Lebanese communities. CBRA provides rehabilitation services and supports the local community to adopt and advocate for the rights of persons with disabilities in order for them to participate in the decision-making and to have an active role within their communities.

*Please refer to Annex 1 for more information about the Community Based Rehabilitation Association.*

### **\*\* Family Guidance Center - Al Buss (FGC-EI Bass).**

Family Guidance Center (FGC) -Al Buss is one out of 5 Family Guidance Centers run by the National Institution of Social care and Vocational Training (NISCVT) in Lebanon.

The NISCVT commonly known as Beit Atfal Assumoud is a non-governmental organization providing cultural, health, educational and recreational services through 12 centers in Lebanon. The “Family Guidance Centers” are one of its health services.

The “Family Guidance Center” in Al Buss camp provides since 2007 comprehensive mental health services to children and their caregivers living in the Palestinian refugee camps and gatherings in Tyre area.

*Please refer to Annex 1 for more information about the Family Guidance Center- Al Buss*

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# PREFACE

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- \*\* What is the objective of this guide and who are the targeted users?
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## **What is the objective of this guide and who are the targeted users?**

This methodological guide aims to document key intervention approaches, practices and tools used in the framework of a mental health project from 2010 until 2015 by two centers, the Family Guidance Center (FGC)– El Bass, and the Community Based Rehabilitation Association (CBRA), with the technical and financial support of Handicap International (HI).

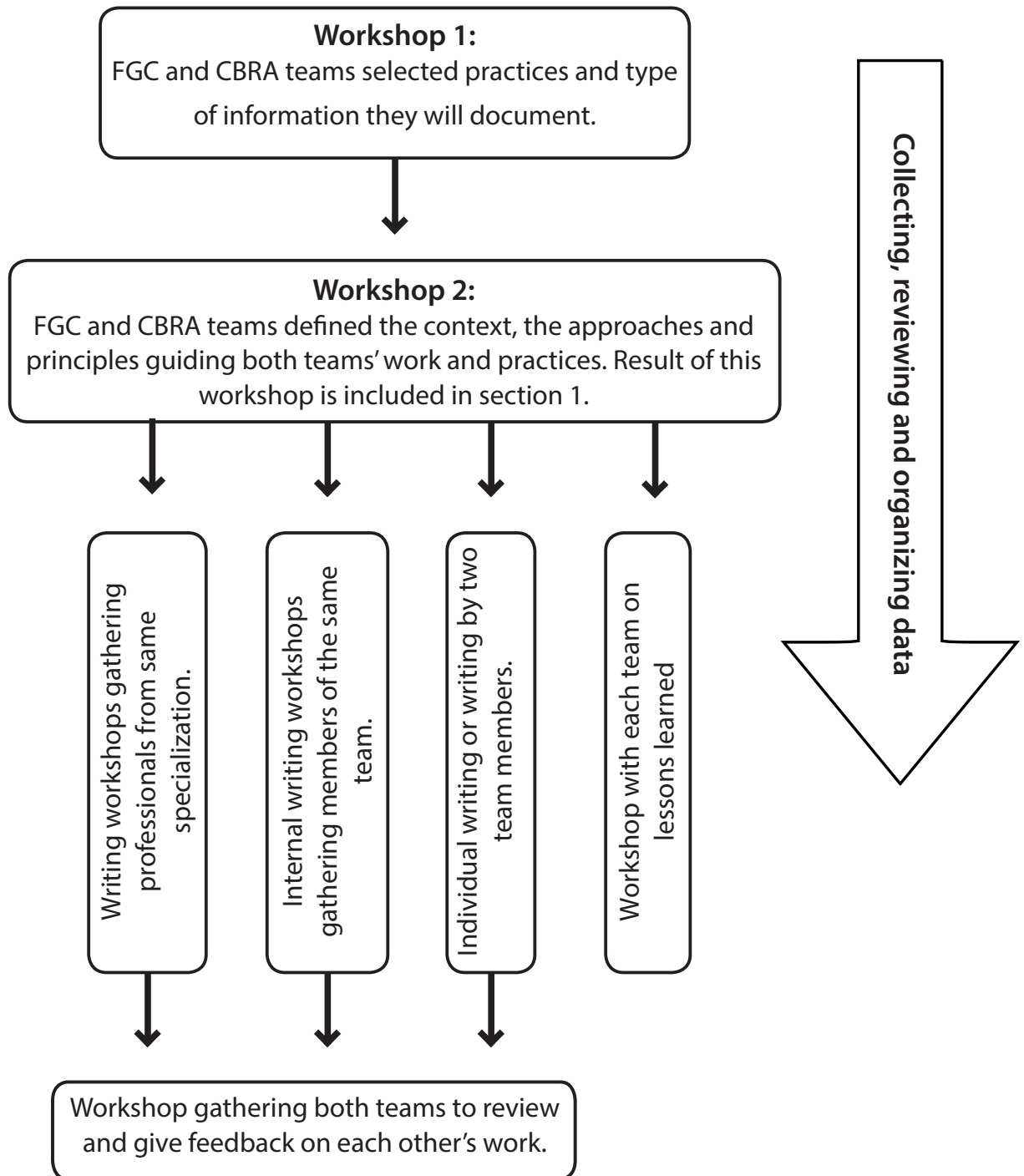
During the past six years (2010-2015), the FGC-El Bass and the CBRA teams have been raising awareness on mental health in the community and have been providing multidisciplinary and community based services to 1077 children with mental health problems and their families living in Palestinian camps in North and South Lebanon and their surroundings.

Throughout this process, and with the support of HI, they have developed multidisciplinary and community based practices aiming to promote and to improve the mental health of children and their families in the community through awareness raising, networking, empowerment and care activities targeting at the same time the children and their families, as well as other community stakeholders working with children at schools, kindergartens and animation and social centers.

Thus, this documentation of approaches, practices and tools aims to provide insight based on both teams' reflection and hands on experience to support the following users:

## How was this guide developed?

The guide was written with a participative approach and is based on the experiences of the team members from the two centers. More specifically the writing process was as following:



## How should this guide be used?

This guide provides elements of good practices based on lessons learned; however, it cannot be used as unique recipe. These practices should be considered in the unique and specific context of each community and organization, and adjusted accordingly to fit with the needs of the children and the resources available in this specific community/context.

This guide does not intend to present content for specialized therapies. It cannot be used to learn therapeutic skills. It aims to support professionals to adapt their already acquired technical expertise to the specificity of a community based multidisciplinary provision of services to children living in marginalized/vulnerable communities.

This guide aims to be clear and practical, providing concrete steps for the users. It can be read either as a whole document or in sections.

It is recommended that the **Preface** and **Principles** and **Frameworks of Intervention** sections to be read before the reader moves to the practical sections. Section on Principles and framework of Intervention focuses on the context we are working in and on the approaches guiding the work and that were adopted based on the specificity of this context. Reading this section on the conceptual and contextual background of our intervention is essential to understand why and how the specific practices were developed by the teams.

**The Practical Guide** targets mostly managers and coordinators who want to develop or improve the services in their centers.

The first part outlines preparation and managerial or organizational activities that constitute the base for the service provision, mainly related to the strategy design, human resources, health information system and child protection policy set up, quality improvement, documentation and research.

The second part presents the service provision practices and processes related to mental health promotion and care activities. Direct links are made to the Technical Files (in section 3) giving very practical steps to follow for each of the awareness and care activities.

The Practical Guide section also includes in each of its parts the challenges met by both teams in service management and service provision, as well as possible solutions suggested by the teams, in order to help the reader give specific attention to some of the difficulties one can meet.

**The Technical Files** target community workers and specialists who work to improve children's mental health in vulnerable communities. This section is divided by activities linked with care and promotion practices presented in the Practical guide. These technical files can be stand-alone documents and can be read independently from others if needed. Each technical file outlines the activity's objective, expected results and target group; and gives the reader very specific steps, recommendations and hints and tips on how to implement the different activities with a multidisciplinary and community based approach. The guidance is not intended to be prescriptive or to be interpreted in a rigid way: readers are encouraged to adapt the material in accordance with their own needs and circumstances.

**The Toolbox** gathers practical examples of tools and forms used by the teams. These are only basic examples readers can build on to create their own tools adapted to the specific needs of their services.

## What are the terminologies used in this guide?

**Child:** persons from 0 to 18 years old.

**Community stakeholders/actors:** all persons and institutions playing a specific role in the community: schools, kindergartens, school and kindergartens teachers, health centers, families, committees.

**Community Worker:** designates the Mental Health Community Worker. It refers to a person from the community recruited by the center to be part of the mental health team and who undergoes on the job training within the team to be able to implement tasks with the child, the family and the community stakeholders under the supervision of the teams' specialists.

**Family:** generally refers to care givers and siblings. However, family can also include persons from the extended family living in the same house (i.e. grand-parents, aunts, uncles, etc.)

**Mental health problems:** designates the two following categories: signs of psychological distress and mental disorders.

- "Psychological distress" as defined by HI is "a state of disquiet which is not necessarily symptomatic of a pathology or mental disorder. It signals the presence of non-severe or temporary symptoms of anxiety and depression which do not meet the criteria for diagnosing mental disorders and which may be a reaction to stressful situations or to existential difficulties."<sup>1</sup>

- "Mental disorders" accordingly to WHO's definition is used to note the «range of mental and behavioral disorders that fall within the International Statistical Classification of Diseases (ICD10). These include disorders that cause a high burden of disease such as depression, bipolar affective disorder, schizophrenia, anxiety disorders, intellectual disabilities, and developmental and behavioral disorders with onset usually occurring in childhood and adolescence, including autism"<sup>2</sup>

**Parents:** child care-givers, usually the mother and father or one of them. When parents are not the ones taking care of the child for any reason (i.e. death, divorce, etc.), "parents" in the guide refers to the adult designated by the family to play that role.

**Specialist:** a person with a certified degree in his/her discipline.

<sup>1</sup> Handicap International, *Mental health in post-crisis and development contexts*, 2011, p.14

<sup>2</sup> WHO, *Mental Health Action Plan 2013-2020*, 2013, p.6

[http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf?ua=1)

# PRINCIPLES AND FRAMEWORK OF INTERVENTION

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- \*\* What is mental health and more specifically what is child mental health?
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***What is mental health, and more specifically child mental health?***

Mental health as defined by the WHO (2010) is a state of well being that enables people to realize their potential, cope with stress, be productive, and contribute to their community. Mental health affects the way we feel, think, and act. It determines how we handle stress, relate to others, and make choices.

Child mental health is more precisely defined with a focus on the developmental aspects, “having a positive sense of identity, the ability to manage thoughts, emotions, as well as to build social relationships, and the aptitude to learn and to acquire an education, ultimately enabling child’s participation in society.”<sup>3</sup>

According to the WHO, 10-20% of children and adolescents experience mental health problems worldwide and half of all mental illnesses begin by the age of 14. Children with mental disorders face major challenges with stigma, isolation and discrimination, as well as lack of access to health care and education, which is a violation of their human rights. If not addressed, mental health conditions influence children’s development, their education and their potential to live fulfilling lives.

***What is the Mental Health situation in Lebanon, and more precisely in Palestinian camps?***

In Lebanon, 1 out of 4 individuals has a mental disorder, but only a minority seeks and receives treatment (Karam et al., 2008)<sup>4</sup>. According to the WHO AIMS report on the mental health system in Lebanon (2010), the country ranks high in the Middle East when it comes to the number of mental health professionals. However, the knowledge of people with mental health problems and their access to mental health services remains limited. One of the reasons is that the mental health system in Lebanon is characterized by a huge gap between public and private services (Kerbage, 2014)<sup>5</sup>, and that until 2014 no policies or strategy supported the development of promotion, prevention, referral and care services in the mental health field.

In addition to the continuing change in stability in Lebanon, the large influx of refugees coming from Iraq and Syria and who have experienced war trauma increased the number of people presenting with mental health problems. This in turn resulted in an increased need for the provision of mental health services.

In 2015, a National Mental Health Strategy was set by the recently created National Mental Health Program. This strategy includes a specific section



concerning vulnerable populations, including the refugee persons living in Palestinian camps.<sup>6</sup> With a status of refugee for more than sixty years and restricted access to services in Lebanon as well as to their civil rights, persons living in Palestinian camps are indeed in a situation of vulnerability and marginalization. Palestinian refugee camps and gatherings in Lebanon were created in 1948 and 1967. Thus, Palestinian children living in the camps are now the third or fourth generation of Palestinian refugees.

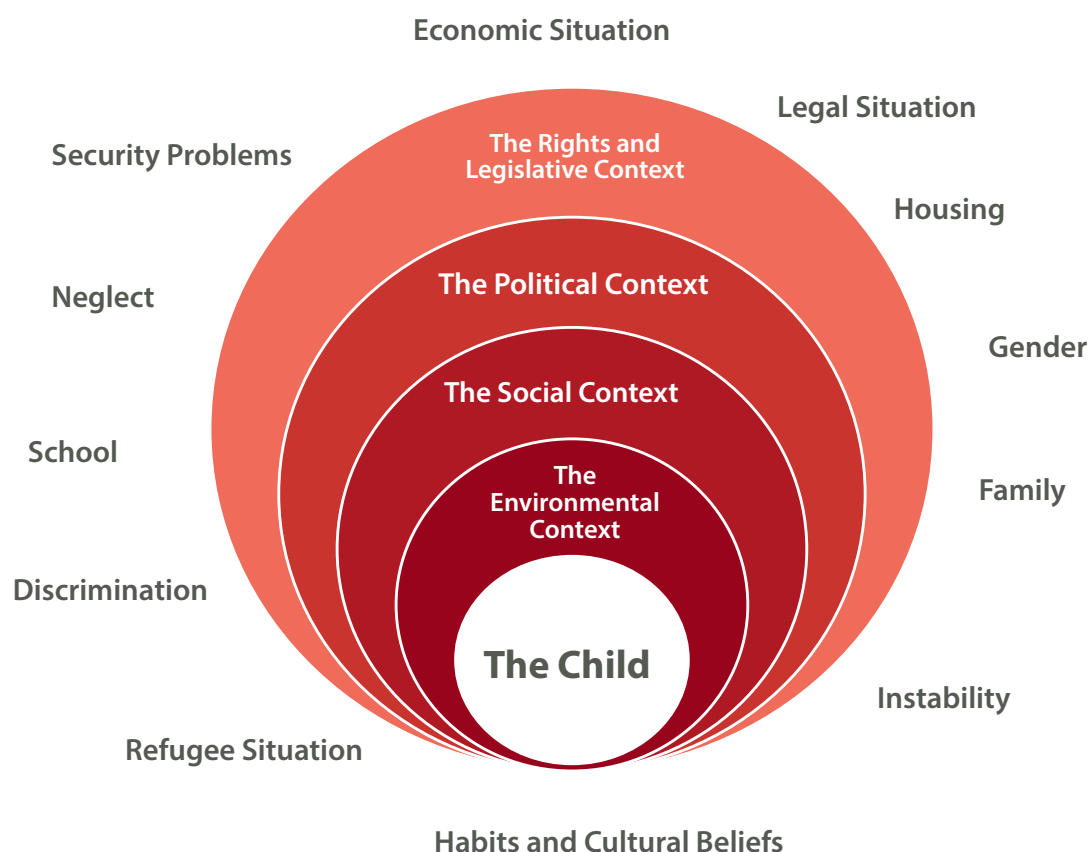
Children and families living in the camps face a complex socio-economic context as they are confronted on a daily basis with political instability, volatile security, violence, discriminative laws, high levels of unemployment, high levels of poverty, hopelessness, lack of access to health and rehabilitation services, low education standards, poor housing and infrastructures, overcrowding and promiscuity.<sup>7</sup>

Additionally, since 2012, Palestinian and Syrian refugees coming from Syria and fleeing war had to share resources and space with the residing refugees. The war in Nahr el Bared in 2007 followed by the recent Syrian Crisis resulted in the displacement of Palestinian families for the second or third time, who are now at the same time refugees from Palestine and refugees from Nahr el Bared or Syria.

The complex environment and situation described above are likely to lead to increased vulnerability to mental health problems among populations especially among children. In fact, determinants for mental health and mental disorders include "social, cultural, economic, political and environmental factors such as national policies, social protection, living standards, working conditions and community social supports".<sup>8</sup>

Children's experiences in building their identity, their feelings of belonging and security, their hope and freedom to choose are influenced by layers of factors going down from rights and political context to the direct environmental context including family, neighborhood, and access to school and care services. All these factors contribute to creating a closed environment, not specifically at physical level, but rather at psychological and social levels, linked with the limited present and future life perspectives and opportunities. Moreover, in this context, children with mental health problems and their families experience discrimination and guilt feelings related to the lack of awareness and knowledge about mental health issues in the community.

## The factors that have an impact on child's mental health in Palestinian Camps.



A study conducted in 2011 by Médecins Sans Frontières in collaboration with the Lebanese American University in Borj el Brajneh Palestinian camp showed that 29% of inhabitants have at least one mental health disorder. It was also found in this study that 96% of people with a diagnosed mental health disorder or those in need of psychological and psychiatric support had not accessed appropriate services (MSF 2011).

Furthermore, according to a study conducted by the American University of Beirut and the UN Relief and Works Agency (UNRWA) in 2010 (Chaaban, Ghattas, Habib, Hanafi, Sahyoun, Salti, Seyfert, & Naamani, 2010), 21% of the 270,000 Palestinian refugees in Lebanon have some form of mental health problems such as depression, anxiety, or distress.

More specifically concerning children, HI in partnership with ICARE implemented in 2010 a study on the prevalence of mental health problems in El Bass camp.

### The results revealed that:

- (a) *A very high prevalence of mental health problems (63.7%) exists among children.*
- (b) *A very limited number of persons are receiving care.*

This study made a certain number of recommendations, mainly concerning raising awareness and decreasing stigma, increasing the availability of services provided, involving parents in service provision, and increasing the coordination between stakeholders. Handicap International Mental Health project was built on these recommendations.

## **The mental health project developed by Handicap International and partners in the Palestinian camps context.**

Following other mental health projects implemented by Handicap International team since 2004 in Palestinian camps, and the study mentioned above, Handicap International progressively developed its mental health project in the North and South Palestinian camps and their surroundings from 2010 till 2016.

### ***The project in 2010 was built on the following givens:***

- The needs assessed in the community: A high number of children with mental health problems need access to adequate services.

- The challenges and opportunities:

\* The lack of specialized human resources

\* The lack of awareness and knowledge of parents about mental health problems and services.

\* The stigma concerning mental health problems.

\* A solidarity culture in the Palestinian community resulting from the common history and shared living conditions: for example a high number of NGOs were founded since more than 40 years by Palestinian persons to provide services to the Palestinian community: KGs, social and rehabilitation centers, etc. Neighbors and extended family play an important role in the life of persons in the camps.

\* The focus made on mental health by the civil society during wars (Lebanon 2006, Nahr el Bared 2007) increased the understanding and acceptance of the psychological components of behavior and feelings, because it can be justified by the crisis situation and therefore less stigmatized.

### **- The resources:**

\* A center specialized in disability services with a community based approach in North camps.

\* A center specialized in multidisciplinary mental health services in South camps.

\* An important number of community based NGOs' centers providing education, social, animation and rehabilitation services in the camps, thus working closely with families and children on daily basis.

Based on these facts, activities progressively planned and implemented in our project were mainly the following:

Results appeared all along the development of the project with:

\* Building a partnership with the two centers, CBRA in the North and FGC in the South, which were already reference centers in the community and had experience in community based practices (CBRA) and in mental health (FGC).

\* Including and training persons from the community to play a role in the mental health teams. Supporting mental health awareness raising activities in the community.

\* Building networks and coordinating with other NGOs and stakeholders in the camps to promote mental health.

\* Supporting the provision of multidisciplinary specialized and community based services to children.

\* Promoting the involvement of parents and community stakeholders to improve the children's psychological well-being, autonomy and inclusion.

\* Building the capacity of parents committees and parents and youth self-help support groups Building the capacity of mainstream service providers to include children with mental health problems in their services.

- More children benefiting from the mental health services,

- Community workers integrated in the teams and their work recognized by the specialists and the parents as having an important added value in children's care,

- An increase in the community members' awareness observed through the increase of referrals.

- An increase in the involvement of parents and acceptance of the mental health services observed in how they spoke about the services and the feeling of empowerment they expressed.

Of course, challenges at various levels occurred throughout these six years. Some changes were made in the service provision model, in practices, in roles of team members depending on the evolving context, challenges met and gained experience. Some of these challenges and difficulties will be presented through this guide.

## **What are the approaches adopted for service provision based on the specificity of the context?**

### ***The specificity of the context***

To address the mental health problems of children in the context described above, a traditional clinical one-to-one setting approach is not always adapted, sufficient, or sustainable if we consider the specificity of challenges and resources in the community:

- \* Specialized resources in the community are very limited compared with the needs.

- \* Specialists are often from outside the targeted community and sometimes need support to understand the community perception of mental health problems and the cultural beliefs and habits that might influence mental health.

- \* Community stakeholders, for example social, animation and educational centers, committees and schools and KGs teachers, are community local resources on which can be built the children's resilience and can be considered as important sustainable vectors for mental health prevention and care. Indeed, they play an important role as references in the life of children and families in the community. They are usually in direct and regular contact with the families and are familiar with their social situation.

- \* Culturally, neighbors and extended family have also an influential role in the life of the child and his/her family, and are a reference to decide what behavior is acceptable or not, what is taboo and what is not. Thus, no work can be really efficient with the child and his/her family if awareness is not made at this level of the community because the community can be at the same time a facilitator and an obstacle to access the services.

- \* Factors leading to the child's mental health problems are often environmental factors in addition to the individual factors, and are often located outside the mental health domain. They include socio-economic and health factors and factors related to educational environment among others.

- \* Moreover, mental health problems have consequences on other components of the child's life: delays in autonomy, speech impairments, problems at level of motor or learning skills, discrimination by the extended family or neighbors, problems at school, etc... All these aspects interact together and have an impact on the child's mental health in a vicious circle.

- \* Some children have permanent impairments and need a sustainable intervention based on capacity building actions targeting their environment and promoting the

child's autonomy and participation beyond any type of individual one to one treatment.

- \* Families are the guarantee for the sustainability of the treatment results; they are the permanent reference for the child and the experts in his/her everyday needs, and therefore need to be empowered, given information and the opportunity to share decision making with the mental health teams. However, culturally, the professionals are still positioned in a power relationship with their authority based on their technical expertise, which leaves little space for parents and children to feel independent and in control of their situation. This results in creating dependency and sustainability issues if the family and children are not empowered by the mental health teams.

Accordingly, three main different approaches were promoted by Handicap International and adopted by the two centers throughout the project to respond to the needs of children and families in the specific context of problems and resources described above. These three approaches promote a holistic vision of the person taking in consideration the different components of his/her personality, as well as his/her interactions with the environment and thus perceiving the person as unique and respecting her/his specificity. The three approaches which will be described are: the community based approach, the person/family centered approach, and the interdisciplinary approach.

## The community based approach:

Within a community based approach, the service provision model follows a decentralized pattern promoting the use of local resources. Services are provided in close proximity to the community they serve geographically speaking, and community stakeholders are mobilized to facilitate the access to awareness, information, prevention, referral, care and inclusion services to enhance the quality of life of the community members. Self-empowerment of persons is also supported to promote inclusion and equitable participation of all.

The community based approach is built on the belief that the community in all its actors can be transformed from being an obstacle or source of problems (i.e. stigmatization, stereotypes on mental health, discrimination, community determinants for mental health problems) to become a facilitator or a catalyst for better social participation of the child with mental health problems. This happens precisely when the mental health delivery system is based on the community strengths and resources, is adapted and integrated somehow to the community and takes it in consideration as an active partner who needs to be empowered to play a role in mental health promotion of the community members.

Moreover, knowing that mental health determinants and the consequences of mental health problems on the children's live are not limited to the mental health sector, but are also linked to other sectors like education, livelihoods, protection, health, social sector etc... the mental health services, within this approach, engage with other sectors in the community to address the determinants and consequences of mental health problems to perceive the child as a whole and deal with his/her problems in a holistic approach. One of the expected results of this collaboration with other types of services in the community is to allow the child to have access to the specialized services when needed (i.e. psychotherapist, occupational therapist...) as well as to the mainstream community services (i.e. education, social, animation services) actively supported to be inclusive. This facilitates the child's participation in the activities in his/her community and it is achieved by promoting the role of the mainstream community stakeholders in the mental health field.

**Practically, within this approach, local resources from different sectors are mobilized in different ways to promote mental health:**

\* Awareness sessions are given in the neighborhood and homes of persons in the community.

\* Networks are created among community actors from different sectors including schools and kindergartens staff, NGOs working in social, animation, rehabilitation and health fields, committees, etc... and these stakeholders are supported, trained, or just sensitized to play a role in facilitating the child's access to mental health prevention, referral, care and inclusion services.

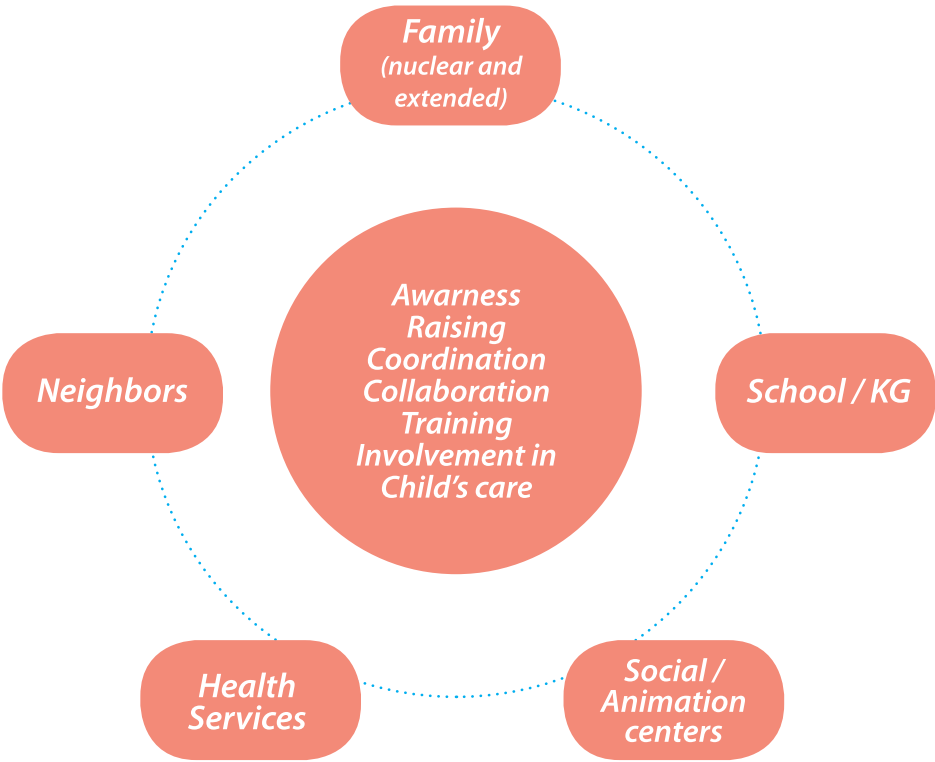
\* Parents committees are supported and empowered to raise awareness in the community and to advocate for their children's rights.

\* Care is sometimes directly provided inside the Kindergarten and teachers are actively supported through training and coordination with the specialized mental health teams to reach better psychological well-being for the child.

\* Furthermore, as one of the application of this community based approach, and to address the lack and cost of specialists, community workers from the Palestinian community are integrated in the mental health teams besides the specialists to provide care services for children through the task shifting model: they work closely with the specialists in the team and are trained and supervised by the specialists to implement specific tasks (i.e. care activities, exercises, etc.) with certain children in the center, at home or at school. This never replaced the need for the specialists but allowed optimizing the use of the specialists' time as the community workers shared some of their tasks. Moreover, community workers' interventions allowed assessing and working directly on environmental factors, establishing therefore the link between the specialized care and the community aspects, and working closely with the schools and families which facilitated the inclusion process.

***Some related topics in the guide:** Networking with community stakeholders, Raising awareness activities in the community, Involvement of other stakeholders in the child's care process, Task shifting.*

**Involvement of community actors in the community based approuch:**





## The person/family centered approach:

*The person-centered approach is also called the user-centered approach or family centered approach depending on the context of the service delivery. It directly refers to the rights based approach. This approach constitutes one of the criteria for providing quality services according to several quality monitoring bodies, such as the National Institute for Health and Care Excellence – UK (NICE) and the European Quality in Social Services (EQUASS).*

### ***This approach is based on the following principles:***

\* The respect for the person's/family's dignity.

\* Considering the person and the family as active partners in the care process at all levels of the process. The power relationship between the professional and the person and family is balanced just as in a partners' relationship; and the person and family are not considered as passive recipient of the treatment. They are rather expected to express their own perception of their situation, their own priorities and needs from their own perspective, and their perception and expectations are taken in consideration in the whole care process as well as in center's activities.

\* Considering the person and family at the center of the service provision model: service provision should be individualized and tailored based on the specific needs and resources of each person and family.

\* Information sharing: persons and families are the expert in their own life experiences just as the professionals are the experts at the scientific level. These two types of information are complementary and need to be shared by both parties with equal importance. Professionals should share all information concerning the person and family like results assessment, detailed action plan using understandable language and words as this information belongs to the person and family. Sharing decision making: The respect of the person's/family's right to make his/her own choice and informed decisions concerning her/his own care process and the belief that the center has a role to empower the family to have the ability to take their own decisions.

\* The empowerment of the person and family: The person and the family are supported through capacity-building activities, accompaniment, etc... to take the lead on their own life. In our project, by empowering the child and the family, the team's attitude was crucial to help persons and families "gain better understanding and control over their lives"<sup>9</sup>, give them the lead and the confidence to manage their problems and to be vectors of change in their own community through providing them with information and tools, and supporting them to develop their own strengths and resources. One of the results of this empowerment was the creation of parents committees.

\* The promotion of the person's and family's autonomy: the person and family are supported to use all available/provided resources to increase their autonomy at all levels going from problem solving and managing in everyday life to self-determination, and participation in decision-making. This is directly related to the empowerment process. Providing psycho-education and involving parents in care sessions are an application of the empowerment and promotion of the autonomy process. Also, one of the indicators for the improvement of the situation of the child was measured through the increase of autonomy of the child.

\* The participation of the person to social policies: by being empowered, persons and families can advocate for the change of attitudes, rules and laws to promote a better social participation of the person. Parents were invited to participate in policy and strategy change in the centers, as well as to participate in conferences at national level to make their voice heard.

These principles in the mental health service provision in our project were applied at two different levels: the management level and the professional-child/family direct relationship level.

At the service management level, procedures evolved to follow the person centered approach: for example, processes were put in place to have families involved in decision making concerning their child's care, users' satisfaction was assessed regularly and a complaint system was put in place. The participation of the families in the decisions concerning the center and to national mental health events was promoted.

At the same time, the relationship between professionals and the child and family became progressively more balanced as parents took more and more confidence as partners in the care process through capacity building and empowerment activities implemented by the teams. This approach is a working culture; it makes the perception of service providers as well as families evolve progressively regarding their own attitude and position in the service provision system.

**For an example of the Person Centered Approach action plan please refer to toolbox doc #10**

**Some related topics in the guide:** Action plan meeting with parents, Involvement of parents. Setting child protection policy and ethical rules, Parents committees, Psycho-education, Co-parents sessions, Parents support groups, Parents-children group activity.

## The interdisciplinary approach:

Psychological problems have determinants and consequences in other aspects of the child's development, for example in the language, motor, medical or social fields. Following again a holistic view of the child, and in order to be effective, interventions cannot tackle one of the child development components and factors without also considering the others. Interventions need to be multidisciplinary and treatment activities need to take into consideration the interaction of the different types of factors and consequences. For example, a child who has a speech delay may have difficulties in expressing his/her emotions, needs and feelings. This could create frustrations and the child might express these frustrations through violent behavior. In this case, even though the initial cause of the problem is related to the speech domain and needs to be addressed, it is not enough to focus on it without also addressing the behavioral problem following therefore a multidisciplinary approach.

**For example:** is a child who has psychological distress because of the family's social or relational issues. This psychological distress resulted in stuttering, which is in this case a consequence of distress and is therefore also related to the speech domain. In this example, the interaction between the social issues, the psychological distress and the speech problem should also be addressed.

Furthermore, developmental disabilities require directly the intervention of a multidisciplinary team to help the child develop his/her motor, language, relational and cognitive skills and to promote the child's autonomy.

Knowing that our objective is a better quality of life, a holistic approach addressing all aspects of the child's development is necessary. Therefore, the team needs to include experts from different disciplines.

Moreover, specialists cannot work with the child separately and independently from each other within this multidisciplinary team. The child is not fragmented by specialization and he/she is not reduced to being a "speech problem" added to a "psychological problem" added to a "social problem". The team members need to be working closely together to have a holistic view of the child's situation in order to reach the right diagnosis, to set together an action plan which including all the relevant aspects contributing to that situation and to respond in the best way possible to each child situation.

The team therefore needs to be coordinating and sharing information about the child's progress and changes in the action plan throughout the process of their work with the child. This is what we call an inter-disciplinary approach implemented by a multidisciplinary team.

At the practical level, this means having regular coordination between all team members at all steps of the mental health care process: from the evaluation of the child's overall situation, strengths and resources, to developing action plans to respond to specific needs of the child, and finally to the discharge decisions.

This coordination aims to share the results of assessments, agree on one action plan, organize roles and tasks during the care process, share information on the progress of the child, understand which aspects are impacting others, agree on where to refer the child when needed based on a holistic view of his needs, etc...

**Some related topics in this guide:** Recruiting a multidisciplinary team. Organizing team meetings. Multidisciplinary assessment. Diagnosis of the child's situation and design of action plan. Evaluation of the child's progress.

## Footnotes:

3 WHO (2013), *Mental health action plan 2013-2020*

4 Karam et al. (2008), "Lifetime Prevalence of Mental Disorders in Lebanon: First Onset, Treatment, and Exposure to War", published in PLOS journal Volume 5. Number 4: e61

5 Kerbage, (2013), « Organisation et pratique des soins en santé mentale au Liban : Dilemmes et contradictions », in the Legal Agenda.

6 The Mental Health and Substance Use Strategy for Lebanon is published on the Ministry of Health website <http://www.moph.gov.lb>

7 For more information on the living conditions of the Palestinian refugees, please check:

- Chaaban, J., Ghattas, H., Habib, R.R., Hanafi, S., Sahyoun, N., Salti, N., Seyfert, K., Naamani, N. (2010), "Socio-Economic Survey of Palestinian Refugees in Lebanon", Report published by the American University of Beirut (AUB) and the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) [http://fafsweb.aub.edu.lb/aub-unrwa/files/AUB\\_UNRWA\\_report\\_final\\_draft.pdf](http://fafsweb.aub.edu.lb/aub-unrwa/files/AUB_UNRWA_report_final_draft.pdf)

- UNRWA reports on Palestinian Refugees from Syria <http://www.unrwa.org/prs-lebanon>

- Needs assessment for Palestine Refugees from Syria, March 2014, UNHCR, file:///C:/Users/User/Downloads/PRSNedAssessmentReportFinal-24062014.pdf

8 WHO, *Mental health action plan 2013-2020*, 2013

9 User empowerment in mental health – a statement by the WHO Regional Office for Europe, 2010.

# PRACTICAL GUIDE

**PRACTICAL GUIDE FOR THE ORGANIZATION AND PROVISION OF  
COMPREHENSIVE COMMUNITY BASED MENTAL HEALTH SERVICES.**

- \*\* Why a community mental health center?**
- \*\* How to establish, run and manage a community mental health center?**
- \*\* How to deliver mental health promotion and care services?**

## ***What is a community mental health center?***

Based on the approaches defined above, a community mental health center is a center providing mental health prevention, promotion and care services geographically close to the population it serves, these services being at the same time specialized and based on the resources of the community itself. In opposition to clinical one-to-one private settings, the services provided at the community mental health center address the children's and their families' needs and resources within a holistic, person-centered and interdisciplinary approach taking in consideration the personal and the environmental determinants, the child and family specificity and their actual interactions with their community. This center promotes the role of the community in the mental health field through awareness raising, coordination, training and sharing of resources with community actors such as schools, animation centers, etc., and promotes the role of the family as a partner in the treatment plan.

### ***More specifically, the role of the mental health center is the following:***

**\*\* Raising awareness and spreading knowledge on mental health issues in the community:** in neighborhoods, in schools and in social centers to enhance prevention, early identification and decrease stigma.

**\*\* Networking and coordinating with actors providing other complementary health, education, social services to facilitate the identification and mutual referral of families upon their needs.**

**\*Providing multidisciplinary specialized and community based coordinated assessments and treatments based on the child and families needs.**

**\*\* Supporting the family to understand the situation of the child and to deal with it at best, through psycho-education activities and to get involved and consider itself as a partner in the care process of the child.**

**\*\* Promoting parent-to-parent support activities.**

**\*\* Coordinating with other stakeholders, mainly schools, animation and social centers to play a role in the care plan of the child through explanation of the situation of the child, advice and capacity building to teachers and animators in order to facilitate the inclusion and participation of the child.**

**\*\* Conducting research and documentation on all data collected about the needs of children in the community and the services received to better design the services at the center level and to constitute evidence based data on therapies and models adopted.**

### ***Based on our experience, the mental health center can be considered as a good model of service provision because it allows:***

**\*\* An increased awareness in the community about mental health, mental health problems and services and prevention aspects.**

**\*\* A better identification of the children with mental health problems, and better access of these children to the services needed as community stakeholders targeted by awareness raising sessions may have increased their ability to refer children in need.**

**\*\* An increased involvement and sense of responsibility of the community stakeholders towards mental health and more precisely prevention, referral and inclusion.**

**\*\* A better adequacy of the services to the community culture, especially with the presence of the community workers who are at the same time from the community and part of the professionals team.**

**\*\* An important involvement of parents in the treatment process of their child which allows better sustainability of the results of the treatment.**

**\*\* Innovative approaches resulting from the common reflection and joint initiatives by the different team members enriching each other's thinking.**

**\*\* Better inclusion and participation of the children in their classes, animation groups and neighborhood.**

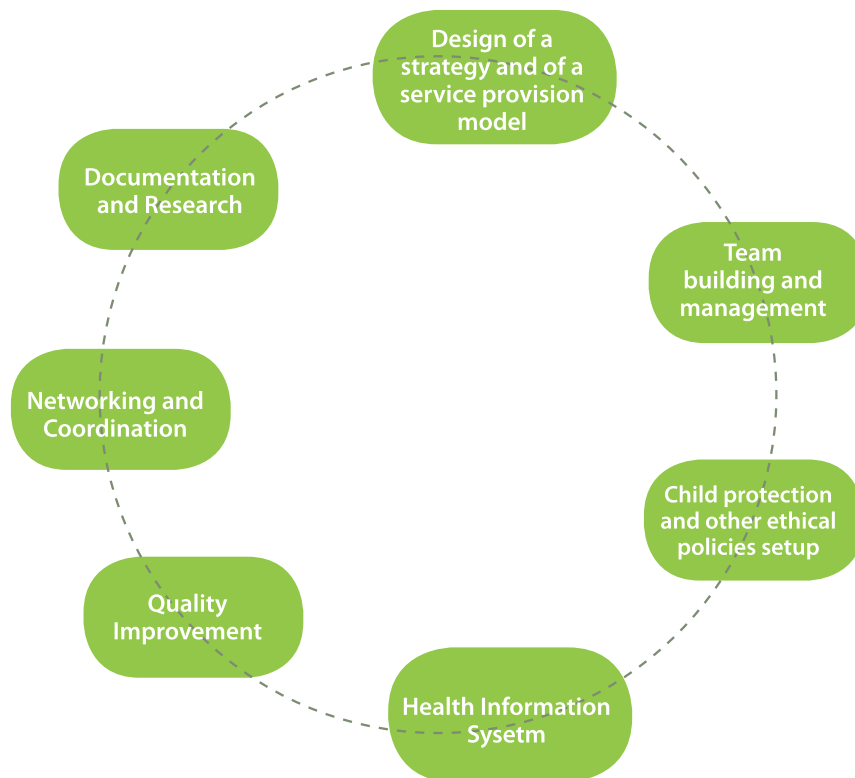
**\*\* The creation of parents supports groups and parents committees where parents can support each other and advocate for the rights of their children.**



## How to establish, run and manage a community mental health center?

### Good Practices:

The management and organizational components that support the provision of services are decisive aspects that will condition the quality of the services. The set of practices presented in the following section might be useful for coordinators and managers. They result from our experiences and lessons learnt in the preparation and management processes of the provision of services.



## **1.Design of a strategy and a service provision model based on a mental health situation analysis in the community**

**Objective:** To build a service provision strategy that is adapted to the specific mental health problems and needs, gaps in the services, care seeking behavior, as well as available resources in the community. Having a strategy allows organizing all the resources and actions coherently to have all the efforts joint towards the same objective.

### **Actions:**

- \* Review literature and studies done by other stakeholders on mental health and related topics in the same area or in the same contexts, and more specifically about types of problems, mental health related representations, community resources and care seeking behavior.
- \* Collect data already available within the center/the project team because of past experiences in mental health or other projects in the same geographical area.
- \* Select a method for the data collection and design a research protocol using relevant techniques. Quantitative or qualitative approaches might be used. However, quantitative data collection to obtain prevalence on mental health problems in the community might take a lot of time and resources if standardized tools should be used (translation and adaptation of tool, training of persons collecting the data, etc...). Qualitative data collection might include focus groups with community members, with main stakeholders' representative in the community, interviews with other service providers based on questionnaires designed to obtain information needed to set out the services, etc...
- \* Analyze collected data on mental health problems in the community, on gaps in services, on case seeking behaviors, etc...
- \* Analyze the characteristics of human resources available in the community.
- \* Analyze the community resources such as the available service providers and their understanding for mental health and how they can contribute to the continuum of services to be provided.
- \* Define the mission and vision of the center, the objectives and target group, as well as the strategy and service provision model that will be adopted for service provision based on the analysis of the context done before.
- \* Define the resources to mobilize and the care process for the children and family including the entry point to the services, the internal referral and coordination system, the end of treatment procedures and criteria, with the related distribution of roles and tasks among team members.
- \* Note that the strategy needs sometimes to be updated to adapt to the evolving needs and resources in the community. This requires a new assessment of the situation of the team and of the service provision context. Moreover, use tools integrated in the follow-up tools of the project and the health information system to collect data regularly during the project implementation (i.e. demographic information as well as information on the types of mental health problems, contributing factors, presence of a disability, party who referred the family, waiting list, etc.) to update the strategy or model of services when needed.

In our project, the model we elaborated with partners was based on the study done on the prevalence of mental health problems and access to services in one of the Palestinian camps and on the data collected throughout previous projects. This data gave us information on the types of problems among children, on the care seeking behavior in the community, on the perception of mental health problems in the community and on the availability of specialized and non specialized resources. The care process for the children and family was designed accordingly, mainly focusing on the collaboration between specialists and community workers to provide the services together through a task shifting model and community based and center based interventions. The role of each team member and the tools to be used were defined for each step of the care process.

## 2. Team building and management

**Objective:** Recruit, orient, train and manage a team including specialists from different disciplines and community workers who collaborate all together to provide comprehensive services following the community based and interdisciplinary approaches.

### **Action 1: Recruit and orient the multidisciplinary team members.**

\* Define the constitution of the team based on the needs assessed in the community and on the strategy and service provision model. Not all professions defined below need to be represented. This depends on the approach and target group of the center.

*Please refer to Annex 3 for detailed information on the profile required for each team member.  
The multidisciplinary and community based mental health team.*

\*\* **Child and family:** They are at the center of the design of the child care plan. They are active partners in the implementation of the child's care process.

\*\* **Psychotherapist:** Evaluates and treats emotional, psychological, cognitive, and behavioral aspects. Provides counseling to parents.

\*\* **Psychiatrist:** Is a doctor who evaluates and diagnoses the mental health disorders, provides consultation, prescribes medication when needed, asks for medical exams when needed, is the reference for all medical aspects and for the overall follow-up of the mental health situation and treatment of the person.

\*\* **Occupational therapist:** Evaluates and treats all development aspects related to daily living skills and child's autonomy.

\*\* **Speech and language therapist:** Evaluates and treats communication, speech and language aspects.

\*\* **Psychomotor therapist:** Evaluates and treats aspects related to body schema, muscle tonicity, laterality, gross motor skills, manual abilities and hand writing skills, time and space.

\*\* **Physiotherapist:** Evaluates and works on physical and motor skills.

\*\* **Community worker:** Evaluates and address social needs and resources. Acts as a case coordinator and as a reference for the family in addition to having sessions with the child at home and in the center through the task shifting model. Is the focal point to coordinate with schools, KGs or other community stakeholders to promote the well-being of the child in his/her environment.

\*\* **Coordinator:** Coordinates and manages practical and organizational aspects of the team work and is involved in the coordination with other stakeholders in the community.

\*\* **Administrative coordinator:** Responsible of the overall activities implementation and involved in the planning and evaluation process at level of the center, and in networking in the community and coordinating with other centers.

\* Define clear job descriptions and terms of references (TOR) for each of the team members to be recruited. **For examples of elements to be included in community workers' job descriptions refer to toolbox doc #1 and in specialists job descriptions, refer to toolbox doc# 2**

\* Announce job openings at least two months ahead of time to allow for applications to be received and interviews to be organized. This would also allow for a handing-over period when necessary. Announcements can be made through:

- Posting the job description/ terms of references on employment internet websites and social media (Ex: Facebook page of the center, Daleel Madani, etc.)

- Contacting universities, employment offices, syndicates or professional groups (ex: speech and language therapist association, psychologists association) and sharing with them the job description.

- *Sharing the job description with the other team members who might share it in their professional networks.*

\* Organize interviews between the selected candidates and the administrative director of the center and the technical team leader/ coordinator. Interviews should include a clear explanation to the candidate about the working context, the center's approaches, methodologies and policies to avoid potential surprises if a person is not ready to work in such context with such methodology. Examples: "we work following a community based approach; if you are recruited you will be expected to do home visits sometimes in the camp". "We work within a multidisciplinary team; therefore you will be required to regularly meet with other specialists to discuss the child's situation and share information about what you're doing with him/her".

\* For better recruitment quality, take in consideration the team's culture when evaluating the profile of a candidate. Culture of the team as a whole may have the following characteristics: having a positive and pro-active attitude to the work, the ability to balance between clinical and community work, being at the same time pragmatic and realistic and ambitious, prioritizing quality of services, finding motivation in team work, innovative approaches, and positive relations with children and families.

\* Organize orientation activities for new team members: Newly recruited persons might be very skilled in their field but sometimes come directly from a university context and are not necessarily familiar with the environment and living context of the persons they will work with. They might not be familiar with multidisciplinary work and community based approaches. This is why they might need time to understand the "way we do things" and will need to be trained in it. Orientation activities and time need to be planned for during the first working period and should be included in the working time of the recruited team member.

**Orientation activities include:**

- Introducing the environmental aspects and helping the person understand the context and reality s/he will be working in.
- Introducing the new recruit to the history, mission, values, principles and working approaches and practices of the NGO.
- Visiting the center.
- Visiting the neighborhood, observing at first-hand the living conditions of the users of the MH services.
- Discussing rules, ethics, appropriate dress code and families' cultural habits to respect, both in the center and on field visits .
- Discussing again working approaches and methods in more details than during the interview.

\* Have a three months trial period. This will allow making sure that the newly recruited person and the rest of the team are able to work together. This period will include orientation, training and observation. It is very important, however, to try to select the most suitable person from the beginning based on a precise and detailed job description to avoid unnecessary staff turnover every three months. This is especially important since in the mental health field a relationship of trust is key for successful work with families.

## **Action 2: Organize staff capacity building activities**

**Objective:** *To improve the knowledge and skills of all the team members to achieve their roles and tasks in the mental health center and to share and adopt the center's working approaches .*

\* Design the training activities in a strategic way based on:

- The strategy and the service provision model set by the center.
- The evaluation of the team members' needs to be able to play their role
- New situations/ types of problems met by the team, example: trauma and refugee situation
- New approaches that the team found interesting to explore or new activities to implement.

\* Organize capacity building activities of different types: formal group training sessions or programs, on the job training, supervision activities, seminar by the team to share readings, etc...

\* Provide community workers with a formal training by the team's specialists or other experts before beginning to work with the children and families about mental health, mental health problems, child language and motor development, different types of interventions, approaches related to disability, social intervention, case formulation, etc...

**For examples of topics for community workers' training please refer to toolbox doc #3.**

\* Provide community workers regularly with sessions on practical issues related to their daily work: how to do a focus group, how to prepare an awareness session, etc... and regular case studies sessions on their work with the children.

\* Provide all the team with training on the approaches used in the center and on specific topics based on the new situations they meet in the center. For example, suicide prevention, trauma problems and treatment, etc.

\* Find budget to fund the trainings. This is one of the challenges faced, however, creative solutions can often be found such as doing the trainings in-house, convincing trainers to volunteer time and saving by avoiding any unnecessary expenses.



### **Action 3: Design and implement a staff improvement assessment and action plan**

**Objective:** For each of the team members to explore what are their strengths, weaknesses, points of interest in the tasks they are responsible for; to identify what they can and would like to improve and how, and to design an action plan to serve as a reference and for monitoring.

- \* Set a methodology and tool to do the assessment and design of the improvement action plan.
- \* Explain the evaluation and improvement plan process and objectives to all the team in a group session. It is important to clarify that the objective of assessing performance is to move towards improvement and better quality of services.
- \* Use the job description and the list of knowledge and skills required to achieve the tasks of each of the team members to do the evaluation.
- \* Include in the improvement action plan the training action plan set with the team member.
- \* Set a regular appraisal system to follow up on the progress of the person accordingly to the action plan set.
- \* Evaluations can be done through annual or bi-annual meetings between each of the team members and the manager and technical leader or by a specific committee.

**For an example for the community worker improvement action plan, please refer to toolbox doc #4.**





#### **Action 4: Organize regular team meetings**

**Objective:** *For all team members to communicate and coordinate regularly about children cases follow-up (i.e. assessment results, action plan, progress of intervention, actions to take) to have a holistic understanding of the child's situation and a coordinated response; and to discuss about the center's activities and challenges and about mental health new studies and approaches. This is essential in order to have coordinated working approaches.*

**\* Set two types of regular meetings in the center:**

- One weekly or bi-monthly meeting to discuss the cases of children, (i.e. results of assessment, difficulties, progress of interventions), take joint decisions, set action plans including internal and external referrals and to coordinate the work of team members concerning the child.
- One monthly meeting to organize trainings, have important lessons learnt case studies, discuss scientific updates and studies in the mental health field, discuss challenges and logistics at the center level, etc...

\* Organize the meeting during the working hours of all team members.

\* Choose the person who will lead and facilitate the meeting and the person who will take notes (this person can change at each meeting).

\* The meeting leader or facilitators will define the meeting agenda before the meeting based on the consultation of all team members, and will share it with participants as well as the minutes of the previous meeting .

\* Depending on agenda, discuss cases of new children and children already enrolled in the care process based on the needs to take decisions concerning the follow-up of these children.

\* Depending on the agenda, discuss challenges met by the team and solutions, trainings to be organized, new studies and concepts to be shared with all the team and opportunities for new treatment approaches.

\* Give opportunity to everybody to express themselves, to communicate and to participate in decision taking.

\* Keep track of minutes of all meetings to follow up on actions decided. For an example of format for meeting minutes, please refer to toolbox doc#5

*Note that in addition to their direct purpose (having a holistic perception of child and family's problem and a unified and coordinated response approach) these multidisciplinary team meetings provide a sort of mutual support for all the team members and allow to develop their abilities through all the discussion, experiences and knowledge sharing in these meetings.*



### **Action 5: Organize regular staff care activities**

**Objective:** *To provide opportunities for staff to take care of their own well-being in their working context. Persons working in the mental health field are under significant stress and there is a need to care for them so that the team can continue working properly with the service users.*

- \* Include staff care activities in the center's policy, strategy and in the time planning and working hours of the staff to ensure the sustainability of these actions and avoid making them an added burden on the staff.

- \* Assess the needs of the team members before deciding on the types of activities to ensure relevance of these activities.

***The following are some examples of activities:***

- \* Train the team on stress management techniques by an external or internal (from the team) specialized professional.

- \* Organize very regular speak-up or support groups sessions that would be included in the work program (it has to be regular and it is sometimes better to have it outside the work location). The facilitator of these types of sessions should be external to the team to ensure neutrality of his/her positioning and expert in this field.

- \* Organize one team building activity per month, for example an "outdoor day" focusing on team building, a team lunch with team building games, etc...

- \* Make individual psychological support available during crisis.

### 3. Establishment of a child protection policy and ethical rules:

**Objective:** *To have a clear and written policy signed and implemented by all team members on child protection related aspects to allow preventing and addressing situations that might happen with the children using the services.*

**Actions:**

- \* Organize a workshop on child protection gathering all team members to train them on child protection basic issues and discuss the difficult protection related situations they face in the center and the cultural and contextual related factors and how to deal with them.
- \* Develop within the team a child protection policy including the use of tools, of follow-up measures and a monitoring system for the implementation of the policy itself.
- \* Invite all staff members to sign the child protection policy and other ethical regulations document.
- \* Designate a referent person, a child protection officer who will be responsible for case management and follow-up for child protection in the center.
- \* The protection officer follows-up on the implementation of the policy through case studies and monitoring of the measures put in place in difficult situations.
- \* Include risk assessment and risk management plans for each of the children in the assessment process and include risk management aspects at the center level.
- \* Set with the team ethics and confidentiality rules, and follow-up on the implementation of these rules that can include the following:
  - *Make sure that children's files are in closed cabinets.*
  - *Avoid conversations about children and families in public spaces and avoid displaying children's and families' names in public spaces (i.e. do not leave the list of appointments in the waiting room)*
  - *Do not share the results and reports of evaluations with anyone other than parents unless it is with their explicit permission.*
  - *Have all interviews with parents, even the first one, in a private space.*
  - *When talking on the phone with families, avoid doing that in front of other persons or try to avoid saying names of the family.*
  - *Always take permission from families if you want to take pictures, film them or audiotape their voice. For an example of picture taking consent form, please refer to toolbox doc#6.*
  - *Do not use your phone to videotape the sessions.*
  - *When providing reports/ information to donors or other NGOs, do not mention the names of children and families except if you have their informed consent, for example in case of referral to another NGO.*
  - *Explain privacy rules to parents in parents' training sessions, in the waiting room, etc...*

## 4. Health information system set up.

**Objective:** *To set a system facilitating the collection, organization, management and processing of information collected throughout the child's assessment and care; and to make use of this information to take decisions concerning the child's care process and the service strategic management.*

### **Actions:**

#### **\*\* To use the health information system for the child's care management:**

\* Set up a filing system: have all the information collected from the moment the family asks for services until the ending phase of the care process in one file for each child. This is essential for the team to have a unified and holistic understanding of the child's and family's situation and the progress of the action plan.

\* The case coordinator follows-up on the filling of information by all team members in the child's file and ensures the confidentiality and accessibility of information. All team members working with the same family might need to have access to documented information related to the other fields (i.e. social, medical, speech, motor and cognitive development) to keep a holistic and integrated vision of the child's problem and progress.

\* Use this information in the child's care management every time there is a decision to be made about the child's care process: design a unified care action plan, change of therapy or type of intervention, ending the treatment process, etc...

***Each child should have one unique file including all documentation concerning him/her, documents may include the following:***

Step of the process	Document in this file
<b><i>First contact with the family :</i></b>	<i>* The "reception or request form" filled; includes demographic information and parents' main concerns.</i>
<b><i>First assessment :</i></b>	<i>* The form filled by the psychiatrist/psychologist including a diagnostic impression and suggestions for follow-up.</i>  <i>* Medical reports – Medical diagnosis, medical treatment reports.</i>
<b><i>Multidisciplinary and community based assessments results for the child's needs and resources :</i></b>	<i>* The forms filled by each team member to note the child's evaluation results (a different colored paper can be used for each field or discipline in order to be able to quickly identify the input/ report of each of the team members in the file) including the notes of the community workers' assessment at home or in the center.</i>
<b><i>Meeting with parents to agree on an action plan :</i></b>	<i>* Action plan form signed by parents.</i>
<b><i>Documentation of care interventions and progress notes :</i></b>	<i>* The sessions documentation form.</i>  <i>* The forms filled by the CWs for home sessions, center sessions, schools visits.</i>
<b><i>Regular and end of treatment evaluation :</i></b>	<i>* The results of any assessment, tests that the child undergoes including recommendations and end of treatment action plan.</i>

**Note: The file should be designed in such a way that papers would not fall or get lost and it should be kept in a closed cabinet.**

**\*\* To use the health information system for the strategic management decisions at the center level:**

\* Decide what type of information might help you take strategic decisions about the activities to be implemented by the center's team, and accordingly what outputs are expected from the collection data tool (if this decision is not well-taken you might end-up overwhelmed with information you do not need)

\* Based on that, create or set a computerized tool that allows you to compile the needed data related to all children in one unique system to be able to easily extract various types of information useful to monitor the care processes of all children and to inform the strategic management of the services, for example:

- Number of children using each type of services,
- Types of mental health problems among the children using the services,
- Types of disabilities among the children in the target group
- Types of factors contributing to their mental health problems
- Number of sessions the child attended each month,
- Percentage of children who progressed over one year,
- Percentage of children enrolled in schools,
- Number of children in need for specialized schools, etc...
- Number of children who are not receiving the services planned for them

\* Use this information to take decisions at level of management of services, to design and decide on new activities according to the needs that are observed when the data is processed. For example: compiling information on factors contributing to the psychological distress among all the targeted children helped us in knowing what are the contributing factors for the mental health problems in the community and to plan activities to address these factors such as awareness raising sessions on specific topics, planning therapies for mothers with depression because it was one of the observed determinants for the child's mental health, etc...

\* Use this information to identify gaps in service provision in the community. For example: when collecting and analyzing information on the children's occupational needs we noticed that a certain number of children needed vocational training and there were not enough services to answer these needs.

\* Use this information to know what were the most needed services by the targeted children and accordingly increase or decrease the time of one of specialists for example.

**An example of a tool to manage information related to the children's situation and follow-up:**

The Children Case Notes (CCN) has been used since 2010 by FGC, CBRA and HI to monitor the children's follow-up and gather and compile important information on children received by the center to serve the strategic management of the services. (For an example of tool to compile and useful data about children Pleaserefer to the Children Cases notes, toolbox #7)

## 5. Networking and coordination.

**Objective:** *To set a network and a coordination system with the community stakeholders as well as the national private and public stakeholders involved in mental health.*

**Actions:**

- \* Identify all community stakeholders working with the same or other target groups in mental health and all other related fields: education, disability and rehabilitation, social services, health, livelihoods, etc...
- \* Identify all academic scientific and national mental health related networks: committees, conference organizers, etc...
- \* Contact and meet all relevant stakeholders to inform them about the center's activities, establish a coordination system (regular meetings, email listing) to involve them in all center's activities (promotion and awareness, referral system), and to ensure relevance of the activities and the continuum of care.
- \* Stay updated about all events and national meetings related to mental health by participating in seminars, national health committee meetings, conferences, etc... because this would help in clinical efficiency (i.e. being updated about researches, treatment protocols and evidence based practices) and as in advocacy and promotion.

## 6. Quality Improvement.

**Objective:**

- \* To monitor the quality standards of the center's activities
- \* To set plans to adjust and improve the center's service delivery and service management strategies. This is important to better meet the quality standards for the service, the evolving needs and challenges and the expectations of families and children using the mental health services.

**Actions:**

- \* Define quality standards for the clinical management of the services and for the provision of services.
- \* Make sure you have tools integrated in the activities follow-up to monitor each of the standards set (minutes of meetings, reporting, children files, etc.) For an example of quality criteria setting with correspondent monitoring tools, please refer to toolbox doc#8
- \* Organize regular evaluations (one every year or one every two years). There can be different types of evaluations using different methodologies. The design the evaluation protocol can be based on the following questions:
  - What is the objective of the evaluation?
  - What aspects do we want to evaluate (the technical aspects of treatment or the quality of service management)?
  - Do we want an external or internal evaluator?
  - What are the quality criteria we refer to?
  - which assessment method do we want to adopt (workshop with the team, workshop with other stakeholders, focus groups with parents, satisfaction questionnaire)?
  - who will participate in it? etc...
  - Write a specific TOR taking into consideration all the protocol aspects decided (i.e. objective, scope, etc...) and share it with the facilitator of the evaluation process?



- \* Collect already available data in the center.
- \* Implement the evaluation (it can be through workshops, focus groups, etc.) and write a report including practical recommendations.
- \* Set an action plan for services quality improvement based on the recommendations suggested by the report following the evaluation.

***Example 1 for an evaluation and quality improvement planning activity in our project:***

We had a self-guided evaluation facilitated by a colleague from HI regional team, through a three days workshop with the whole team on quality aspects.

**The objective** for the evaluation was to assess the management of services and not the technical aspects of treatment services. The assessed quality criteria were the following:

- \* Availability
- \* Affordability.
- \* Accessibility and accountability of the services.
- \* Adoption of the person centered approach.
- \* Safety of services and risk management, and
- \* Effectiveness of the services.

For each of these criteria, specific questions were raised by the evaluator during the workshop and analyzed and answered by all team members. Recommendations to improve the management of services were set all together based on the information provided by the evaluator. Based on recommendations following this self-guided evaluation, an action plan at the level of the quality of management of services was designed and implemented.

This evaluation approach allowed the team, with the support of the evaluator, to analyze what they already do and what still needs to be developed. It constituted a capacity building activity as the evaluator explained how to analyze the quality criteria, and team members were active participants in the evaluation process. This gave team members a sense of responsibility and ownership concerning the process. Moreover, setting up an improvement action plan based on recommendations allowed a better self-monitoring and follow-up for the implementation of the recommendations.

- For an example of quality improvement action plan following based on our self-guided assessment, please refer to toolbox #9
- For an example of how the person centered approach can be improved and monitored within this - action plan, please refer to toolbox#10

***Example 2 for an evaluation method used by the teams: Having a formal satisfaction survey among families using the services as one component of the service evaluation:***

\* A questionnaire was created to inform the team about the feedback of parents on the following quality criteria which were mainly related to the person-centered approach criteria:

- Respect and dignity of families by the center,
- Information sharing,
- Participation to decision making and treatment action plan,
- Empowerment activities, etc.

\* This assessment method provided more information when the facilitators for the survey were not members of the team themselves. The parent committee members helped in facilitating the survey implementation among other parents which helped in avoiding complaisance answers.

\* Results allowed understanding what the positive aspects in service delivery are and what the main complaints of parents are; and defining the gaps in the service provision based on the priorities of the parents to readjust the services accordingly.



## 7. Documentation and Research.

**Objective:** *To build the work done in the center on evidence based data and to share evidence based practices and methodologies with other stakeholders in the mental health field. Documentation can also serve advocacy activities, research purposes and monitoring and evaluation of the activities. It facilitates the ability of the staff to reflect on the activities as a team.*

### **Actions:**

- \* Specify the objective for documentation before choosing the documentation technique and process.
- \* Document the center's activities through keeping minutes of meeting, compiling specific information on targeted users such as the number of children with specific diagnoses and their progress, filming videos of sessions to show the progress of the child's situation between beginning of treatment and the end of the treatment or show specific techniques, keeping assessment and evaluation reports on the work of the center and monthly and annual reports.
- \* Always take into consideration ethical and confidentiality rules during the process.
- \* Organize methodological studies to prove hypotheses or answer specific questions to better understand the needs and challenges of the community, better adapt services to the community needs and to evaluate outcomes of a specific type of intervention to improve the efficacy of the interventions used by adopting an evidence based approach. To do that you can:
  - *Identify problems or questions that need to be studied.*
  - *Define the general hypothesis and operational hypothesis*
  - *Select adapted instruments and study methodology*
  - *Choose the most adapted sampling method and accordingly participants*
  - *Train the team who will do the field research/data collection if needed*
  - *Implement a pilot phase when needed*
  - *Implement the collection of data phase*
  - *Analyze the results that confirm or refute the hypothesis*
  - *Write recommendations, draw lessons and suggest steps for improvement*
  - *Sample size and representativeness and availability of time and resources are one of most important challenges in research field.*

## **Recommendations based on our experiences are the following:**

- *Allocate budget and resources for studies.*
- *Study problems directly related to the center's interests.*
- *Give importance and time to the preparation phase, the choice of tools, sampling method and participants' selection phase*
- *Be realistic and choose the methodology based on available resources and opportunities.*
- *Mobilize university students in relevant majors because they are valuable resources and can also benefit from this opportunity while participating to the study process.*
- *All the team can participate in the research process. Persons leading the research should have good methodological capacities and allow for team participation.*

## Lessons Learnt: challenges and recommendations

From 2010 to 2015 many aspects in the mental health service organization and service delivery in both FGC and CBRA centers have evolved through time and challenges met by both teams. We will present in the next paragraphs the difficulties and challenges met by the teams at level of organizational and management aspects as well as their recommendations based on what they've changed, or what they would have changed.

### ***1.Challenges in updating the service provision strategy based on the needs and especially to adapt to the increased flow of demand and resulting confusion in roles.***

One of the main challenges was to update the service provision strategy regularly to respond to the increasing different mental health needs of children and growing demands in the community; and to keep a clear framework for the service provision processes.

As mentioned above, since 2010, the two teams adopted a task shifting model and a community based approach as a response to the needs in the community. Within these approaches, the roles of each one of the members were clear. However, the project evolved progressively: community workers acquired new skills and got trained in different approaches, the number of children needing long term treatments increased, and the waiting list continued to grow because of increased awareness in the community and the growing visibility of the center.

As a consequence, readjustments were made on the service delivery processes and options. For example, as a way to decrease the waiting list and waiting time for the users, the CBR approach was also adopted, which induced in some cases beginning the process of service delivery by the community workers evaluation and by basic interventions or Portage, then referring to the specialist when and only if needed. This created some confusion concerning the roles of community workers' role (i.e. implementing tasks through task shifting model, case coordinators, Portage implementer?) and specialists (i.e. supervision, evaluations, or therapies?) and the tools used and tools needed.

### ***Main recommendations of the teams are:***

\* To regularly review the strategy for the service delivery as a whole to update it or adapt it to the new situations and to give a framework to adjustment phases. This requires a reflection by the team on the objectives, the context, the resources and the way to define again the new service provision model.

\* To do that, a regular update on the evolving needs would be helpful and one of the tool is the waiting list management: collecting and analyzing data on the needs of the children on the waiting list; and setting methods to manage this waiting list is required early in center's life to

prevent being overwhelmed by unprocessed data about demands and lack of resources to respond to the needs.

\* Based on the elaborated strategy, set adapted objectives for the treatment plans. For example, when a child has a disability, one of the objectives would be to increase his/her level of autonomy and the empowerment of the family. This objective is linked with the approach chosen by the center in the framework of the strategy. Accordingly, decide on the new roles and tasks of each team member, update the job descriptions and design training plans and adapted tools.

\* One of the solutions would have been for example to include in the strategy a CBR program combined with a center based program early enough to prevent the growth of the waiting list. Another option is to collaborate with other CBR programs, or NGOs providing services for children with disabilities who need long-term rehabilitation services. Group therapy programs were also one of the solutions adopted to respond to the increasing demands.

### ***2. Randomly provided training: Need to design a capacity-building strategy***

During the past years, much training was provided to the team members. However, training topics were often organized randomly and based on the opportunities: trainings organized by other NGOs specialized in certain domains (i.e. SGBV), training on programs provided by donors who want to promote a specific approach, training on techniques provided by consultants who have interesting expertise in specific areas, etc...

Even if these trainings are very important and enriching capacity-building activities for the team members, and even if they opened new opportunities, receiving training on program approaches and techniques that are not coordinated in a clear strategy created sometimes overwhelming tasks, frustrations and confusions about what are the priority tasks.

Recommendation of the teams is to plan training topics strategically based and on the specific needs of the team members in the framework of the working strategy and thus not randomly. Moreover, follow-up on the acquired skills and knowledge should be done regularly to monitor the way these skills are applied and to build other relevant training plans based on it.

### **3. Quick turn over: Need to set priorities in recruitment criteria.**

*When the mental health services were created in each of the centers, priorities among recruitment criteria were not always clear. In both teams, challenges occurred when recruited persons were:*

*\* Specialists with clinician's expertise but who do not adapt to the way of working in a multidisciplinary team and in a community based setting and who do not have the will to rethink their practice to work in such challenging conditions.*

*\* Community workers who did not have any basic background in social work or mental health and who were not at the same time able to learn and to adopt a professional attitude in the mental health field (i.e. ethics, professional relationships, etc...)*

*\* Persons who did not have the same thinking and working culture as the rest of the team.*

This sometimes led to quick and time consuming turnovers or working with persons who are not really interested or able to work in community, social and mental health fields which created frustrations for the person, the other team members and the families using the services.

One recommendation would be to set clear criteria for recruiting the team members based on the center's strategy and the role requirements within this strategy, knowing that even if orientation activities, trainings and supervision will be done for each newly recruited team member, some minimum standards are required as education, background experiences and especially interest in mental health in community based approach. While recruiting, there is also a need to grow and maintain the team spirit for all team members as part of the team's culture. For example, some specific and key attributes were noted as general characteristics of both teams working in a community based center with children living in complex context.

#### **You can take the following criteria in consideration while recruiting:**

- Respect of ethics and professional attitude.
- Positive and pro-active attitude towards the work.
- Balance between clinical and community work.
- Being at the same time pragmatic and realistic and ambitious .
- Prioritizing quality.
- Finding motivation in team work, innovative approaches and positive relations with children and families.

### **4. Time management of the team: Aspects to be taken in consideration since the beginning.**

*Different challenges occurred related to time management at very practical and at strategic levels. As the team needs to be multidisciplinary and team members need to meet all together regularly (two to four times per month), it was difficult to find a common time to meet for the specialists who are working part time and to manage the number of rooms needed on these days. The time agreed on with the specialists was also sometimes based on their own availability and did not always match the availability of children and families using the services (i.e. school time, etc...).*

On a more strategic level, the time allocated to each specialist was not always balanced with the type of needs among children using the services. For example, the time allocated for each type of therapy was the same although there was more need for one type of therapy than for the other. Another example is that occupational therapists sometimes need to do home visits and this was not taken into consideration in time/budget planning.

The time allocated for community workers was sometimes underestimated relatively to the tasks required from them: case referent and coordinator, awareness raising activities, parents' support, etc... There were times during the project life where the community workers' tasks were too many compared with the number of tasks and children they had in charge, which meant that there were not enough community workers in the team.

At strategic level also, some parents needed to have themselves therapeutic sessions, because their children's mental health problems were strongly related to their own mental health problems. This was not planned when the project was written, so there was no time specifically allocated to provide psychotherapy to parents.

#### **The teams' recommendations are:**

- \* Make an agreement on a common working day for all team members to be present in the center since the recruitment phase.
- \* A management system for rooms should be implemented to have a private and specific space for each team member (specialists and community workers) to achieve his/her tasks (i.e. the session or the interview with parents) where full confidentiality is ensured, even if on that day when all team members are present.
- \* Take into consideration the time conditions related to children and families (school time, etc...) while deciding on the availability time required from the team members.

- \* At strategic level, assess the needs of the children in the community to define the scope of intervention needed. For example, if there are many speech problems among the children, ensure enough availability or working hours for the speech therapist compared with other specialists.

- \* Decide on the number of children a community worker will be in charge of, taking into consideration all the tasks required in the job description and a weekly action plan.

- \* Ensure that some of working hours of the specialists are allocated for home visits because in some situations there is a need to have the specialist do a home evaluation (i.e. occupational therapist).

- \* Ensure that some working hours of the specialists are allocated for parents' psychotherapy sessions.

#### ***5. Absence of a computerized program for child's filing system.***

One of the teams had a very good computerized filing system to document all the data related to children's assessment and follow-up and this system was destroyed during Nahr el Bared war. Since then, both teams expressed the need to create and put in place such a computerized system but this was not done until now. This creates challenges when the team wants to retrieve old files, or even to have a report on all the interventions done with the same child. This also creates frustration because studies cannot be done despite the huge data collected throughout the years because this data has never been processed due to paper and complicated filing system.

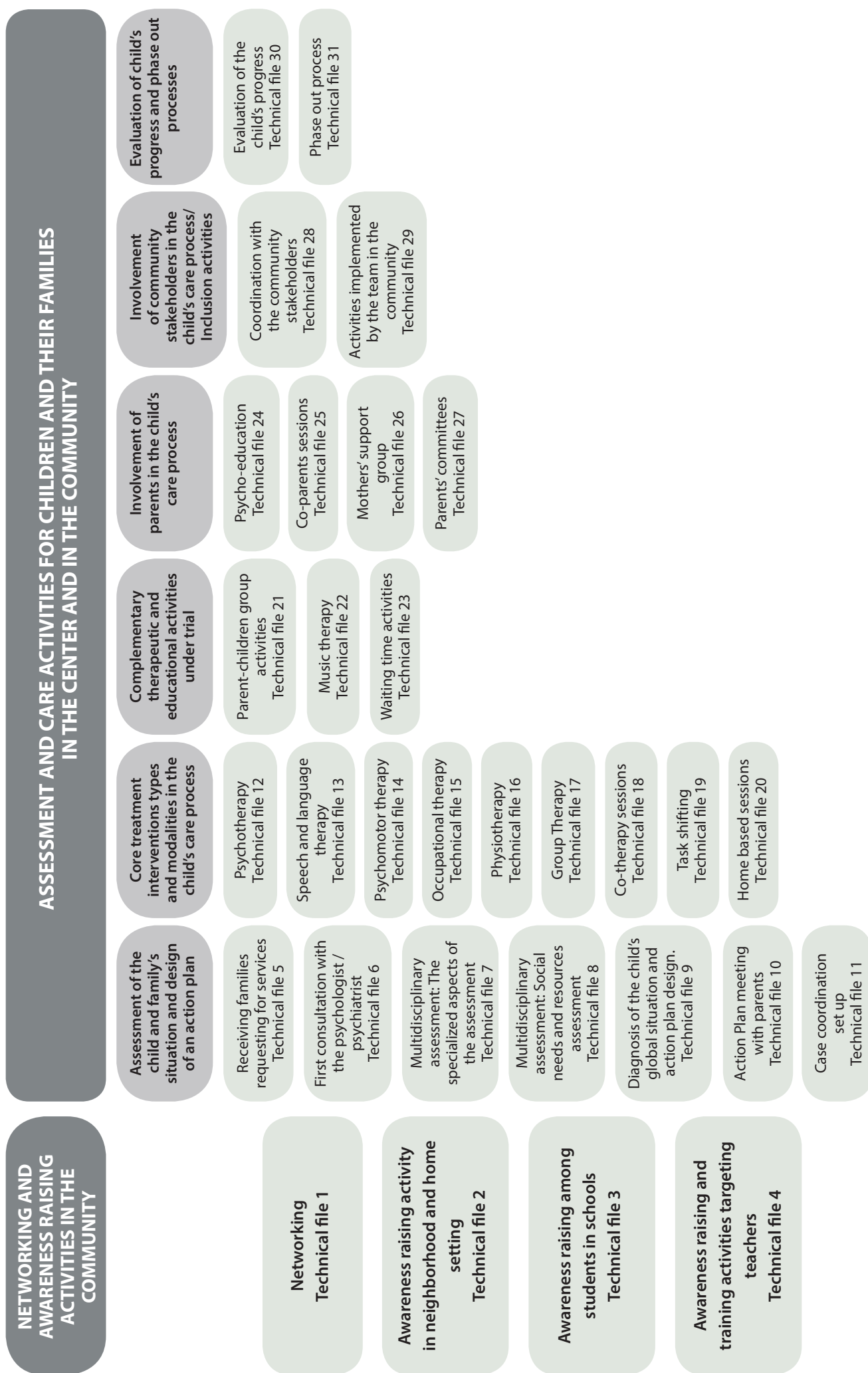
**Recommendation** would be to have the computerized filing system as one of the priorities in the center's management, and to ensure the means (i.e. computers, training, time) to use it. Based on the set service provision strategy, the team should decide on the data to be collected and documented.

## How to deliver mental health promotion and care activities?

### *Good practices:*

Based on the strategy designed for the services (cf. paragraph on strategy design), and approaches presented in section 1, we will present here a set of coordinated and linked practices aiming to promote and improve the mental health of children and their families in the community implemented by the mental health teams. All the details about each one of the practices, their target users and the steps to follow during the activities are presented in the **technical files**.

## The Practices.





## 1. Networking and raising awareness activities in the community.

**Objective:** To raise awareness and promote mental health related concepts and the services provided by the centers in the community to increase understanding on mental health issues, decrease discrimination, improve care seeking behavior and referral, prevent problems and promote coping mechanisms.

**Rationale:** A child's mental health is dependent on the community in which he/she lives in, positively and negatively.

\* Many mental health determinants are community related, like cultural representations related to education, parenthood and childhood, representation and challenges related to the situation of refugees, discrimination and isolation related to mental health problems and disabilities.

\* On the other hand and at the same time, the community has its own intrinsic protective factors. Solidarity and cooperation among families and community members, NGOs' culture in the camps, the strong relationship between service providers in education, health, rehabilitation and social field and the community members represent protective community factors for mental health.

The community mental health center needs to take into consideration these community aspects to address negative factors on one hand and to build on protective factors on another hand.

*"Accumulated evidence shows that strengthening protective factors in schools, homes and local communities, can make important contributions to improving developmental outcomes of vulnerable young people".*

### Example :

When the Palestinian refugees came from Syria fleeing war, the mental health centers noticed an increase in the number of children having speech delays. Parents fleeing war had many worries and priorities and did not give much attention to communicating with their children. Some parents also think that children do not need to be talked to before a certain age. Thus, the environmental and community related factors increased the speech delay prevalence among children. Raising awareness on language stimulation through the NGOs working with refugees coming from Syria helped parents to understand their role in preventing language delays more effectively.

### Example:

Following educational related beliefs, the child's oppositional behavior is sometimes answered by violent parental behavior or inadequate educational attitudes, sometimes leads the child to develop behavioral problems. To address this problem, the centers developed culturally related activities: community members like to meet often in extended families or among neighbors through regular social gatherings (for example in the morning there is a ritual gathering women for a coffee, etc...) and this social gathering was used to promote mental health messages related to their daily life worries such as how to deal with a child's behavioral problem.

### Actions:

\* Build a network with other community actors providing education, health, social and rehabilitation services to children to inform them about the activities and services provided by the mental health center and to highlight their role and encourage their collaboration in all mental health related activities (i.e. awareness raising, referral, inclusion activities). This network also allows the creation of a referral database *(Please refer to technical file: networking with other stakeholders working in education, health, rehabilitation, etc.)*

\* Organize and implement awareness raising and prevention activities in homes with a group of neighbors or in public spaces to increase the community members' knowledge on how to take care of their child's mental health, how to manage behavioral problems of children and when to seek care. These sessions aim to find a common language and perception among cultural perceptions and scientific knowledge. *(Please refer to technical file: Awareness raising through gatherings in home settings, also known as home stations)*

\* Organize and implement awareness raising and training among teachers in schools and KGs or animation centers, for them to better understand and accompany the child's mental health development in the most efficient way and to be able to identify and manage the child's problems. *(Please refer to technical file: Awareness raising and training targeting teachers)*

\* Organize and implement awareness raising activities among students to promote positive mental health messages and increase knowledge about mental health concepts. *(Please refer to technical file: Awareness raising and training targeting students).*

<sup>10</sup>Child and adolescent MH, WHO, 2012

## 2. Assessment for the child and family's situation and design of an action plan.

**Objective:** *To assess the mental health situation of a child and family requesting for services and to design a treatment action plan.*

**Rationale:** Networking and community awareness raising activities lead to the referral of children and their families to the center. In fact, parents arrive to the center to request services referred by the KG, the school, the clinic, a neighbor, or because the parents attended an awareness raising session on mental health problems and their child face difficulties they can cannot cope with.

The assessment system for the needs and resources of the child and family should therefore be ready and procedures clear. This assessment should be multidisciplinary when needed and person-centered to take all the needs and resources of the child into consideration when diagnosing his/her situation.

### **Actions:**

\* Receive the family requesting for care through a basic interview with the community worker who is the entry point of the care system. The community worker operates a first screening. In case the request of the parents is mental health related, the community worker gives them an appointment to meet with the psychologist or the psychiatrist. In case the needs expressed are relevant to another domain and cannot be answered by the mental health team, the community worker gives the parents information about other relevant service providers (i.e. health, education, rehabilitation, livelihoods and social services, etc...) depending on the needs and based on a referral database previously prepared throughout the networking phase (Please refer to technical file: receiving families requesting for services)

\* When the request is mental health related, provide the child and the family a first consultation with the psychologist or psychiatrist who will make a first specialized assessment of the problems of the child providing a diagnostic impression/hypothesis, a first picture of the child's problems and resources and of parents' requests and worries. (Please refer to technical file: first consultation with the psychiatrist/psychologist).

\* During a team meeting, the psychologist/psychiatrist suggest other actions for further assessment or for therapeutic intervention if no further assessment is required. For example: a child has recently expressed anxiety following a difficult event in his/her life and has obviously no other problems in other fields (i.e. speech, motor, etc...). Therefore, according to the first consultation, there will be no need for speech, occupational or psychomotor assessment, and the therapeutic intervention can start directly. On the contrary, if a child has a communication problem, language delay, and difficulty to control his/her movement and autonomy issues, and is victim of violence in the family, then he/she might go through speech, psychomotor, occupational and social assessments.

\* Provide the child and family with the assessment sessions agreed on during the team meeting and suggested by the psychologist or the psychiatrist after the first consultation. Some children might need only one type of assessment in one area; others might need several types of assessments. Other children might need only a center based assessment, or might need an assessment through a home visit. This depends on the type of information missing to complete the holistic picture of the needs and resources of the child and family. (Please refer to the two technical files: the multidisciplinary child's situation assessment: The specialized aspects of the assessment and The social needs and resources assessment).

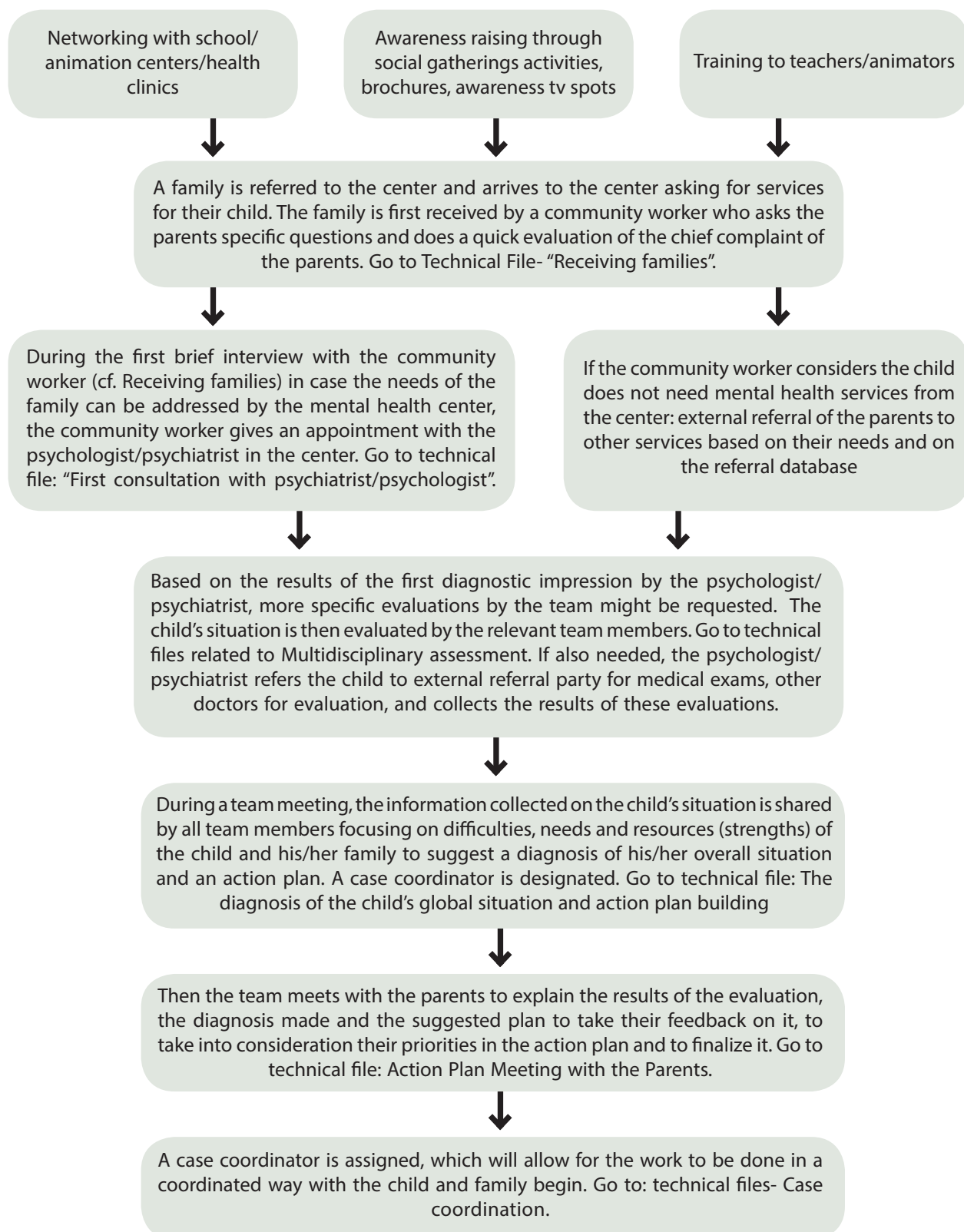
\* Share all assessments done in one team meeting to decide on an accurate action plan suggestion based on priority actions decided by all the team together (Please refer to technical file: The diagnosis of the child's global situation and action plan suggestions).

\* Meet with parents and explain the results of the assessment, focusing on problems as well as resources and strength points, using simple and understandable terms. Following a person-centered approach, all worries and questioning expressed by parents must be listened to and parents need to be accompanied in the process of understanding the evaluation made by the team. They should be encouraged to share their own expertise of the child's problem based on their own experience with the child. Their priorities should be listened to and taken in consideration in the action plan design. (Please refer to technical file: Action plan meeting with the parents).

\* Assign the role of case coordinator to one of the team members, usually one of the community workers, to coordinate all the issues related to the child's treatment. This community worker will be the focal point for parents and for external service providers like the KG, the school, the psychosocial animation center, etc... and will make sure all

aspects of the treatment are documented. (Please refer to technical file: Case coordination). Generally, this person will also be responsible of all social, community based and task-shifting interventions. It is important to note that when a child needs only one type of treatment and there is no need for social or community based interventions, the focal point is the specialist implementing the therapy. In this guide we are using the terminology

case coordination because case management might require in some framework some additional technical expertise. The community worker has of course some freedom to take basic decisions concerning the case management. However, it happens always under the supervision of the team and all important decisions concerning a child are taken based on the team's discussions and consultation and never by one team member alone.



### 3. Treatment core activities.

**Objective:** *provide treatment for the child based on the action plan designed and agreed on with parents.*

**Rationale:** There are different types of intervention and therapies that can be implemented through different types of modalities. Thus, each child has a unique designed action plan made of one or more types of therapy, and with one or more of the modalities. All combinations are possible as each child is considered as unique and each of the action plans is personalized based on the needs of the child.

#### **Actions:**

\* Provide the child with the sessions in one or more of the following types of intervention based on the designed action plan: Psychotherapy, Speech and language therapy, Psychomotor therapy, Occupational therapy, Physiotherapy (Please refer to the related technical files).

\* When the child is provided with more than one type of therapy, coordinate among the team members involved in the child's follow-up, including the case coordinator, through meetings.

\* Provide sessions following different modalities depending on the action plan decided for the interventions:

- *Through individual one-to-one sessions.*

- *Through group sessions to a group of children who have the same type of problems, who are from the same age range and for whom group therapy sessions can have a positive impact in the treatment (i.e. more motivation to participate, imitation effect, speak-up group allowing to share experience, etc...). It also allows making use of the specialists' time in a more efficient way when relevant (Please refer to the technical file: group therapy)*

- *Through the task shifting model: the community worker attends all therapy sessions provided to the child by one or more specialists, and progressively implement sessions with the child on his/her own but always under the supervision of the specialist using some basic techniques learnt in the sessions at home and/or at the center (Please refer to the technical file: task-shifting).*

- *Through co-therapy sessions: two specialists working with the same child with two different types of therapies have one or more specific and well-planned joint sessions together with the child to facilitate the generalization of acquisitions (Please refer to technical file: Co-therapy session).*

- *Through home based sessions: exercises and techniques used in the center are adapted by the community worker to the home setting allowing a direct translation between technical aspects of care at the center and home based experienced aspects related to care. Furthermore, the community worker can have an impact on the family dynamics aspects in a more direct way as she/he can observe and intervene directly on these aspects in the living place and context of the child. (Please refer to technical file: home based sessions)*



### 4. Other complementary and under trial therapeutic and educational activities.

**Objective:** *To initiate and implement alternative complementary types of interventions supporting the treatment process, knowing that new techniques are always under trial until efficiency is proven through a scientific process.*

**Rationale:** Throughout the experience and capacity-building of teams by external trainers, and based on the evolving situation of the targeted groups, some new activities are organized and tried in the centers. We can consider these as complementary therapeutic and educational activities that help in supporting the treatment process of the child. No study has been done yet to prove its effectiveness through a scientific process. However, a good impact on children and parents was observed by the team. The initiation of these activities shows that therapeutic activities might evolve through time and teams should be creative to answer the needs of the targeted group, while always respecting the "do no harm" principle.



We will share these activities as “under trial” types of activities, taking into consideration the limitation related to the fact that these are not evidence based practices yet. If readers are interested in adopting these shared practices, more research should be done to see how they can be adapted to another center with more attention measures to respect the “do no harm” principle.

#### **Activities:**

\* Music therapy is provided for children with specific types of problems to initiate a communication with them. This activity should follow a structured training program provided by a certified music therapy expert to community workers to learn how to use music therapy with children benefiting from the services in the center. Please refer to technical file: music therapy.



\* A joint parent and child group activity was initiated by one of the therapists with the community workers for parents of children with autism who were very engaged in their children care. It is important to have this activity with parents who already benefited from some type of “psychoeducation” or support through the “parents support groups” for example. Please refer to technical file: parent-child activity.

\* More simply and less technical, activities are organized to use the waiting time of parents in the waiting room to provide some type of awareness and information to these parents, as well as to create a sharing and secure space. Please refer to technical file: Waiting time activities.

## **5. Parents’ involvement in the child’s care process.**

**Objective:** *To support parents to understand the situation of their child and to be actively involved in the care process; and to empower parents to increase their autonomy in taking choices in their child’s care and child’s life, in dealing with everyday’s difficulties and in advocating for their child’s rights.*

**Rationale:** Following a person/family centered approach; the parents are considered as the constant and the reference in the child’s life as well as the experts in the child’s abilities and needs in everyday life. Children live most of their time with their family and family dynamics represent at the same time positive and negative factors contributing to their mental health situation. Working with the child with a specialist-child exclusive relationship without considering working with parents will therefore not allow having a holistic intervention and the results of this type of intervention will be limited. Thus, the mental health team considers families as having a crucial role to play in the service provision system and promotes their involvement as active partners in all steps of the treatment plan and in the center’s activities in general.

#### **Actions:**

\* Listen to parents in all steps of care and trust them in the quality of information they provide to the center to shed the light on the child’s problems and resources. The teams sometimes feel that parents do not give enough information during the assessment. In fact, some parents need time to trust the team and to understand the type of information that the team needs for their work. It is the role of the team to create trust through the way they interact with the family and precise with very simple questions the type of information needed.



\* Inform parents using words they can understand about what their child's situation is, what are his/her problems and strengths points. Give them updated information regularly on the progress of their child and parental guidance on what is expected from them to do as activities at home, under the supervision of the community worker and/or alone.

\* Take into consideration the parents' concerns and priorities in the decision making process for the treatment plan decided for their child as they are the ones who know what is the most important for the child in everyday life. A balance is always to find between the professional and the parents' point of view as it is the case between any two partners. Please refer to: Action plan meeting with parents.

\* Train and inform parents on the topics needed for them to understand their child's situation and problems and to know how to deal with it at best. This training can be done through individual psycho-education sessions or group training sessions, always based on the needs of the parents and following a very practical approach while giving theoretically important information. Please refer to the technical file: psycho-education sessions targeting parents/parental training

\* However, we noticed throughout our experience that this training is not enough. This is why parents were progressively more and more invited to attend some of the sessions with their child. What we called "co-parents sessions" allowed parents to better observe and notice the problems and the capacities of their child by observing him/her during the session and also to use the therapist as a model for the interaction with the child. From our experience, this method created new opportunities for parent-child relationship evolution in some cases, and parents learn a lot in this direct observation. It is to note that this method is not adapted for all children and all types of therapy. Always respect the "do no harm" principle when planning any type of session. Please refer to technical file: co-parents sessions.

\* Provide support and counseling for parents when needed. Sometimes, parents are the ones in need for therapy, support and counseling. The service provision system needs to allow this to happen. Parents might be the ones benefiting from the therapy when the initial complaint was about the child, especially when the observed factors contributing to the child's mental health problem are related to parents' stress.



\* Provide opportunities for parents to support each other and share experiences. Parents support groups constitute a space and time for expression and mutual support, sharing of feelings in difficult moments and sharing of solutions. This activity creates social support which has an impact on mental health well-being. Please refer to the technical file: Parents' support group.

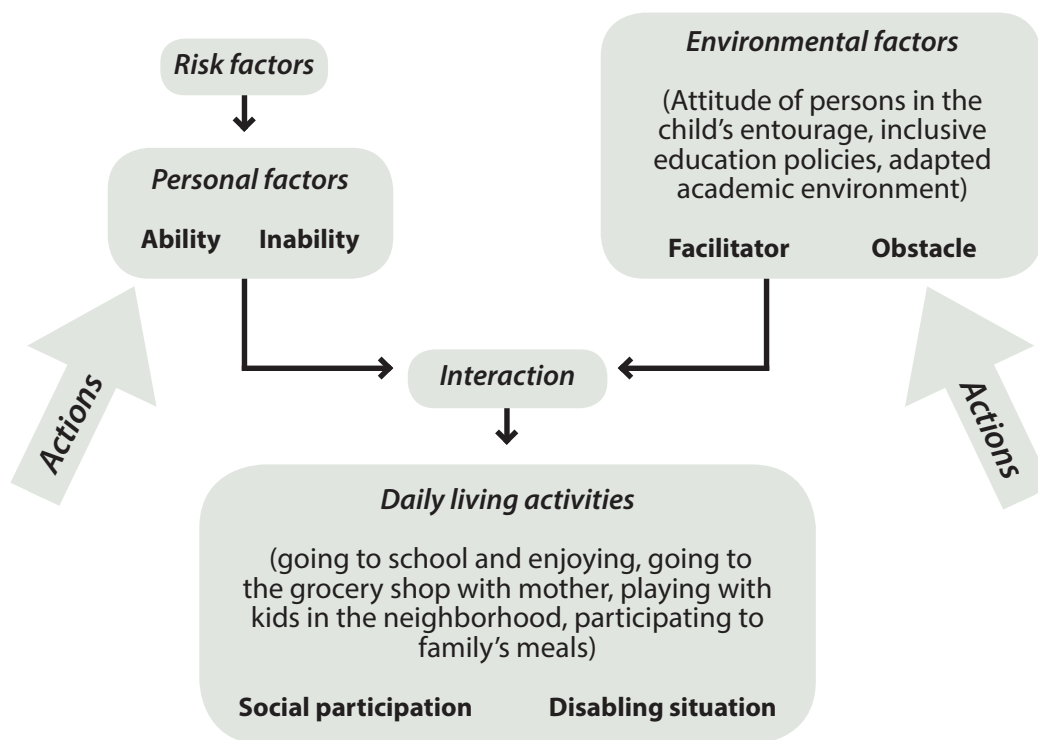
\* When some of the parents are ready, promote and support the creation of parents committees by providing opportunities for persons to meet, to share, to get trained and to decide on common actions to advocate for their children's rights, even if at local level first, beginning from changing their direct environment's attitude. Please refer to technical file: Support to parents committees.

## 6. Involvement of other stakeholders in the child's care actions.

**Objective:** To encourage and support other community stakeholders to play a role in the child's improvement for better inclusion and social participation of the child and to address the environmental factors that might lead to the decrease in the quality of the child's participation.

**Rationale:** As mentioned in paragraphs above, environmental factors are determinants for mental health problems on one hand and interact with these problems and increase them on another hand. The child's environment may be a possible source of difficulties and frustrations. Here are two examples: a child who has stuttering may have increased psychological distress and frustrations because of the teacher's reaction to his/her stuttering in class. A child with autism might be frustrated because the persons at the grocery in the neighborhood are aggressive with him/her. Thus, the attitude and role of the environment are decisive in child's social participation.

**Following the Disability Creation Process model, the community mental health interventions implemented need to target at the same time personal factors and environmental factors.**



### Actions:

\* Coordinate and collaborate with the community actors like schools, KGs or animation centers in contact with the child and who can have an impact on the child's life, and more precisely the child's well being and participation to have with these community actors unified or at least coordinated objectives and approaches to improve the child's psychological well-being. This happens through sharing information on the child's situation, setting together common goals with specific role for each party, providing guidance and recommendations on how to deal with difficult situations at the KG or school, etc. (Please refer to technical file: coordination with KG, schools, educational centers, etc.).

\* Implement care activities inside the community (i.e. in class, in the neighborhood, etc...) to facilitate the translation process between skills

learnt and developed with the child in the center and the use of these skills in his/her everyday life and the participation in the community. For example, when a child with autism is accompanied by the community worker to the grocery store after some preparation to use specific skills that the occupational therapist and speech therapist are working on with him/her in the center, the child experiments the link between these two words transferring his/her acquisitions to his/her life in the community. When a child with hyperactivity is accompanied by the community worker in his/her first football game at school to help him/her understanding and respecting game's rule, this allows the child to experiment social participation with his/her peers more successfully. (Please refer to technical file: Activities implemented by the team in school and KG for a specific child)



## 7. Evaluation of the child's progress and phase out activities.

**Objective:** *To evaluate each child's progress regularly and more specifically at the end of treatment to organize phasing out activities for the child and his/her family.*

**Rationale:** Following the interdisciplinary approach, the team needs to form a holistic understanding of the child's progress regularly. A holistic evaluation takes into consideration not only the technical aspects (skills acquired during the sessions, expression of the increase in psychological well-being) but also the observation of the progress of the child at home and in other living places (KG, schools, etc...) considering the increase of his/her autonomy at all levels, including at psychological level (ability in problem solving, in dealing with own feelings, etc...). The evaluation might lead to ending the treatment process.

The therapies' length depends on each child's case, on the action plan and goals set at the beginning of treatment and on the approaches used. However, the objective of all therapies in general is to increase the autonomy of the child and his/her family to manage their problems at all levels, throughout the treatment and the empowerment approach adopted during the treatment. Ending the treatment is a step that must be well prepared to sustain the results of the care process after stopping it.

### **Actions:**

- \* Set a clear system and criteria to assess the children's progress in a holistic approach. In our project, the decrease of psychological symptoms, increase in daily living skills, in social skills and in self-esteem, and overall, the increase of psychological well-being and autonomy were set as global criteria for the child's progress assessment independently of the type of care the child would take.
- \* Decide on a system and criteria to end the treatment of children in general. This can be that the child has achieved the treatment goals and his/her overall situation has evolved positively with his/her parents empowered as needed. It can be that the child is not improving and he/she needs another type of intervention (educational, medical, or simply working on the parent's support). This is why there is a need to set clear and realistic objectives as much as possible when beginning the follow-up with each of the children.
- \* For each child, launch the evaluation process. It can be because the child has been enrolled in the care process since a specific length of time, or because one of the team members working with the child notices an important progress or at the contrary the stagnation of the child's situation. (Please refer to the technical file: evaluation of the child's progress)
- \* Once all the team members working with the child have done an evaluation within their field, the multidisciplinary team meeting allows discussing the case of the child as needed to have a unified perception and understanding of the child's progress.
- \* Based on the evaluation and team's discussions, set new goals for the child's care process, or decide on a change in the therapies or modalities of treatment. For example, the team might decide to go for home based sessions after the child have underwent more sessions at the center, or having group therapy because the child would be more motivated and ready to work in a group. There might be a decision that the child does not need the therapy sessions anymore but the mother for example would benefit from the parents committee activities, etc...
- \* Depending on the goals set up at the beginning of treatment and the evaluation of the progress of the child's situation, the evaluation can lead to a phase out or end of treatment period. (Please refer to the technical file: Phase out process)
- \* Address the challenges to prepare the after discharge phase. Will the child be referred to another center that provides other types of services? Will the mother join a support group? Will the community worker continue the follow-up for a short period of time for specific objectives? There are many questions the team must answer before and while communicating with the parents about the end of treatment process.
- \* Communicate with parents to share preparations of the phasing out process. Parents are partners also during the ending to treatment process, and the end of treatment criteria and system must be explained and discussed also as early as possible in the process. Some parents have other expectations towards the treatment and some parents are emotionally related to the center. They need to be accompanied during the phase out process.
- \* In all cases, the centers make sure to guaranty that the child will finish this process in an organized way and that the results of the care process are as sustainable as possible at level of psychological well-being and autonomy.

## **Majed's story: A case study to illustrate the assessment and care process.**

Majed is a 3 years and 6 months old child who was referred to the mental health center by the family's neighbor. In fact, the neighbor noticed that Majed speaks very few words for his age and suggested to his parents to have a consultation at the center after she participated herself in an awareness raising session organized by the mental health team in a house in the neighborhood.

When received by the community worker for the first time, Majed's mother explained that it seems to her that her son had a speech delay comparatively with siblings and was a little bit isolated socially: he did not know how to play with his siblings and neighbors. The parents knowing that the child did not talk well yet and interacted very poorly with peers, they did not try to integrate him in a KG. The community worker gave them an appointment with the psychologist for a first consultation.

The consultation with the psychologist allowed ruling out autism, general developmental delay and medical problems, and setting the hypothesis that Majed had a simple language delay due to lack of stimulation. The assessment also allowed noting that the mother had non treated depressive symptoms after Majed's birth. The mother got well progressively but is overwhelmed by family tasks.

The child was referred for speech and language assessments. The speech therapist met with the child and parents, assessed the difficulties and strengths points, confirmed the lack of stimulation hypothesis and suggested a treatment plan to all the team during a team meeting. The community worker responsible for the living area of the child was assigned as a case coordinator. A meeting was set between the parents, the psychologist, the speech therapist and the community worker who was the case coordinator. The results of the assessment were shared with the parents. Together, they agreed on an action plan for the sessions in the center and the sessions at home. Parents were given basic advice on language stimulation and on how to give Majed more time and attention in the family.

The child benefited first from four sessions per month of speech therapy with a task shifting model: the community worker attended all the sessions and the therapist asked the community worker to repeat some specific basic exercises with the child. The community worker repeated these exercises under the observation of the therapist first then alone, during individual sessions with the child in the center and at home.

At home, the community worker did the exercises with the presence of the parents, using available material at home, for parents to acquire some stimulation skills to use with their child at home regularly to increase his language skills. Meanwhile, she noticed a constant specific dynamic between the parents and their child. He was the youngest of the children and was a little bit left alone and very little attention was given to him. She reported this to the psychologist who gave some advice on how the community worker can practically help the family making their dynamic evolve: giving more attention to Majed and a symbolic place in the family, especially through modeling and showing Majed's possibility to evolve.

The community worker also took some advice from the psychologist to increase the child's self confidence and social skills during the sessions. Following the psychologist's recommendations, the community worker facilitated the interaction between the child and his siblings at home through playing and showed the parents, through modeling, how to communicate positively with the child to increase self-confidence and encourage communication. The community worker explained to parents the importance of their role in their child's development and treatment. The community worker had an impact, through her home sessions, her guidance and modeling, on the family dynamics around Majed.

The child progressed but he still needed support. Two other children had the same type of language problems. The community worker and the speech therapist suggested to create a group and do group sessions aiming to improve language and communication skills among the group of children. Group sessions were prepared and implemented by the community worker under the supervision of the speech therapist. Some advice was provided by the psychologist on the way to manage and facilitate the relationship between the children.

The team suggested to the parents to try to integrate the child in a KG, now that he has made some improvement. The community worker visited the KG chosen by parents. She explained the situation of the child and the work that was being done with him. The KG teacher was given some advice on how to include him in class. The community worker had a session in class twice per month, to observe the child's improvement and interaction with others, and to do a small activity organized with the teacher for communication stimulation in small groups. This activity aimed to facilitate the communication of the child in the group and to show the teacher examples of exercises to be done to promote communication skills for the child and for the entire class group.

After 9 months, the child had progressed a lot, had better social skills, communicated with siblings and peers and enjoyed their company. Some minor language difficulties remained. The team began an evaluation and phasing out process. The child's progress at home, in the KG and during the sessions in the center was evaluated. A meeting with the parents allowed sharing the results of the evaluation and setting together an action plan to end the treatment. The parents were met once more to give them advice on how to sustain results of treatment and the community worker continued visiting the family once per month to work on the minor difficulties through suggested exercises by the speech therapist and to monitor the child's progress.

<sup>10</sup>*This case study aims to provide an illustration of the activities' process and not on the technical psychological or language development aspects.*

## **Lessons Learnt: challenges and recommendations.**

*From 2010 to 2015 many aspects in the mental health service delivery in both FGC and CBRA centers have evolved through time and challenges met by both teams. We will present in the following paragraphs the difficulties and challenges met by each of the teams and the relevant teams' recommendations based on what they have changed or what they would have changed in service delivery activities.*

### **1. An adapted awareness approach to the community's specificity.**

*One of the challenges in the first phase for both centers was the lack of interest of the community as well as the inadequate awarenessraising approach.*

- \* Sessions were often provided inside the center and therefore only reached specific persons.
- \* Information given by the team members to parents was sometimes very theoretical or not adapted to the conditions they are living in. For example: insisting on the need to have separate rooms for children and parents while many families have only one room in their house, or saying that hitting a child is inhuman without giving alternative ways to set discipline while hitting is perceived as an educational tool by the parents and they need support to find alternatives.
- \* Families therefore did not take instructions and exercises into consideration and had difficulties to apply advice at home as it was sometimes too theoretical and sometimes too far from their living conditions and their actual concerns or cultural habits. Moreover, mental health was not always considered as a priority for the families and there was a lack of awareness of the impact of mental health on other aspects of life.
- \* Stigma was very important and prevented families to access awareness raising and care services and made also people reluctant to talk about their mental health problems or their children mental health during the sessions.

#### **Awareness raising sessions got more efficient when it evolved at the following levels:**

- \* Awarenessraising activities were more and more provided in the community, in houses or neighborhoods
- \* Topics discussed were from the daily life concerns of the families and the communities.
- \* Sessions were prepared jointly by specialists and community workers combining the mental health expertise of the specialists and knowledge of the community workers on the community life conditions, interests and concerns, vocabulary used to name mental health issues, etc...
- \* This joint work helped in building a common language between the facilitator of the session and the participants to the awareness raising session and helped to create solutions together: solutions based on the specialist expertise and adapted to the community understanding and situation. This also helped in shifting the community culture to a more open minded culture concerning mental health.

#### **Moreover, teams suggested the following recommendations:**

- \* The awareness raising scope could grow by focusing on positive mental health, sending messages in the community aiming to help persons increasing their own family's mental health well-being.
- \* The increase of the awareness raising scope would be for example through a media and communication plan (i.e. marathon for mental health, celebrate the MH day with positive messages on t-shirts, etc.) and could reach more public places like municipalities through increasing the network of key stakeholders involved in this cause. Social media can also be used to disseminate information or messages on mental health to reach more persons in the community.
- \* However, messages should be oriented towards prevention and at the same time there should be a clear planning for how we will respond to the growing demand for mental health care services in case such awareness activities were organized.

\*Topics were discussed during sessions in a more practical way, the facilitator introducing some elements of theory then giving the possibility for the participants to discuss, to express themselves about their own experiences in their daily life and then to build on it practical recommendations about the session's topic.

## **2. Challenges to take in consideration when working with schools:**

*While working with KGs was easier for several reasons (less institutional barriers, usually better learning conditions), working with schools to raise awareness or to set collaborative action plans for a specific child represented important challenges for both teams:*

- \* Inclusive culture is very poor: teachers are not well trained on inclusion approach (attitude, ethics including confidentiality), programs are not adapted, and there are architectural obstacles.
- \* There is a lack of accountability culture and a lack of follow-up.
- \* There is no sufficient time to take care of the specificity of each child.
- \* The academic staff often lacks motivation to learn and make things evolve.
- \* The number of children in each class is very important.
- \* There is a separation between academic objectives and social and psychological objectives.

Although there are very interesting collaborative experiences based on the personal commitment of some directors and teachers, one should be aware of the limitations depending on the context. All the above conditions resulted sometimes in difficulties at the level of involvement and commitment of the teachers and the school administration, difficulties for the schools staff to collaborate, to understand and follow-up on the instructions, advice and guidance provided by the teams.

### **Therefore, recommendations of the teams would be to:**

- Promote inclusive policies, strategies and culture in surrounding schools through training and awareness raising and follow-up through regular meetings on the inclusion aspects.
- Coordinate regularly through meetings and mutual visits at managerial and technical levels with schools and KGs and build strong relationship.
- Provide incentives to school teachers and schools management. Incentives might include the following: highlight the collaborative and inclusive work done by one specific KG or one school through events presenting the methodology of work and results, which will encourage others to adopt same methods. This can be done through a pilot project focusing on the collaboration between the care center and the school and communication events would aim to share the result of this collaborative project with other schools to motivate them to do the same.
- Ensure the presence of shadow teachers in classes or train a number of persons from the community as shadow teacher and then provide the list of these persons to the KGs and schools as trained local resources.
- Base the trainings designed for schools and KGs teachers on their own direct concerns, needs and demands to increase their involvement and ownership. Organize trainings based on their working hours. Ensure follow-up session to support them in the adoption of the learnt techniques, approaches, etc.
- Request a report to be provided by the school about the activities it is doing. This will enhance the accountability system and increase the sense of ownership and shared responsibility.
- Focus on the most cooperative teachers and directors and help them act as models for others.

### **3. Challenges related to the evaluation of the children's situation and the diagnosis phase.**

*Difficulties met by the team during the child's situation assessment are the following:*

- \* There is a lack in the specialized assessment tools adapted to the culture of the community.
- \* There is a lack in financial resources to renew the tools already brought and that are outdated.
- \* In some areas, there is a lack in external resources such as specialized doctors who can collaborate with the team to set a diagnosis.
- \* Some specialized evaluation reports include technical words that are not understandable by team members.
- \* There was sometimes delay in the diagnosis because there were contradictory diagnoses provided by external doctors/stakeholders, or contradictions internally between diagnoses set by two different therapists. This situation might result of working within a multidisciplinary team and creates confusion among the team members and induces sometimes delays in action plan designing and in working with the child. Setting a clear diagnosis might also take time because symptoms do not reveal clearly the diagnosis or because there is a need for more tests. This created debate inside the teams: should we begin working with a child without setting a unified and clear diagnosis to design the action plan?
- \* There are challenges related to the process, tools and methodology used for the evaluation depending of the approach behind this process. For example, when the evaluation with the family is done by the community workers, even if the community workers are skilled enough to observe and assess specific aspects of the child's situation, there are still difficulties to formally set the internal referral system within the team on clear criteria, procedures and forms. The situations are processed case by case.

#### **Team's recommendations to respond to these challenges are the following:**

- To allocate budget/funding to renew the assessment tools.
- To create a reference guide for all technical and professional terminologies: gather all technical and scientific words/concepts and create a local reference book for our work.
- To create locally adapted tools and tests that include all aspects related to the team's work in Arabic language understandable in the area.
- To have a doctor visiting the center regularly, for example a neuro-pediatric doctor once a week.
- Look for funding or support to cover the cost of medical exams and specific tests.
- Communicate directly with the doctors who are following the child outside the center but always with the approval of parents.
- When there is a delay in the diagnosis, do not abandon the family and the child while waiting for the diagnosis. Agree and set an action plan based on what can be done at this stage with this child without harming him/her. For example: working on promoting the interaction when a child presents interaction problems and we do not know yet if it is autism, depression with autistic symptoms, or any other syndrome. Adopt the no harm principle in these cases.
- Try to have all the team agreeing on one unified evaluation and working approach with the child through discussions in the multidisciplinary meetings.
- Set assessment and internal referral procedures/methodology/tools/criteria/forms for the evaluation in link with the working approach and strategy.
- Set precise criteria that help to determinate if the child needs the intervention by the community worker through portage or CBR, or rather needs a clinical evaluation in the center by the specialist.



#### **4. Challenges met throughout adopting the different therapeutic practices.**

\* Some parents find it difficult to understand all the different types of approaches proposed to their child for example: the co-therapy sessions

\* Even if many types of practices can be proposed to the families, there are difficulties to adopt some of the practices in specific situations. For example: there is no adequate space at home to have the home based sessions, or the child's home is too far; there are not enough children having the same problems and willing to do group therapy or with a profile allowing to do with them this type of therapy; the therapist does not find it efficient or convenient to have the parent participating in the session.

\* Waiting time is a big issue: Some children need multidisciplinary follow-up and cannot benefit from more than one type of therapy for a certain period of time because of the high number of demands. However, we addressed this important issue in the first point of this paragraph.

\* The distance between the center and the living place of some of the users is too far.

\* Because of no regular renewal for the tools and materials, this material is not adapted anymore to the needs of some of the children and professionals in the framework of some of the practices.

#### **Recommendations of the teams are the following:**

- Take time to explain to parents the different types of therapies provided, their complementarities and their different objectives.

- Be flexible about the types of therapy to be provided and organize it always based on the needs of the child, in collaboration with the parents, and taking in consideration all contextual issues.

- For group therapy, try to create harmonious groups of children who can come at the same time, have the same types of problems and accept to work together. Expect and accept that some children refuse to work in group, or for some children it can be counterproductive because this method is not adapted to them.

- For the task shifting process, organize and decide in the action plan at what time (or after which duration) the community worker will be in charge of specific tasks under the specialist supervision.

- Organize home stations by areas to avoid wasting time on the roads.

- Ensure transportation means for team members and for the families.

- Have more specific and clear tools for home visits, for CBR and Portage programs.

- If you have the opportunity to choose the location of the center, choose most accessible location for the persons of the community.

- Allocate budget to update material used by professionals regularly and not only at the beginning of the project.



## 5. Challenges to involve parents in the treatment process.

*One of the important aspects of the treatment process is to involve parents in this process. Challenges met by both teams were the following:*

\* Parents are not always committed to the time agreed on for the session, or to the action plan and number of sessions set, or to the training workshop sessions. This may be related to:

- *transportation issues (center too far, not easily accessible, transportation not available),*
- *cultural and prioritization issues (receiving a visit from someone at the moment to come to the center to get the session and considering the sessions as not priority).*
- *lack of understanding of the treatment process.*
- *lack of interest or awareness on the importance of the training workshops.*
- *daily life stressors also prevent parents from participating to the activities and therapeutic sessions.*
- *lack of motivation when there are long term action plans for example to apply the exercises/instructions*

\* **Fathers' lack involvement:** This was one of the main challenges when the services were created. It evolved progressively but is still a challenge: fathers consider all educational and health issues as being the responsibility of the mother. They often do not have time to come to the sessions. However, their role in the therapy process is sometimes very important.

\* Some parents express dependence on team members: trust in the relationship can sometimes lead to important dependence of the parents on team members which make it more difficult to share responsibilities with the parents and to end the therapy process.

\* Recommendations given to parents are sometimes not realistic or adapted to the situation of the family in this community: for example the child should sleep in a separate room.

\* Parents do not have access to adapted material resources as tools and equipment.

\* Extended family can be intrusive at level of decisions and non-acceptance of the therapeutic care.

\* Parents have difficulties to talk in the presence of the other mothers when there are group activities. They are afraid that what they say would come out of the group session and be disseminated in the community.

\* Psycho-education was not very efficient when it was done in groups based on the common problems of the child because the information stayed very theoretical, abstract and general and there were differences in the level of understanding of parents.

\* Facilitation of group sessions was sometimes challenging because of the leadership management issues (i.e. difficulty to help the leader be useful for group dynamic without taking all the place), parents comparing their children skills and being frustrated about it, and because parents only asked advice about their children and took time before talking about their own needs and request for help.

### Recommendations

\* Ensure that there is a room for community worker's consultation (or group sessions) with parents because some parents need a secure and private space to share important information which would increase the parent-team quality of relationship/trust/feeling of belonging to the center.

\* Ensure transportation fees or other transportation means for parents.

\* Give as much information as possible about the accessibility means to the center and facilitate access.

\* Provide some material and tools that can be used by parents (like games) during trainings or teach them how to create it when you train parents on specific treatment approaches, techniques.

\* Agree on conditions and rules with parents about commitment and involvement required during the therapeutic phase (attendance to sessions, ...)

- \* Decide on one reference person in the family who could follow the therapeutic process of the child during this phase. This doesn't mean involving other family members in a coordinated manner whenever possible, but having at least one permanent referent person to insure continuity and transmission of information to other family members.
- \* Adapt activities time to fathers' conditions when organizing home visits or training workshops. You can use cultural opportunities or religious rituals to invite fathers to awareness raising workshops (i.e. iftar in Ramadan, father's day, etc...), and use places where fathers can feel comfortable.
- \* Provide individual psycho-education sessions where messages provided are specific, adapted to the needs of each family and child, very practical and solution oriented.
- \* Give enough time for group dynamics to evolve before expecting that personal worries and concerns will be shared in a support group or a parents committee meeting.
- \* Facilitators of group sessions need to be trained about group dynamics and how to handle difficult group situations to give space for each of the group members to express themselves in a safety atmosphere.
- \* Involve parents who have children with long-term rehabilitation needs in new activities where they can be motivated to play an active role such as in parents committees and in support groups where they can share experiences with others and give and receive social support with other parents.

## **6. Challenges related to the new and under trial therapies.**

*Throughout collaborations with other NGOs, experts and programs new therapy practices were sometimes introduced in the center's activities. The team members also enriched the team with experiences in practices used in other centers and ideas for innovative techniques. This is of course very enriching and opens the horizons for innovative therapy approaches. However, throughout the adoptions of these new practices, there were also some challenges:*

- \* These practices are often not evidence based yet.
- \* There are sometimes no links between the various innovative or alternative approaches adopted, which is again related to the need for a clear strategy allowing innovations and change by giving a clear framework for the innovative and new approaches adopted. Example: music therapy was a very interesting new therapeutic tool, but it was not evidence based and did not match with the center's need to have more community based interventions because it is a more individual-group based intervention reaching a limited number of children, and therefore did not respond to the challenges related to the long waiting list.
- \* Parents are sometimes reluctant when new innovative activities are proposed because they don't well understand the concept or accept it and express that they have other priorities (for example: commitment of parents was difficult in the beginning in the parent-child activity or the music therapy)
- \* Children who had severe difficulties made the sessions more challenging.
- \* There is sometimes a lack of material and equipment for the activity.
- \* The tasks of the community workers were very diversified which created overloads.  
The recommendations of the teams are the following:
- \* Try to base new therapy on already available evidence based practices.
- \* Suggest to have a study using the new introduced practice (for example comparison of the results with the results of a control group) to create evidence of its efficiency. Collect data based on your study hypothesis and protocol.
- \* Take time to explain the therapy more in depth to parents, explain the specific techniques used and objectives of this therapy and expect some dubitative thoughts in the beginning. You might allow them to attend a session if relevant for the treatment plan of their child (this is not always the case).

\* Have a clear strategy in the activities order: for example you might prepare the parents through the support groups where they can express themselves in a trustful framework before doing the parent child activity with them.

\* Precede the activity with training for community workers: expect the difficulties that will occur during these new activities (i.e. behavioral difficulties of children in parent-child activity) and be prepared: train the community workers on what to do in difficult situations through role plays for example. There is a need to train community workers to deal with parents in a group especially with a big group of parents and children at the same time which is challenging.

## **7. Challenges during the final evaluation of the child's situation and discharge phase.**

*When a center begins providing services in the community the team does not think spontaneously about how and on which basis therapies with the children would be ended. However, the phase out is a very important process that ensures a better sustainability for the results achieved with the child, whatever these results are.*

In our project, we set the following improvement criteria: the increase in the level of autonomy and psychological well-being (we had taken in consideration four more detailed criteria for that). However, this was a little bit general.

The lack of evaluation tools, and the lack of ownership by the different team members on common criteria in the team for ending the treatment and the lack of common understanding concerning a systemized phase out process were some of the challenges met by the team. An external main challenge was also the lack of resources in the community and the lack of availability of complementary services to refer the child to specialized educational services or example.

### **The recommendations of the team at this level are the following:**

\* To agree all together as team members on why, when and how the treatment of a child should be ended and to define these criteria based on the center's interventions goals and strategy.

\* To systemize the continuous evaluation.

\* To set a clear action plan for the period following the discharge and to insure a regular follow-up by the community workers every three months to insure recommendations are taken in consideration, to support the family in its new challenges, etc...

## **8.Challenges related to the waiting list: setting up a waiting list management system from the beginning of the services.**

*After raising awareness in the community and after networking with community stakeholders, the request for mental health services rapidly exceeded the available resources, and families had to wait to receive the services they need. This waiting time is sometimes confusing for the families. Furthermore, some simple problems might become more complex meanwhile. The team was quickly overwhelmed by the requests and at certain times the waiting list was not really "manageable" as information on all children was not processed in an efficient way.*

### **Recommendations:**

\* Each center needs to find a way to manage their waiting list. For example, a triage process based on specific criteria for "urgent" "emergency" cases and on other criteria depending on the context should be set by the team. All detailed information about the needs and situation of each family on the waiting list should be collected and organized in a way that emergency criteria would clearly appear. A regular update of the waiting list should be undertaken for example when team members have the availability to receive new children or to make sure which children still need the services.

**Specific activities are organized with families on the waiting list; the following are some examples of practices tried in the centers:**

\* While waiting for specialized services, the family may be visited and supported by the community workers to make links between their needs and the resources available in the community in any of the sectors needed. The community workers assesses the family's psychosocial situation and addresses, while waiting for specialized services, what can be addressed at community level by mobilizing and using the community and family resources. For example, the child can be referred to the other relevant community services needed: health, rehabilitation, provision of assistive device, livelihoods services, etc... Information about these services is shared by the community worker based on a referral map.

\* The family is accompanied to operate the changes the family can make without specialized help to make the situation for the child and family better and less problematic. The family is provided with basic guidance and recommendations. For example: a child has speech delay; the community worker teaches the parents basic language stimulation techniques and gives information on how the parents-child dynamics that she observed during the visit can delay the acquisition of language. Another example: a child with autism is isolated because of the fear he would hurt himself or others. The community worker suggests basic changes at physical level in the house as well as at communication level and distribution of roles in the family to increase the child's participation to his family life in a safe place. This intervention lessens the child protection problems that would have continued during the waiting time if this intervention was not done. Furthermore, this intervention allows the community worker to know better if the family meets the emergency criteria in which case they would be referred to the specialized team.

\* The Portage program is also used by the community workers to implement techniques and activities with the child and train parents to improve their child's abilities in all domains of child development.

\* Group awareness sessions are also provided to parents on the waiting list. This allows providing basic messages on education or child development, and what to do or not to do to make the situation of their child evolve positively. Moreover, a structured program called the "Parents deal" developed by War Child Holland was used with groups of parents for whom it was adapted to their needs. This allowed parents to re-question their role as parents and to discover new things about themselves and their relation to parenthood operating a certain change in the educative methods which might be one of the factors contributing to their child's mental health problem.

\* When relevant to their needs and when available, children are referred to a "psychosocial support program" which can help them increase their self-esteem, social interaction and integration in their own environment and to increase the parents' awareness on different topics (i.e. child development, rights and duties for parents and children, needs...)

\* Parents might also be encouraged to connect with other parents who have a similar situation and more specifically with parents committees. In our centers, some parents who have already been using services in the center are willing to support other parents who are new in a challenging situation with a child with mental health problems. This helps the new parents to receive social support, as well as practical information about other services available and based on personal experiences, etc... while waiting for the specialized services to be available.

<sup>12</sup> [http://www.warchildlearning.org/moredeals/parents\\_deal](http://www.warchildlearning.org/moredeals/parents_deal)

# TECHNICAL FILES

TECHNICAL FILES.

## TECHNICAL FILES

- 1- Networking with other community stakeholders
- 2- Awareness raising through gatherings in home settings
- 3- Awareness raising among students in schools
- 4- Awareness raising and training targeting teachers
  
- 5- Receiving families requesting for services
- 6- First consultation with the psychologist/psychiatrist
- 7- Multidisciplinary assessment: specialized aspects of the assessment
- 8- Multidisciplinary assessment: Social needs and resources assessment
- 9- Diagnosis of the child's global situation and action plan design
- 10- Action plan meeting with parents
- 11- Case coordination and follow-up
  
- 12- Psychotherapy
- 13- Speech and language therapy
- 14- Psychomotor therapy
- 15- Occupational therapy
- 16- Physiotherapy
- 17- Group therapy
- 18- Co-therapy sessions
- 19- Task shifting
- 20- Home based sessions
  
- 21- Parents-children Group activities
- 22- Music therapy
- 23- Waiting time activities
  
- 24- Psycho-education
- 25- Co-parent sessions
- 26- Mothers' Support groups
- 27- Parents committees
  
- 28- Coordination with the child's KG, school, educational center or animation center
- 29- Activities implemented by the team in school/KG setting for a specific child
  
- 30- Evaluation of child's progress
- 31-Phase out process activities

## 1. Networking with other community stakeholders working in education, disability, animation, social and health fields.

### Definition:

*Communication process with civil society organizations: schools, kindergartens, the popular committees, associations and social centers, educational, youth and health service providers, to inform them about the mental health program and its services and coordinate with them.*

### Objective:

- 1- Coordinate all efforts done at human resources and services level to raise awareness on mental health topics and facilitate the process of obtaining mental health services through the complementarities of roles among all local institutions (educational, medical, care, rehabilitation and youth).
- 2- Establish a framework for the cooperation process to take an organized form and to reduce the competition between civil society organizations; and develop the cooperation and teamwork to serve the interest of the children.

### Expected results:

- \* Better complementarities in the quality of services provided to the children and their families to improve their mental health.
- \* Encourage and organize children's referral mechanism, and benefit from the existing resources to support psychological services (exchange of services and partnership).
- \* Improve the integration process and adopt the concept of the integration by the institutions.
- \* Organize trainings for the staff of some institutions (associations, schools) to be able to work with children with mental health problems.
- \* Participate in organizing campaigns to raise awareness and pressure and influence policies, particularly with regards to mental health, child protection and rights.
- \* Share basic principles in dealing with the child and his/her family (for example: Person centered approach, the rights of the child) with the organizations to improve the situation of the child.
- \* Inform organizations about new activities (awareness campaigns, a new type of therapy) and involve them in significant activities like conferences ... to increase their commitment to mental health issues.

### Target group and Number of persons:

- Employees and coordinators/managers among providers of other services (educational, medical, rehabilitation, and social) or other people who play a referential role in the surrounding community.

### Steps for implementation:

1. Prepare a list of institutions, associations and centers that provide educational, health, youth and animation services.
2. Prepare a list of coordinators/managers with their phone numbers and e-mail addresses
3. Preparing lists of children who need follow-up within these centers to facilitate coordination with the person in charge .
4. Take an appointment from the coordinators/managers/directors of the institutions to visit them (coordinators, managers) .
5. Explain the objective of the meeting and explain the services provided by the center and their significance.
6. Inquire about the quality of the services of the organization with which the coordination is taking place.
7. Agree on joint goals and activities: awareness, referral and training and on a specific action plan.
8. Share publications or brochures about the center or organizations.
9. Write the minutes of meeting and the joint action plan.

### Time needed / Frequency:

Intensified at the beginning of the provision of services and becomes regular or depending on need and joint activities.



**Means of verification:**

Minutes of the meeting and the joint action plan.

**Difficulties/challenges:**

- \* Prior attitudes regarding some issues, particularly the psychological topics in general.
- \* Time constraints and difficulties in coordination because of the busyness of some organizations.
- \* The large number of organizations that coordinate randomly and which constitute a bad example of the process of coordination.
- \* Lack of proper leadership of meetings for them to be organized within the pre-prepared agenda.
- \* Expenses related to joint activities.

**Do's and Don'ts: tips and hints from experience:**

- 1- Always inform partner organizations about the topics being worked on in the field of Mental Health (Posters - Brochures - movies ...).
- 2- Always remind about the importance of coordination process by showing how it reflects positively on the interest of the children.
- 3- The person who represents the organization must be the person who attends all meetings and not be replaced at each meeting.
- 4- Do not exaggerate in the coordination process so that this process does not become overwhelming.

## **2. Awareness raising through gatherings in home settings (also known as home stations):**

### **Definition for this activity:**

*An awareness raising session provided in the form of a social gathering (for example a “sobhie”) held with persons living in the same neighborhood either in a house or at a public space, to discuss and provide information about a specific mental health topic.*

### **Objective:**

- 1- Increase knowledge and awareness on MH issues in the community or neighborhood.
- 2- Exchange experiences and highlight the resources of community itself to cope with mental health issues.
- 3- Promote care seeking attitude among parents in need.

### **Expected results:**

- \* Improved coping mechanisms in the community.
- \* Improved early intervention and referral.
- \* Improved family dynamics and ways to deal with problems.
- \* Decreased stress levels.
- \* Decreased stigmatization.
- \* Corrected misconceptions.

### **Target group:**

- Persons in the community, mainly parents or other care takers,
- 12-15 persons per session.

### **Implementing persons:**

Specialists or Community workers. Usually two persons are needed to facilitate.

### **Steps for implementation:**

#### ***Before the session:***

1. Do a needs assessment (focus group discussions, data collection from problems observed in the center, chief complaint of families, information from other NGOs/stakeholders) to decide on most relevant topics to be planned/prepared for the home stations in the community.
2. Decide on the topic for the session and main messages to be shared with participants.
3. Prepare the information to be shared during the session by the community workers in collaboration with the specialists and prepare answers to commonly asked questions on the planned topic.
4. Select participative techniques and prepare material to facilitate the acquisition of information and of practical techniques.
5. Select an active person in the community and ask her/him to invite her/his neighbors to her/his home.

#### ***During the session:***

6. Welcome and introduce the team of facilitators and ask participants to introduce themselves.
7. Introduce objectives of the sessions and basic rules of the session
8. Share the information prepared using different techniques: brain storming, quick role play, exchange of experiences, exercise, etc.
9. Allow a “Questions – Answers” time: answer questions of the participants
10. Explain about the center’s services to promote help seeking behavior when there is a need for specialized support.
11. Evaluate the session with the participants and take their suggestions for potential next sessions.

### **Time needed / Frequency:**

- 1h to 1h30 (with eventually a break),
- Can be done once a month in the same neighborhood.

**Means of verification:**

Pre-post test,  
Number of persons who attended the session.

**Tools and materials needed:**

Hand-outs, visual aids as needed: videos, brochures and leaflets, toys, needed material to do a specific exercise, etc.

**Difficulties/challenges:**

- \* Not being able to involve men as much as women.
- \* Not being able to find a time that suits all.

**Do's and Don'ts: tips and hints from experience:**

- 1- Take in consideration time constraints of the targeted group. For example, do not plan session at the time parents have to collect children from school
- 2- Encourage as much participation as possible from participants, encourage them to share their own experience, positive and negative.
- 3- Do not use jargon/technical words they won't understand, make links between technical words and community used words for same concept when needed.
- 4- Propose case study to help participants to reflect on their own situation
- 5- Use visuals: brochures, videos, etc. and practical exercises when possible.
- 6- You can invite men and women to the same session. However, they sometimes have different time availabilities and different interests. So you can do an activity specific to men using public spaces they use (coffee shops, etc.) while similarly addressing women in separate sessions
- 7- Give some time at the end of the session for persons to ask questions individually in private to the facilitator of the session.
- 8- Tell participants where they can go for more specialized advice, counseling, evaluation, specialized services, etc.

**Examples illustrating the activities:**

Examples of topics for the session: behavioral problems, bedwetting, stuttering, stress factors and stress management techniques, etc. For each of these topics, information shared was about: factors leading to the problem, ways to prevent it, ways to cope with it, when to go to a specialist.



### 3. Awareness raising activity on mental health with students in schools:

**Definition:**

*Awareness and preventive services working on the psychological, relational and social aspects of the students.*

**Objective:**

- 1- Prevent and raise awareness on the mental health of students.
- 2- Help students to understand themselves, their abilities and their personal and environmental potential; and invest them to achieve the greatest mental health possible

**Expected results:**

- \* Positively changing the behavior of students,
- \* Improving the educational environment,
- \* Developing students' personalities, developing their abilities and maintaining their mental health.

**Target group:**

- Students from 6 to 13 years,
- From 10 to 15 students in each group.

**Implementing persons:**

- Psychologist in cooperation with the social workers who have training skills.

**Steps for implementation:**

1. Selecting the school and communicate with the principal to determine the date and targeted classes
2. Selecting the topic based on the needs (through discussion with students, parents observations and recommendations of the staff at the school during the visit of community workers)
3. Preparing the information and key messages that will be discussed with the students
4. Selecting and preparing activities - Techniques: puppets, role play, drawing, dialogue, films, discussion about the brochures, a poster according to the age of the students and the subject.
5. Preparing media (video, powerpoint, brochures) tools for group games ...
6. Selecting a place within the school (preferably non-academic setting which can be equipped with tools).
7. Implementing the session (introducing the team and the objective of the session, tackle the topic through the technique – prepared activity and discussion ...)
8. Making an assessment and listening to the feedback on the session.
9. Recommendations and suggesting other topics.

**Time needed / Frequency:**

- 1 hour for each group,
- It is possible to repeat the activity once a month with the same group or with other groups depending on needs and resources.

**Means of verification:**

- Pre-post test which can be done through a game, a form, a discussion, orally...

**Related tools and materials needed:**

- Assessment form in case the assessment was done through forms; brochures, papers, pictures, puppets depending on the activity.

**Difficulties/challenges:**

- \* Difficulties at the level of responsiveness of the school administration and academic administration (bureaucracy).
- \* Specifying the time that fits with the syllabus and the time of the team.
- \* Student do not take the matter seriously.

**Do's and Don'ts: tips and hints from experience:**

- 1- Commit to good management of time.
- 2- Give an opportunity for all participants to express themselves.
- 3- Do not use passive teaching; provide information in an active participatory manner.
- 4- Do not give an example about a student enrolled in the school.

**Examples illustrating the activities:**

Topics that have been worked on with the students: development and personal development, self-esteem and self-confidence, violence among students and conflict resolution, stimulation of attention and focus, test anxiety, stress management, positive attitudes towards persons with disability.

## 4. Awareness raising and training activities with teachers and animators.

### Definition for this activity:

*Awareness raising activity or training activity performed with kindergarten and school teachers or animators at the psychosocial animation centers.*

### Objective:

- 1- Increase the awareness of teachers, educators and animators on mental health.
- 2- Increase their knowledge to understand and notice the problems and difficulties of children at schools, kindergartens or centers.
- 3- Increase their knowledge and acquisition of techniques to find solutions to these problems or difficulties.

### Expected results:

- \* Participants can better deal with the problems of children in school or kindergarten or psychosocial animation centers
- \* The quality of school life or in kindergarten or in the center is improved.
- \* School integration process- in psychosocial activities for children with disabilities, is facilitated.
- \* The relationship between the school or kindergarten or animation centers with the mental health center is improved.
- \* The children in need of treatment and their families are referred to the specialized center.

### Target group:

- Educators, teachers and animators.
- From 8 to 15 persons in each group.

### Implementing persons:

- \* The coordinator.
- \* The community worker.
- \* The specialist concerned in the subject of training.

### Steps for implementation:

1. Implement an assessment on topics of interest of teachers or animators and around which awareness raising is needed.
2. Identify the topic which will be tackled in the training or awareness session according to priority shown in the statistics and identify the target group.
3. Set an agreement with the principals of schools or kindergartens or centers who will participate in workshops.
4. Identify and prepare the content and material of the training or awareness sessions, which means the basic messages and information to be transferred and discussed with the trainees .
5. Identify audio-visual support materials.
6. Determine the time and place.

### During the activity:

7. Explain the objectives of the session and its methodology.
8. Explain the importance of not mentioning the names of children if case studies were raised to maintain privacy.
9. Present and discuss the information.
10. Give some time for trainees' questions and discussion of real life situations they face.
11. Distribute of material/ Brochures/ posters if any.

### Time needed / Frequency:

- From 1 hour to 1 hour and 30 min for each session
- The frequency of sessions is determined based on needs.

*Some sessions might be implemented with several groups, or several sessions for the same group depending on needs and resources.*

**Means of verification:**

- Pre-post surveys.

**Tools and materials needed:**

- \* Pre-post surveys.
- \* Brochures, publications, CDs and other audio-visual materials.

**Difficulties/challenges:**

- \* Time constraint of teachers/administration and difficulties in finding common timings.
- \* The place is not prepared.
- \* Teachers leave and enter the session frequently .

**Do's and Don'ts: tips and hints from experience:****Do's:**

- \* Try to do the workshop in a closed space that allows the creation of atmosphere that facilitates concentration and privacy, especially if some children cases will be discussed.
- \* Follow-up as much as possible with the trainees through case study sessions or other trainings.



## 5. Receiving families requesting for services.

### **Definition for this activity:**

*The first meeting with the family applying for services.*

### **Objective:**

- 1- Listening to the family's request to determine the quality of service they are applying for
- 2- Collect the necessary information and explain about the services provided by the center.

### **Expected results:**

- \* Determine the appropriate service for the child and his/her family, and if the service is available at the center or in other centers.
- \* Determine the next step with the family to answer their request (appointment with a specialist or psychiatrist, referral to another center ....).
- \* Obtain preliminary information on the family and the child.

### **Target group:**

- One of the family members who applied for services.

### **Implementing persons:**

- \* Community worker.

### **Steps for implementation:**

1. Greeting the family and introducing the social worker's name.
2. Listening to the complaint - the problem – the request of the family seeking the service.
3. Introducing to the family the services available at the center and the way of working at the center in a simple way.
4. Filling out the application to the service form by asking some key questions to obtain preliminary information about the targeted individual (name, age, residence, kindergarten - school, and parents' request).
5. Identifying the next step: giving a date or specifying the waiting period before calling them to schedule an appointment.
6. Clarifying the service fees if it is offered in the center.
7. Giving the number of the center.
8. Referring to another center based on the list of services in the surrounding area if the center's services do not fit the request and needs of the family, and helping the family in contacting the other center if needed.

### **Time needed / Frequency:**

- From 15 to 30 minutes; this meeting happens once.

### **Means of verification:**

- Service request form filled out.

### **Tools and materials needed:**

- \* Service request template.

**Difficulties/challenges:**

- \* The member of the family who is applying for service does not know all the information about the child (sometimes Aunt - stepmother ...).
- \* Some prejudiced ideas and misconceptions about psychological problems which lead the family to provide unclear information sometimes or to fill out the form in a quick and stressed way.

**Do's and Don'ts: tips and hints from experience:****Do's:**

- \* Smile and greet the family with welcoming face expressions.
- \* Make your questions clear and simple using the family's language.
- \* Explain things simply and do not exaggerate in giving detail.
- \* Pay attention to the terminology used by the family and do not use new technical terms.
- \* Inform the family about confidentiality and the basic rules of the center.
- \* Use a private and closed place for meetings to maintain confidentiality and privacy.

**Don'ts:**

- \* Do not suggest a diagnosis of the child's problem.
- \* Do not give solutions because the problem is not specified at this stage, and the image of the situation of child is not clear yet.
- \* Do not suggest answers when you ask questions while filling out the form with the family.
- \* Do not make promises especially about the services that are not available on a permanent basis at the center.
- \* Do not use terms that were not used by parents: for example, avoid using the word "concentration problem" when parents have spoken about "comprehension problem".

**For an example of service request form, please refer to toolbox doc #11**

## 6. First consultation with the psychiatrist or the psychologist .

### Definition for this activity:

*Primary specialized bio-psychosocial assessment based on the child's situation.*

### Objective:

1- Form a diagnostic impression and an initial picture of the child's bio-psychosocial situation, and the difficulties and resources of the child and the family.

### Expected results:

- \* A preliminary action plan for the interventions of the rest of the team members to assess the child's difficulties and abilities in specific fields and give guidance to the family.
- \* The child is referred to do medical tests or other assessments outside the center when needed to complete the picture on his/her situation.
- \* The family gains a greater understanding of the nature of the difficulties of the child and the next steps to deal with these difficulties.

### Target group:

- The family of the child who shows psychological difficulties, behavioral problems, adjustment problems, delays in one or more fields of growth.

### Implementing persons:

- \* Psychiatrist or psychologist (in case there is a psychiatrist in the team, he/she can also assess the medical situation and medical needs).

### Steps for implementation:

1. Checking out the child's file (reception form and other documents if available).
2. Greeting the family and listening to their complaints or the difficulties they are facing.
3. Checking out the medical history and the history of the development of the child.
4. Inquiring about the symptoms and their history; and the medical, environmental, social, relational factors, which can be associated with the symptoms.
5. Giving the family the necessary preliminary explanations of the symptoms, their causes and how to deal with them.
6. Requesting medical examinations when needed.
7. Determining the need for assessments, treatments or other interventions in the areas available at the center.

### Time needed / Frequency:

- From 30 to 45 minutes.

### Means of verification:

- The specific form used by the psychiatrist or the psychologist .

### Tools and materials needed:

- \* The specific form used by the psychiatrist or the psychologist

### Difficulties/challenges:

- \* The family might hide some basic information out of fear of being judged.
- \* Services are free, which can lead to lack of commitment from the family.
- \* Fear of stigma: A family member might come secretly which complicates the working process.
- \* Lack of documentation of medical information or information about the development of the child might make it difficult to form a clear idea of the diagnosis.

### **Do's and Don'ts: tips and hints from experience:**

#### ***Do's:***

- \* Remind the parents about the team's confidentiality rules.
- \* Answer all the family's questions as clearly as possible because they have the right to understand all matters related to them.

#### ***Don'ts:***

- \* Do not use technical words without explaining them and ensuring that the family understands them.
- \* Do not blame the family but give them the responsibility of following-up rehabilitation process.

## 7. The multidisciplinary assessment: the specialized aspects of the assessment .

Most of the children go through assessment in **one to three of the following disciplines**, based on the first assessment and referral done by the psychologist/psychiatrist.

	Speech and Language Assessment	Occupational therapy assessment	Psychomotor Assessment	Psychological assessment	Physiotherapy assessment
<b>Definition</b>	<p>Assess the child's communication and language skills:</p> <ul style="list-style-type: none"> <li>✓ Communication skills</li> <li>✓ Articulation (utterance),</li> <li>✓ Speech and fluency</li> <li>✓ Oral language (spoken)</li> <li>✓ Spelling, reading comprehension, reading, literacy skills and math)</li> <li>✓ Voice</li> </ul>	<p>Assess the child's following abilities:</p> <ul style="list-style-type: none"> <li>✓ Motor abilities (fine and gross motor skills, bimanual coordination, hand manipulation...),</li> <li>✓ Sensory abilities (visual ability, tactile ability etc.)</li> <li>✓ Cognitive abilities (visual perception, visuo- spatial ability, memory, visual attention, spatial organization and</li> </ul>	<p>Assess the child's psychomotor skills:</p> <ul style="list-style-type: none"> <li>✓ Interactive modalities (communication skills)</li> <li>✓ Body schema (knowledge of the body parts, gestures imitation and body image representation)</li> <li>✓ Tonicity (controlling the muscle tone)</li> <li>✓ Laterality (knowledge of left/right concepts on self, on others and according to objects)</li> <li>✓ Gross motor skills (dynamic/static coordination &amp; balance)</li> <li>✓ Manual abilities (fine motor skills, eye-hand coordination, bimanual coordination)</li> <li>✓ Hand writing skills (pencil grip, body posture, perceptive decoding)</li> <li>✓ Time (time orientation and</li> </ul>	<p>Assess the difficulties and capacities of the child at one or both of the following levels:</p> <ul style="list-style-type: none"> <li>✓ Emotional, relational and behavioral levels to identify causes and types of psychological distress</li> <li>✓ Cognitive level (memory, concentration, analysis, logical</li> </ul>	<p>Assess physical abilities of a child with a mobility problem</p>

	time concept, body schema....)	<ul style="list-style-type: none"> <li>✓ organization)</li> <li>✓ Space (spatial notions and perceptive analysis)</li> <li>✓ Cognitive functions (attention tests.</li> </ul>	sequencing, etc.) through standardized tests.	
<b>Objective</b>	<ul style="list-style-type: none"> <li>To determine the child's capacities and difficulties in a specific domain according to the standards for his age</li> <li>To determine the resources of the child and his environment: parents, family, school, in relation with each of the disciplines.</li> </ul>			
<b>Expected results</b>	<ul style="list-style-type: none"> <li>✓ Share the diagnostic impression and information on the assessed difficulties and resources of the child with the rest of the team</li> <li>✓ Contribute to set a diagnosis of the child's situation and suggest a treatment plan for the child and family including short/mid/long term goals.</li> </ul>			
<b>Target group</b>	Children presenting communication and language difficulties	Children presenting motor, and / or sensory and / or cognitive difficulties impeding their independence in the daily living activities	Children presenting difficulties in one or more of the psychomotor domains mentioned above.	Children with mobility problems, physical disabilities
<b>Persons implementing</b>	Speech and language therapist	Occupational therapist	Psychomotor therapist	Clinical Psychologist Physiotherapist
<b>Steps for implementation</b>	<ol style="list-style-type: none"> <li>Consult the child's file to review information on the medical and developmental history (psychological, motor, language) as well as information on social background already collected by the team</li> <li>Meet the parents to discuss with them the child's main problems, specific information about the child's development in the specific domain of assessment, potential factors and life situations contributing to his difficulties, the family's priorities and needs related to the child's situation, etc.</li> <li>Start the assessment sessions with the child using adequate tools</li> <li>Analyze and report the results to be shared with the team and the parents.</li> </ol>			
<b>Time needed Frequency</b>	<ul style="list-style-type: none"> <li>- 2 to 3 evaluation sessions for each of the disciplines.</li> <li>- 45 min per session</li> <li>- Time needed for reporting is 1.5 to 2 hours and should be taken in consideration when organizing the specialists' time in the center.</li> <li>- Steps 3 and 4 can be repeated to evaluate the child's progress every 6 months to 1 year to update the action plan.</li> </ul>			
<b>Means of verification</b>	Report including results and recommended action plan present			
<b>Tools used and materials</b>	<ul style="list-style-type: none"> <li>- Standardized assessment tests in each of the disciplines.</li> <li>- Qualitative observation checklists, interviews forms</li> <li>- Papers, pencils, games and toys for play based observation,</li> </ul>			



	- Other specific material for each of the disciplines
<b>Difficulties/ challenges</b>	Lack of standardized tests adapted to the community which might lead to a misinterpretation of results Parents' attitude towards mental health problems or disability or of their child.
	Parents unrealistic expectations Parents not giving all information in a precise way
<b>Do and Don'ts: tips and hints from experience.</b>	<p><b>Do's</b></p> <ul style="list-style-type: none"> <li>✓ Take your time to assess the social implications (ex: integration in schools) and have a global perspective of the child (social, familial, academic).</li> <li>✓ Develop a partnership with parents, through building a secure/trustful framework with them and gaining their confidence</li> <li>✓ Give time to parents: listen to them and note their remarks</li> <li>✓ Do not judge/blame the parents for their children difficulties.</li> <li>✓ Take into consideration the parents complaint when assessing the child (start assessing with test that responds to parents / child needs).</li> <li>✓ Explain to the parents and child the evaluation process with words they are able to understand, and explain about the confidentiality rules if needed</li> <li>✓ Be sure that the child knows what is going to happen and understands your instructions.</li> <li>✓ In addition to the quantitative evaluation, it's important to have a qualitative analysis of the results.</li> </ul> <p><b>Don'ts</b></p> <ul style="list-style-type: none"> <li>✓ Don't teach/coach the child, let him/her do and observe him/her quietly.</li> <li>✓ Don't judge the child before assessing him/her or only based on the information given by parents. It may take time for a child to show her/ his ability.</li> <li>✓ If needed, accept to work with the child in the presence of his/her parents in the first session (it helps to calm the child and prepare him/her to respond to your instructions).</li> <li>✓ Don't be mislead/biased by the cultural differences especially at level of language and don't overlook the specificity of the setting of the users</li> <li>✓ Don't have an assessment session to a child who is has fever or is sick</li> <li>✓ Give the necessary time to do the tests.</li> </ul>

## 8. The multidisciplinary assessment: the social needs and resources assessment.

### Definition for this activity:

*The process of gathering information and checking the social status of the child and family through an interview with the family at the center or an interview and observation at home.*

### Objective:

Identify needs and social and environmental resources of the child and family to contribute to forming a picture of the general situation of the child to be shared with the team to develop a follow-up plan.

### Expected results:

- \* Comprehensive view of the economic, social, health, educational and developmental situation of the child.
- \* Propose and develop a modified intervention plan adapted to the situation of the family (the economic, health, social and educational situation).

### Target group:

- Child and Family intended to be followed up therapeutically.
- Family that requires social intervention.

### Implementing persons:

- \* Community worker.

### Steps for implementation:

- 1- Checking the information in the child's file.
- 2- Contacting parents and scheduling an appointment with them at the center or at home with an explanation of the objective.
- 3- In addition to the application, preparing questions to be asked to the family based on the recommendations of the team, and the list of things to be monitored in case a home visit was done.
- 4- Accurately preparing monitoring and observation tools.
- 5- Meeting parents at the center or in a home visit.

### During the visit or meeting:

- 6- Explaining to the parents the purpose of the visit or meeting.
- 7- Filling out the form through a conversation with the parents (one of the parents or both, or another caregiver if needed), and monitoring and observing issues related to the situation:

- **Economic:** for example, the geographical situation of the housing, and economic resources of the family.
- **Social :** For example: people who participate in child-rearing, presence of people with a disability or with health problems at home, identifying resources that can be beneficial for treatment such as people that the person is taking care of them at home, games ...
- **Relational:** For example: the quality of communication with the child, among brothers, among parents or other family members.
- **Daily living skills** acquired by the child, for example: his/her ability to go to the bathroom alone, to move independently in the house
- The stage of motor, language and cognitive development for the child as agreed with specialists: for example, the ability to concentrate, name items in the house, playing specific games...

- 8- Sharing information with the team, developing an action plan for social intervention, referring the family to other services and coordinating with referred centers, home therapy sessions and case management in general.

### Time needed / Frequency:

- From 40 minutes to 1 hour.
- This assessment happens once usually at the beginning of the rehabilitation process.

**Means of verification:**

- Filling out a form and monitoring tool.

**Tools and materials needed:**

- \* Form- monitoring tool

**Difficulties/challenges:**

- \* Presence of visitors at home, having more than one family in the house, security situation, small house.

**Do's and Don'ts: tips and hints from experience:*****Do's:***

- \* Listen.
- \* Respect the home, customs and traditions (sitting position, dress, cleanliness, hospitality).
- \* Commit to maintaining confidentiality.

***Don'ts***

- \* Do not blame or let parents bear the guilt.
- \* Do not use terms that are not understandable or in another language.
- \* Do not give uncertain promises.
- \* Keep a professional framework for communication (to maintain the specified objective of the meeting, without delving into things outside of the frame of targeted subject).
- \* Do not address the personal information relating to you as a community worker.

**For examples of forms or questionnaires, please refer to toolbox #12-13**

## 9. The diagnosis of the child's global situation and action plan building.

### Definition for this activity:

*The meeting aiming to discuss and determine the diagnosis of the child's situation and the action plan by the whole team.*

### Objective:

- To share the different evaluation results done with the child.
- To define the diagnosis for the situation of the child.
- To propose a clear and a interdisciplinary treatment plan.

### Expected results:

- \* A clear diagnosis for the child's difficulties and a clear situation analysis for the child and family strengths and needs.
- \* A holistic action plan as a team.

### Target group:

- Children who were evaluated earlier by the team members

### Implementing persons:

- \* Specialists and community workers who were involved in the child's assessment.

### Steps for implementation:

- 1- Each specialists share his/her diagnostic impression according to his/her specific evaluation defining difficulties and resources of the child and family.
- 2- The team designs a short-term, mid-term and long-term action plan including:
  - \* Types of therapy or interventions the child will have and by whom.
  - \* Short/mid/long term objectives of these therapies/interventions.
  - \* Frequency of sessions.
  - \* Referral to other centers when needed.
- 3- A case coordinator is designated to work with the child and family.
- 4- A meeting is decided to share with parents the results and action plan.

### Time needed / Frequency:

- 1 hour of discussion for each child. This diagnosis phase happens once.

### Means of verification:

- Meeting minutes.
- Action plan format filled.

### Tools and materials needed:

- \* Report of the evaluation done by each of the team members. Action plan format.

### Difficulties/challenges:

- \* The financial difficulties of completing the medical examinations outside the center.
- \* Lack of time to do this meeting for all children.

**Do's and Don'ts: tips and hints from experience:**

- \* Allocate specific time for this meeting in the team's schedule.
- \* Take in consideration the request of parents in setting the priorities in the action plan because they are the ones who live with the child and now his daily needs.
- \* Be flexible to put a suitable treatment plan according to child's difficulties.
- \* Don't give up on diagnosis difficulties.
- \* Don't over generalize according to symptoms: each child is unique in his treatment plan.

## 10. The Action Plan Meeting with the Parents.

### Definition for this activity:

*A meeting with the child's parents to discuss with them the results of the assessment and the proposed treatment plan, and to agree on it.*

### Objective:

- Present and explain to the parents the skills and difficulties of the child compared to his/her age range.
- Inform them about the intervention plan: introduce the different types of therapies proposed, their objective, the different modalities (individual center sessions, group sessions, home based sessions, school visits, etc.) and the link between them.
- Listen to their input (priorities, choices, expectations) and take it in consideration as much as possible in the action plan.

### Expected results:

- \* The parents are sensitized on the child's difficulties and understand the therapeutic interventions and modalities proposed in the action plan.
- \* A partnership is created between the team and the parents to implement the intervention plan
- \* Increased responsibility and contribution of the parents
- \* Misconceptions and wrong behaviors are adjusted (on the long-term)

### Target group:

- Parents. (Presence of the child is an option depending on age and objective of having the child present).

### Implementing persons:

- \* Team members involved in the child's action plan and treatment, or at least representatives of these team members who will be the most involved in the treatment.

### Steps for implementation:

- 1- Identify and explain the diagnosis to parents.
- 2- Explain the difficulties and strengths of the child.
- 3- Specify the suggested areas of intervention and the goals.
- 4- Explain possible options if any.
- 5- Listen to and answer the questions of parents (concerning diagnosis, causing factors, treatment options and process).
- 6- Highlight the crucial role of the parents' engagement in the treatment plan
- 7- Agree with them on the action plan: frequency of sessions per month, home visits, their own role and activities.
- 8- Both center and parents sign on the action plan.

### Time needed / Frequency:

- 1 session, 45 to 60 min.
- This meeting happens each time the action plan needs to be updated.

### Means of verification:

- Meeting minutes.
- Action plan signed.

### Tools and materials needed:

- \* Action plan signed by both center and parents.
- \* Minutes of meeting form.



**Difficulties/challenges:**

- \* Normal stages in diagnosis announcement: rejection and resistance to the information, anxiety of parents and need for support to better accept and understand the situation of the child.
- \* Lack of knowledge concerning the diagnosis.

**Do's and Don'ts: tips and hints from experience:**

- \* Listen to all questions and answer with accurate information
- \* Do not give false expectations and do not "simplify" the difficulties and the same time do not hesitate to stress positive aspects or strengths.
- \* Use parents friendly language: explain all technical words, speak their language, and avoid jargon.
- \* When talking about the objectives of treatment, talk about how this will impact daily life of the child.
- \* Don't take rejection of diagnosis and treatment personally and accompany parents in their questioning.
- \* Give choices to parents concerning types and modalities of intervention when possible and give the parents support to make informed decisions.
- \* Give time to the parents to make their decision if needed.

**For an example of action plan format please refer to toolbox doc# 15**

## 11. Child's case coordination and follow-up.

### Definition for this activity:

*Managing and following-up on the rehabilitation process for the child and family.*

### Objective:

Follow-up on the implementation of the action plan and coordination with the concerned parties in the rehabilitation process: family, school, specialists, psychosocial activities centers ...

### Expected results:

- \* Communication among the three parties: the child and his/her family, the team at the center, and other services (educational, social, medical, etc...) is insured.
- \* The child and family obtain different services in other centers through following up on the referral process (educational, social, for example, to ensure or to give financial assistance, medical, recreational activities etc...).
- \* Integrating the child in school and in other public services.
- \* Child file is updated and maintained.
- \* Parents are supported to understand and apply the comprehensive goals for the child's situation and work with them to achieve the action plan.

### Target group:

- Children and their parents using services from the center.

### Implementing persons:

- \* Community worker (case manager).

*Note: The case manager is often the one who identifies the resources and social needs, and who does some tasks - therapy sessions following "task shifting" approach, and gives the family guidance.*

### Steps for implementation:

1. Determine, by the team, who is the community worker who will manage the child's situation (case manager).
2. The community worker (case manager) makes sure that the necessary data for diagnosis, follow-up and review of the information relating to the situation of the child exist in the child's file.
3. Meet with specialists to discuss the diagnosis of the child's situation and agree on a follow-up plan.
4. Participate in meetings between parents and professionals.
5. Make sure appointments are taken by the family and follow up on them.
6. Refer the child and his/her family when needed to a specialized center, vocational center, a kindergarten, psychosocial activities, livelihood activities, assistive devices, etc...
7. Follow-up on the referral and coordination with the center where the person is referred, and support the center when needed through guidance and orientation.
8. Coordinate with school or educational service provider for the child and support them.
9. The application of guided therapeutic programs with the child through the plan agreed on with the team.
10. Give support and guidance to families based on the agreed plan with the team.
11. Make sure that the child's file is updated by the team and the required data are filled out.

### Time needed / Frequency:

- Constant follow-up of the child as long as he is using services from the center.

### Means of verification:

- Child's file is filled out, data are existing.

**Tools and materials needed:**

- \* Child's file.

**Difficulties/challenges:**

- \* Family discontinuity the follow up.
- \* Heavy load on the community worker due to working with a big number of cases of children.

**Do's and Don'ts: tips and hints from experience:*****Do's:***

- \* Organize your time and document everything that is related to the child's follow up during sessions, home visits and coordination with the school or kindergarten.
- \* Speak always with the language of the family.

**For an example of community worker and case coordination action plan please refer to toolbox doc#14**

## 12. Psychotherapy.

### **Definition for this activity:**

*An accompaniment method allowing supporting a child and his/her family to manage and overcome psychological distress.*

### **Objective:**

- Promote a significant change in the child's functioning at cognitive, emotional and behavioral levels.
- Promote a significant change in family dynamics.

### **Expected results:**

- \* Improved capacity of the child and family to adapt, manage and confront met difficulties.

### **Target group:**

- Children with psychological difficulties.

### **Implementing persons:**

- \* Psychotherapist.

### **Steps for implementation:**

#### ***First session:***

- 1- Explain to the child the role of the therapist the objective for him/her to come to the sessions.
- 2- Explain to parents and child the therapy objectives, framework and rules, the therapeutic process, the professional confidentiality, etc.

#### ***Follow-up psychotherapy sessions:***

- 3- Use oral expression, as well playing, drawing, storytelling, role playing with the child to allow him/her expressing him/herself, putting words on emotions, relational conflicts and events that happened, understanding and managing his behavior, etc.
- 4- Meet with the parents upon needs to give parental guidance. It can be after the session with the child or in a specific meeting with the parents.

### **Time needed / Frequency:**

- 30-45minutes, once per week.

### **Means of verification:**

- Individual Therapy Session form filled.

### **Tools and materials needed:**

- \* Drawing/painting tools, make belief games, toys, stories, puppets.
- \* The child's file containing drawings, psychologist notes, etc. which is a confidentiality file kept by the psychologist.

### **Difficulties/challenges:**

- \* Misconceptions about mental health, stigma, not believing in the needs for psychotherapy and in psychotherapy as an efficient solution.
- \* Difficulties getting the family engaged in the process.

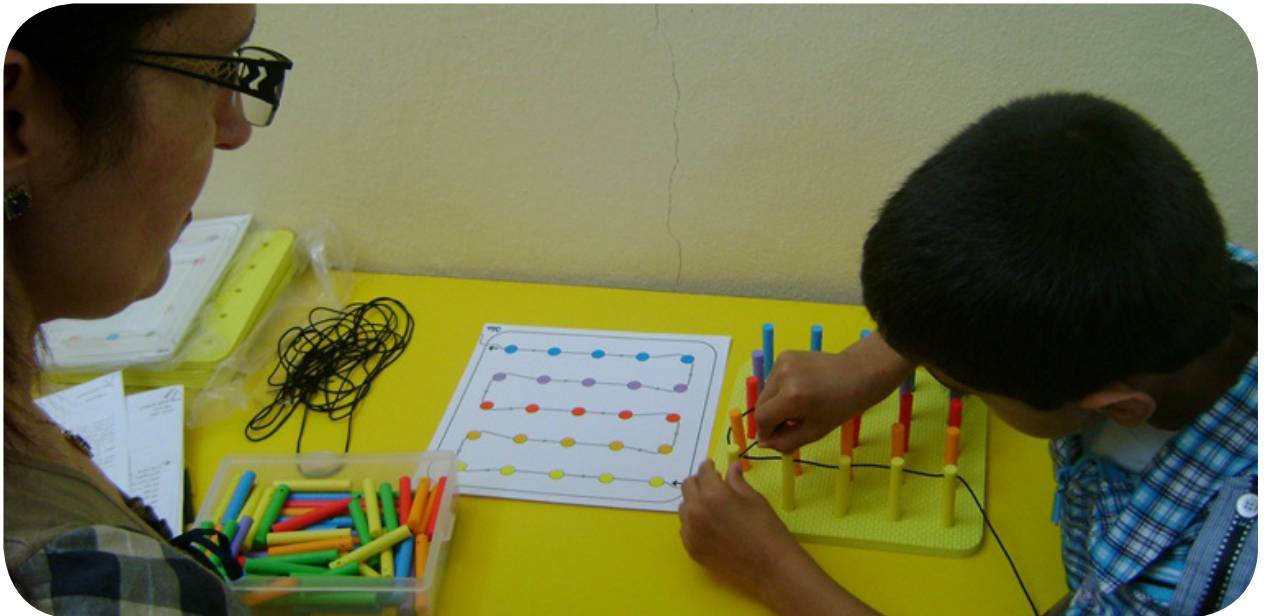
### **Do's and Don'ts: tips and hints from experience:**

#### ***Do's***

- 1- Valorize the role of family: working with the child alone is not enough and parents need to be involved.
- 2- Explain to the parents what they would say to the child about the therapist before the first session.
- 3- Ask the child if he knows why he is coming and explain the role of the therapist.
- 4- Respect the decision of the child to come or not to come to the session.
- 5- Respect cultural differences and sensitivities (example: clothing, hand shaking, etc.)
- 6- Remark and report health symptoms to the rest of the team.
- 7- Explain to parents the relation between health problems and psychological issues.
- 8- When meeting with parents, explain to the child the objective of this meeting: supporting the parents to find ways to better communicate with the child, to help him/her feel better, and reassure him/her about professional confidentiality .

#### ***Don'ts***

- 9- Don't use words and languages the parents and child won't understand, and explain all technical words.



## 13. Speech and language therapy.

### Definition for this activity:

*Treatment to improve communication, language and speech skills.*

### Objective:

- To improve the child non verbal and verbal communication skills including speech intelligibility of sounds and words and sentence production.
- To improve written language skills.
- To strengthen oro-facial muscles and to regulate respiration.
- To improve voice usage.

### Expected results:

- \* Children will increase their ability to communicate with their environment and/or use speech and language in an more appropriate way.
- \* Children will be able to improve their academic performance and more specifically reading, writing and logic skills.

### Target group:

- Children assessed with communication and language problems, for example: children with autism, children with dyslexia, children with learning difficulties, children with stuttering, children with swallowing problems, etc.

### Implementing persons:

- \* Speech therapist.

### Steps for implementation:

1. Discuss with parents the short-term goals and activities to be done during the coming sessions based on the assessment's results.

#### *For each session:*

2. Prepare the activities and material based on the objective of the session.
3. Adapt the room according to the child's situation when needed.
4. Explain to the child what will be the activities to be done during the session.
5. Implement the planned activities for the session
6. Take five minutes with parents to explain what was done during the session and give recommendation and exercises to be done at home.
7. Assess the child's progress every 6 months or depending on the child's situation.

### Time needed / Frequency:

- 1-2 session per week to 2 sessions per month of 30 to 45 minutes.

### Means of verification:

- Session sheet form includes: date of the session, objective, material used and therapy session outcome.

### Tools and materials needed:

- \* Individual therapy session form.
- \* Examples of games: flashcards (example: action verbs), stories, pictograms, puzzle, bubble soap, stacking cup...

**Difficulties/challenges:**

\* Sometimes we have to reduce the number of sessions per child in order to have time to see more children in a limited time.

**Do's and Don'ts: tips and hints from experience:****Do's**

- 1- Do task shifting with community workers and give an active role to parents in order to reduce number of sessions per child.
- 2- Do parental guidance and involve parents in the therapy: they are the 1st therapists for their children
- 3- Follow child's needs with parents and give them materials to work with him/her at home
- 4- Involve the child's teachers or other stakeholders in therapy by giving them tips and ways to facilitate for the child his/her tasks at school and at home (example: using pictograms at home, adaptations of academic material).
- 5- Don't over generalize cases: each child has a special unique case that you have to deal with
- 6- Continuous researches and literature review help therapists in dealing with new cases of children.





## 14. Psychomotor therapy.

### Definition for this activity:

*Therapy that acts on the mental, psychological, motor functions through the body and using playing techniques.*

### Objective:

- Reeducation of the psychomotor disorders in order to improve the psychomotor domains depending on each child difficulty.

### Expected results:

\* Optimizing the adaptation abilities and the personal fulfillment of the child through the restoration of the psycho-corporal harmony and balance.

\* Improved abilities in the following domains: body schema awareness; gross and fine motor skills (walking, climbing, hand writing skills), manual skills (coordination between two hands...); space and time structuring (understanding concept of time and of space), cognitive skills, interactive modalities (eye contact, child demanding what he needs etc.)

### Target group:

- Children presenting any of the following: developmental delay, motor impulsivity, instability, coordination difficulties, writing difficulties, space/time organization difficulties, learning difficulties, communication difficulties, etc.

### Implementing persons:

\* Psychomotor therapist.

### Steps for implementation:

- 1- Meet up with child and parents in order to inform them about the specific short-term action plan and goals based on the assessments' results.
- 2- Implement the regular therapy sessions with the child with pre-set objectives based on the action plan.
- 3- Engage parents in the intervention plan through parental guidance or/and their attendance to the sessions when needed.
- 4- Meet with the CW in order to plan/oversee the work of the CW in home based sessions if any (cf task shifting).
- 5- Refer the child for complementary exams and evaluations if needed (medical, psychological, speech).
- 6- When needed, reports are written or meetings are established with teachers in order to set an individualized plan or to adjust the academic program according to the child capacities and to give teachers recommendations.
- 7- Regular meetings with the other specialists taking the child in charge (psychologist, psychiatrist, and speech therapist).
- 8- Reevaluation after 6 months of weekly individual therapy sessions in order to decide whether the therapy sessions will be continued or stopped or the intervention plan will be oriented differently (such as home based intervention by the social worker).
- 9- Modify the intervention plan accordingly.

### Time needed / Frequency:

- 1 or 2 sessions per week of 45 minutes each.
- A minimum of 6 months intervention plan followed by an assessment of progress in which the psychomotor domains are reevaluated. According to the progress report results, psychomotor therapy can be stopped or extended.

**Means of verification:**

- Intervention plan.
- Follow up sheets (session by session).
- Progress report.

**Tools and materials needed:**

- \* Psychomotor sheets/forms.
- \* Toys and games: cognitive, gross motor, fine motor, sensory materials, etc.

**Difficulties/challenges:**

- \* The repetitive use of some material at times due to the lack of material.
- \* Lack of institutions and centers to refer the child when needed (especially for children with severe disorders).
- \* The non-cooperation of parents.

**Do's and Don'ts: tips and hints from experience:**

- 1- Establish a proper, secure and comfortable space/time framework for the sessions.
- 2- Build a confident and therapeutic relation between the child and the therapist.
- 3- Do not judge/blame the parents for their child's difficulties.
- 4- Build a trust relation with the parents: parents are partners and their role is crucial in reinforcing their children's abilities. Listen to their complaints and needs and encourage them to be engaged in the intervention plan (allow parents to attend the sessions, proposing practical activities through tools/material available at home, filming parents/children activities established at home).
- 5- Have a global perspective of the child (social, familial, academic) in the individual treatment plan.



## 15. Occupational therapy.

### Definition for this activity:

*The use of purposeful activities or interventions designed to improve functional life for child with disabilities/ disorder affecting their motor, sensory or cognitive skills.*

### Objective:

- To help the child improving his/her motor, sensory and cognitive skills.

### Expected results:

\* Enhanced independence of the child in activities of daily living.

### Target group:

- Children with motor, and / or sensory and / or cognitive difficulties impeding their independence in daily living activities / social activities/ school activities.

### Implementing persons:

\* Occupational therapist.

### Steps for implementation:

- 1- Based on the assessment and action plan done previously, design a short-term action plan and document it in a time frame.
- 2- Inform parents and explain to them about the short-term action plan.
- 3- Start sessions based on the most appropriate types of interventions (sensory integration techniques, gross motor techniques, body awareness ....)
- 4- Give parents continuous recommendations, guidance after each session and follow on their implementation of these recommendations (If parents have the opportunity, they can make videos and show you during the session so you can give feedback on the way they implement techniques, or they can also take notes about what they did and how it went and share it with you)
- 5- For children with motor difficulties, suggest the convenient adaptation (of tools or environment) directly to parents and follow it through community worker.
- 6- Invite parents to attend the session and train them during the session on implementing techniques in front of you so you can give them feedback.
- 7- Reevaluate the progress of child within 6 months.
- 8- Modify the intervention plan and document changes in the child's needs, goals and performance.

### Time needed / Frequency:

- 2 sessions per week of 45 minutes.
- 6 months or to be determined according to the child's case.

### Means of verification:

- Follow-up format filled.

### Tools and materials needed:

- \* Occupational therapy follow-up file.
- \* Toys, games: balls, sensory games, play dough, sand, memory games, etc.

### Difficulties/challenges:

- \* Lack of parent's awareness about the occupational therapy importance for their children.
- \* Lack of material and games can have an impact on the session's quality.
- \* The health situation of the child can make the implementation of the session more difficult and far from the "ideal" session.

**Do's and Don'ts: tips and hints from experience:**

- 1- Put a clear frame for the session from the beginning of the follow-up.
- 2- Choose the appropriate techniques for the intervention.
- 3- Allow the child to show his/her strength.
- 4- Explain to the child and parents what you are doing with him/her.
- 5- Create games, tools during the session with local materials so that parents are able to develop their own and offer more experience to the child.



## 16. Physiotherapy.

### Definition for this activity:

*Treatment based on motor exercises, often carried out through a range of non-drug treatment methods such as manual exercises, exercises using stimulating equipments and machines.*

### Objective:

- Physiotherapy aims at the recovery, or maintaining and improving the motor performance and functions, and reducing pain.

### Expected results:

- \* Improved motor and muscular performance.
- \* Distortions and muscle restriction, stiff joints and ulcers are prevented.
- \* Rehabilitation after surgery is done.
- \* Type of assistive devices is determined.
- \* Parents are trained and guided.

### Target group:

- Children with disabilities and motor difficulties. For example: a child with cerebral palsy, or scoliosis, or amputation of one of the limbs, or congenital dislocated shoulder and hip, respiratory problems, or fractures.

### Implementing persons:

- \* Physiotherapist holds a Bachelor's degree in physiotherapy.

### Steps for implementation:

- 1- Determine, based on the summary of the assessment, short term and long term goals for physical therapy and share it with parents.
- 2- Determine the frequency of sessions.
- 3- Clarify for parents and child the goal of exercises during each session.
- 4- Start with the planned exercises in the presence of the family and community worker.
- 5- Answer queries of parents.
- 6- Give parents home tips and guidance.
- 7- Refer when needed to other services (a neurologist - orthopedic – assistive devices)
- 9- Document the session.

### Time needed / Frequency:

- 45 minutes for each session.
- 3 sessions per week.

### Means of verification:

- Fill out the file in the center.

### Tools and materials needed:

- \* Assessment form, bed , tools used in the treatment of physiotherapy: balance ball- stair- staircase - cylindrical pillow – jumping ball - balance circle, Games.

### Difficulties/challenges:

- \* Lack of child's responsiveness.
- \* Lack of parents' attendance of the session or their participation in treatment.
- \* Lack of equipments that contribute to the success of the treatment.
- \* Lack of devices to assist the child in a timely manner: afo - kafo – splint- parts.



**Do's and Don'ts: tips and hints from experience:**

**Do's:**

- 1- Diversify exercises among sessions so that parents and child do not feel they are repetitive and therefore get bored.
- 2- Explain the exercises and what we do during the session for parents and children.

**Don'ts:**

- 1- Do not use techniques that might harm the child.
- 2- Do not ask the parents to apply techniques before making sure of their skills.
- 3- Do not do the session while the child is sick.



## 17. Group therapy.

### Definition for this activity:

*Treatment directed to a group of children having similar difficulties or problems, and provides an atmosphere of cooperation and support for the child.*

### Objective:

- Promote group work among children: cooperation, interaction and sharing with others, acceptance of loss and winning, and respect for the rules and the roles.
- Generalize acquired concepts in the individual sessions.
- The ability for the child to express himself/herself about what he went through because other children's circumstances are similar.

### Expected results:

- \* Economize/save the time of specialists.
- \* Promote self-confidence and the child's observation of capabilities and skills.
- \* The ability to adapt to stressful situations in the group, such as competition.

### Target group:

- Children having similar difficulties and who are of similar ages.
- 3 to 5 children in each group.

### Implementing persons:

- \* Community worker.
- \* One of the followings: psychotherapist, occupational therapist, speech therapist...
- \* The worker or the therapist should be familiar with this technique and informed about the individual files for each child in the group.
- \* The team should not exceed two (community worker and therapist or two therapists).

### Steps for implementation:

1. Preparing a list of children who have similar difficulties.
2. Taking the children's and parents' consent regarding the participation of children in the group, explain the goal of the group and its importance and listen to their opinion.
3. Putting specific plan for the whole group.
4. Organizing a time that works for all members of the group.
5. Preparing the specific tools for each activity.
6. Welcoming game for children.
7. During the first session, doing ice-breaking activities and formulating the rules for the group by the children (what is forbidden and what is allowed).
8. Explaining to children what are the group's activities and the session's program, and listen to their suggestion to implement what is possible.
9. Implementing the activities planned by the therapist and community worker.
10. Evaluating activities with the children.
11. Documenting the course of the session.

### Time needed / Frequency:

- 1 hour, twice a month with each group.

### Means of verification:

- Group report.
- Children's file.
- Pictures.



**Tools and materials needed:**

- \* Group report.
- \* Cards- games according to the group.

**Difficulties/challenges:**

- \* The availability of some children does not coincide with the availability of the rest of the group
- \* Refusal of some boys to work with the girls or vice versa within the group sometimes.
- \* Commitment of children to the time of session.
- \* Underestimation of this technique by some parents.
- \* Lack of commitment of children by the group which leads to uneven progress.

**Do's and Don'ts: tips and hints from experience:****Do's:**

- 1- Change and diversify the type of tools and techniques used every once in a while.
- 2- Prepare the activities and methods before the session based on plan previously put.
- 3- Inform parents consistently about activities provided and their importance.
- 4- Do the session in a wide, equipped and friendly place for children.
- 5- Get the children's and their parents' consent before taking pictures of them within the group.



## 18. Co-therapy sessions between two therapists.

### Definition for this activity:

*Two different therapists working with one child during one session.*

### Objective:

- To support the child in using different types of strategies acquired in both types of therapy to complete a specific task (example: reading, writing) .
- To help the child to generalize skills/strategies acquired in one of the therapies.

### Expected results:

- \* The generalization of the skills already acquired in both therapies.
- \* Child's trust in the first type of therapy introduced in his action plan is transferred to the second type of therapy by the presence of the therapist he knows.
- \* More accurate coordination is done between both therapists' objective in individual sessions.

### Target group:

- One child benefiting from two different therapies and working on two different action plans.

### Implementing persons:

\* Each session should include two therapists, not more, and the choice of the therapists involved is based on the specific objectives of the session:

- Speech therapist.
- Occupational therapist.
- Physiotherapist.
- Psychotherapist.

### Steps for implementation:

- 1- The therapists discuss the child's therapeutic plan.
- 2- Agree on specific objectives to work on during the session to reach one joint common goal (for example: working on visual attention and reading strategy to achieve reading).
- 3- Define and prepare material that serves the multiple purposes .
- 4- Define specific roles to each of the specialists and decide on time management during the session
- 5- Explain to parents why it is important to have this type of session.
- 6- Explain to parents if present during the session every step's objectives.
- 7- Evaluate the response of the child to the session and the process to decide on next steps (other co-therapy sessions, or moving on to another objective in individual sessions).

### Time needed / Frequency:

*One session is 45 minutes. Co-therapy sessions take place:*

- \* When specific objectives are reached in individual therapies and an additional step for generalization of skills acquired is needed.
- \* Upon needs when objective of the session is to facilitate transfer of trust feelings from one specialist/ type of therapy to another.

### Means of verification:

- Sessions chart filled.

### Tools and materials needed:

- \* According to the objectives put for each co therapy: story, flashcards, lights, etc.

### Difficulties/challenges:

- \* Parents may not encourage this kind of sessions if they don't really understand the benefit of it and might be confused by the presence of both therapists at the same session.

- \*Therapist may not have the same working days at the center which is a challenge for the implementation of the session as well as for preparation phases.
- \* Administration may see this issue as time consuming.

**Do's and Don'ts: tips and hints from experience:**

- 1- Explain to parents and administration the importance of this co therapy session and have verbal approval on it.
- 2- Prepare the objectives with the other therapist before the session and based on the child's action plan and assessed needs.
- 3- Discuss with the team if the child is able to undergo co therapy session. For example, in joint speech therapy/occupational therapy sessions, the child should have some prior attention and coordination skills to be able to benefit from co-therapy.
- 4- Systematically ensure the therapists debrief at the end of the co-therapy session to discuss the child's progress, the need to adjust the interventions, etc.
- 5- Don't use this type of sessions for the assessment sessions.



## 19. Task shifting.

### Definition for this activity:

*A process of task delegation from a specialist to a community worker, to increase access to care for children with mental health problems in low-resource settings, applicable at home and in the centre.*

### Objective:

- To build the capacity of the community workers to have sessions with the child and to support parents in intervening with their child.
- To deliver specialized services by community mental health workers under the supervision of the specialists.

### Expected results:

- \* Community worker gain expertise to help the child acquire and develop the intended skills and apply them in a home setting.
- \* Community worker is able to work in parallel with the therapist as a co-therapist.
- \* Community worker guides the parents and orient them to adjust and improve the way they deal with their child's difficulties.
- \* Waiting lists are shortened.
- \* Child's development in his natural environment is supported.

### Target group:

- Children benefiting from one or more of the following therapy: speech therapy, occupational therapy, psychomotor therapy and physiotherapy.
- Children with simple language delay on the waiting list.
- Children with minor and simple behavioral problems or bedwetting and whose parents need simple behavioral advice and guidance.

### Implementing persons:

- \* Speech and language therapists, occupational therapists, and psychomotor therapists.
- \* Community workers.

### Steps for implementation:

- 1- Conduct a package of theoretical training for the community workers on essential topics in child's development (motor, emotional, sensory, language and communication), and on other important topics as depression, suicide, etc.
- 2- Community workers shadow the specialist (observation of sessions, discussion and analysis of the goals, means and results, coaching on writing session logs)
- 3- Community workers prepare and conduct sessions for children under direct supervision of the specialists (implementation of sessions first under direct supervision and observation, followed by an evaluation meeting with the specialist). Number of sessions depends on the child's need and availability.
- 4- Community workers deliver the sessions at home level involving parents and building their skills (he/she can help installing rituals and discipline at home, works with the child and his/her parents to improve the child/parent relation, develop child's and parents' skills).
- 5- Community workers conduct sessions for children on their own and weekly report to the specialists (using different tools: videos, written reports or individual meetings).
- 6- The specialist follow the progress of the child on a monthly basis through an individual session

### Time needed / Frequency:

- \* Continuous activity.

### Means of verification:

- Community work sheets (home visit/ follow up sheet, preparation sheet...)

**Tools and materials needed:**

- Toys, other materials (from home...).

**Difficulties/challenges:**

- \* The opposition of parents ( non acceptance of CW intervention).
- \* Overload of cases followed by the community worker.
- \* Task sharing isn't applicable for some children's when specific treatment and intervention are needed.

**Do's and Don'ts: tips and hints from experience:**

- 1- Give time to community worker training.
- 2- Make a detailed evaluation for home setting to have a clear idea about the resources for intervention.
- 3- Design a detailed plan for the community worker intervention (at home, in the center...).
- 4- Choose cases of children carefully because task shifting is not applicable with all children and depends on the child's type of difficulties and needs.
- 5- Avoid over loading the community workers with technical detail.

**For example of form used to document sessions provided by the community workers, please refer to toolbox doc#17**



## 20. Home based sessions.

### Definition for this activity:

*Implementation of part of the treatment plan for the child at home through home visits to the family including: providing support, counseling and guidance for parents and/or therapeutic techniques with the child by a community worker or therapist in specific situations..*

### Objective:

- Benefit from the resources of the family and home to serve the interests of the child's therapeutic service.
- Involve parents in the implementation of the therapeutic treatment program for their child.
- Educate parents and empower them through practical techniques on how to make use of existing resources at home to improve the child's situation and to work with him/her.
- Help the family to deal with the difficulties of the child in a better way (to reduce stress on the child and the parents, changing attitudes in dealing with a child who has difficulties).
- Take into account the time and circumstances of the parents and their economic capabilities, and intensify therapy sessions instead of doing them weekly or monthly at the center.

### Expected results:

- \* Cooperation and responsiveness of parents, making them feel relieved and appreciated during the session because they are in their living environment.
- \* Implementation of the therapeutic program in a shorter time in some cases because the problem is solved directly within its frame, therefore reducing the waiting list at the center.
- \* Understanding of the family of the goal of the treatment plan and the techniques, because they are carried out in their life frame.
- \* Continuity of the work inside the house by the family.
- \* Activation of the complementarities between team and the family.
- \* Saving time and effort for the family.

### Target group:

- Children benefiting from the services of the center and their parents.

### Implementing persons:

- \* Community worker responsible of following up on the child's case (case manager); and if required, another person from the team.
- \* Specialist in a few situations: the inability of the attendance of the child to the center because of a temporary health situation...

### Steps for implementation:

- 1- Based on the request from the team to do a home intervention, determine the action plan and the goal of the home visit under the supervision of therapists.
- 2- Look at the child's file before the visit.
- 3- Identify the tools that will be used during the visit and the activities; and define the role of each person of the team.
- 4- Determine the time of the visit in a way that is in line with the home conditions.
- 5- Prior coordination with parents with a prior explanation of the purpose of the visit and the importance of the role of parents in the process of treating their child.
- 6- Implement the home session and explain the steps and its significance for the parents in a simple and understandable language.
- 7- Always start with social interaction with parents.
- 8- Deliver to the family pictures, publications or illustrative tools related to their child's difficulties.
- 9- Allow parents to participate in some simple activities that they can implement under the supervision of the team.
- 10- Give parents advice and guidance to help them to implement home program during the week without the presence of the community worker.
- 11- Before leaving, remind parents of their program in the absence of the therapist or community worker.

**Subsequent visits:**

12- Review with the parents what has been implemented and review the goal that we will work to achieve through these sessions.

13- Remind about activities, implement them in the participation of parents to and allow for repeating the implementation by parents in the presence of the community worker

14- Ask parents about the difficulties they faced during the implementation of the sessions and discuss them with them.

15- Escalation of the activities: new activities after making sure that the parents are able to carry out previous activities. When giving any activity, remind parents about its goal

16- Record the course of the session in the child's file, difficulties, and notes so that they are discussed with the specialists and the team

**Time needed / Frequency:**

\* 30-60 minutes each session according to the child's needs, situation and treatment plan.

It is important to take into account the time needed for transportation.

Once a week or half a month for each child or according to the intervention plan.

Visits are reduced gradually whenever parents take their role more.

**Means of verification:**

- Home visit report.

**Tools and materials needed:**

\* Games to use in purposeful activities: small cubes - motivational games (voice -light) - small balls of different sizes depending on the target - papers and colors.

\* Books and stories targeted for children.

\* Booklets and brochures specialized in psychological and social health.

\* Form to measure the development of the child filled with parents.

\* Home visit form.

**Difficulties/challenges:**

\* Initial fears of parents about the nature of the service of the center and the concept of mental health.

\* Reservation by the parents regarding some information and some things related to them

\* Some parents are not convinced of their significant role.

\* The impact of social and cultural factors:

\* Crowding inside the house / narrow home / more than one family in the house and interventions during the session from the extended family).

\* Presence of guests during the session.

\* The security situation in some areas.

**Do's and Don'ts: tips and hints from experience:****Do:**

1- Respect the privacy of the home.

2- Emphasize confidentiality and privacy.

3- Reassure parents and make them feel secure and confident

4- Explain the steps of implementation to parents and provide them with information directly and indirectly.

5- Respect the views of present persons and their fears, understand their problems and accept them.

6- Give the session sufficient time as if it is in a clinic

7- Be acquainted with the surrounding environment

8- Maintain the privacy of house and its secrets.

9- Dress appropriately for the environment in which the visit will be carried out and do not wear jewelry during the visits

10- Respect parents' time, in case you are not able to attend call them and apologize.



***Do not do:***

- 11- Avoid misunderstandings about the privacy of families and individual differences.
- 12- Do not use incomprehensible terms.
- 13- Do not conduct a session for a child who has fever or has a medical problem.

**For an example of tool to document home visits please refer to toolbox doc #19**

## 21. Parents - Children Group activities.

### **Definition for this activity:**

*Interactive and sensory group activities targeting a group of mothers and their children with autism spectrum disorder all together.*

### **Objective:**

- To promote parent-to-parent support
- To reinforce the social interaction between the children through sensory activities.
- To improve communication and the relation between the child and his/her parent through play.

### **Expected results:**

- \* Parents are empowered and encouraged to improve communication with their children.
- \* Parents are guided to provide constructive play activities for their children.
- \* Parents suggest and take initiative for new activities.
- \* Each parent will have a better understanding of her own interaction pattern and how she can improve it through watching the filmed session.

### **Target group:**

- Children with Autism Spectrum Disorder and their parents.
- Age between 5 and 11 year old.
- Each group can include a maximum of 5 children and their mothers. Groups should gather children with same types of abilities: a group of children with verbal abilities and a group with children with non-verbal abilities.

### **Implementing persons:**

\*Psychomotor therapist or other therapist trained in sensory integration (occupational therapist...) and two community workers .

### **Steps for implementation:**

- 1- Set a list of potential participants (children and parents) based on specific criteria (example: non-verbal/verbal abilities)
- 2- Introduce parents of children selected to the objectives and rules of the group activities and check if they are willing to be part of it.
- 3- Register the mother and the child in the appropriate group according to the child's capacities.
- 4- Sessions are prepared by the psychomotor therapist in the presence of the community workers.
- 5- The sessions are conducted by the community workers and filmed and include activities targeting the social interaction as well as the sensory integration such as soap bubbles, bouncing on the big ball, finger and hand painting, cream on the hands, etc.
- 6- On the first session, take time to facilitate ice breaking between the mothers in order to build a trustful relation between them.
- 7- Discuss with parents the planned activities for the session.
- 8- Conduct and film the sessions after taking permission from parents.
- 9- Finish the session through a song with a recapitulation of the implemented activities (you can use pictures of objects or show the objects used).
- 10- After every session, the mothers are invited to watch the film with the community worker and to comment on it and provide feedback.
- 11- Parents suggest desired activities for next time.
- 12- The psychomotor therapist watches the video after each session to evaluate the process and progress with the community worker.

**Time needed / Frequency:**

- \* 30 to 45 minutes depending on the children's abilities.
- One hour for watching the film and providing feedback.
- One session per month is performed for each group.
- One evaluation session following each session (once monthly).

**Means of verification:**

- Each session is being filmed, watched and evaluated by the psychomotor therapist.
- An assessment form is presented and filled anonymously by the parents in order to evaluate the session, to express their feelings and to suggest activities for the upcoming session.

**Tools and materials needed:**

- \* Toys.
- \* Two evaluation forms : one for the activity (used by the CWs and the therapist), and one for the parents.
- \* Video camera.
- \* Video screen monitor.

**Difficulties/challenges:**

- \* Behavioral problems of the child, for example an anger tantrum that might occur during the session and the difficulty to managing it during the sessions by the parents and the community workers.

**Do's and Don'ts: tips and hints from experience:**

- 1- Suggest this type of activities to parents who already has benefited from parents support groups (cf related technical file) because it is a good preparation step to engage in the parent-child activity more efficiently.
- 2- Build trust with parents/children.
- 3- Help the parents to gain each other's confidence.
- 4- Make sure the room setting is stable, well organized and safe.
- 5- Install rituals during the sessions and help children feel comfortable in order to be more cooperating and interactive. Example: install rituals in the beginning of the session through a rhyme mimed or a song that introduces all the participants and initiates the start up.
- 6- Introduce the activities clearly and in details to the parents/children.
- 7- Give the parents the needed support in case of tantrums or when the child is not responsive.
- 8- Make sure to treat them all equally.
- 9- Observe all the group members and engage them all in the activities.
- 10- Give time to parents: listen to them and take their suggestions into consideration.
- 11- Always take written permission for filming.



## 22. Music therapy.

### **Definition for this activity:**

*Treatment method that depends on the interaction through the use of musical instruments for expression and communication between the child and therapist.*

### **Objective:**

- Promote expression.
- Self-confidence and self-esteem building.
- Communication, interaction and social participation.

### **Expected results:**

- \* Child enjoys the activity and feels comfortable.
- \* Child or group gain confidence through dealing with a therapist and through dealing with each others.
- \* Children's ability to express feelings and emotions is improved.
- \* Communication and social interaction of children is improved as well as taking their role at the family and the surrounding levels.

### **Target group:**

- Children with psychological difficulties, behavioral problems, delayed growth... For example: Autism / cerebral palsy / depression / school difficulties / Attention Deficit and Hyperactivity Disorder / behavioral problems / intellectual disability.
- One child or a group of five children maximum.
- Criteria to form the group: the similarity in age and level of difficulty.

### **Implementing persons:**

- \* Community worker in mental health who received intensive training in music therapy, working under the supervision, support and guidance of specialists in music therapy.
- \* Two social workers for group sessions.

### **Steps for implementation:**

#### ***Preparation phase***

- 1- Select a list of children who meet the criteria for music therapy.
- 2- Look at the child's file. Put action plan with the child.
- 3- Inform parents about music therapy and the follow-up plan and take their approval.
- 4- Specify the objectives of each session and prepare the appropriate tools to implement it and the right place for the therapeutic session in case it was with a child or group.

#### ***Implementation of therapeutic session:***

- 5- Choose musical instruments before the session according to the objective: rhythm, string instrument, wind instruments...
- 6- Put the tools on the floor or on the table within reach of the child
- 7- Let the child choose the tools he/she prefers.
- 8- Choose your tool after the child's choice. It might be a different tool than the one he/she chose.
- 9- Follow an organized session (activities and targets specified in advance) or improvisational (let the child lead the session).
- 10- Be flexible in managing the session, you can add physical movements, play sounds, singing, play back songs, vocalizations.
- 11- Take videos of the session to evaluate the therapeutic skills of the person implementing the session, and measuring the development of the child, and bring them.
- 12- Fill the evaluation form of the session after it ends.
- 13- Use the special assessment tool for music therapy: IM TAP, and use the tool twice: first time after the second session and the second time after the end of the treatment plan.
- 14- Monthly meeting among all the community workers implementing this program to discuss the cases of children and share experiences.

**Time needed / Frequency:**

- 30 minutes for individual sessions and 45 minutes for group sessions.
- Individual therapy: once per week through 12 weeks as a primary plan.
- Group therapy: once per week for 12 sessions.

**Means of verification**

- \* Specific form for music therapy sessions filled after every session.
- \* Evaluation sheet to be filled by the community worker after every session.
- \* Video recording.

**Tools and materials needed:**

- \* Monitoring and evaluation form. Before and after I MTAP, it is a tool to evaluate the development of the child on emotional, social and musical levels.
- \* Musical instruments for implementing the therapy sessions: piano, harmonica, guitar, flutes, xylophone, maracas, drums....
- \* Camera Video .
- \* Video Screen.

**Difficulties/challenges:**

- \* Lack of commitment to sessions.
- \* Refusing music because of the influence of social and cultural factors.
- \* Difficulty in persuading some children that the session is finished (some refuse to leave and want extra time).
- \* Children deal with musical instrument in a violent way leading to damage.
- \* Lack of musical instruments needed to implement sessions.

**Do's and Don'ts: tips and hints from experience:****Do:**

- 1- Build trust with the child to accept and continue the treatment.
- 2- Leave the child the freedom to express his/her thoughts and feelings.
- 3- Respect the child's abilities and his/her privacy starting from the cultural, social and religious environments.

**Do not do:**

- 4- Do not use a camera phone to preserve the privacy of the information and to make sure it does not fall into the hands of strangers.

## 23. Waiting time activities.

### Definition for this activity:

*Varied and targeted activities held with parents while they wait for their children to start their session at the center or while their children are in the session.*

### Objective:

-Investment of parents waiting time.

### Expected results:

- \* Parents feel that the place is safe
- \* A partnership with the parents through the confidence and access to information and communication is built.
- \* Parents introduce themselves among each other and share their personal experiences about their children's problems with the facilitation of community workers, and they support each other.
- \* Parents acquire information through communication with the community worker, with each other, through books, stories, brochures, video display, and illustrative tools, etc...
- \* Commit to regulations and rules of the place
- \* Borrow some books and get some brochures

### Target group:

- Parents of children who are waiting to enter the sessions or who are waiting for their child's session to finish.
- In group or in individual setting.

### Implementing persons:

- \* Community worker.

### Steps for implementation:

- 1- The presence of a social worker during the waiting time to welcome parents.
- 2- Provide information to parents according to inquiry or depending on the situation.
- 3- Introduce the center and its services for new parents.
- 4- Reassure parents who are afraid of the type of treatment, how it is implemented and how to follow up on it; and of the social stigma .
- 5- Inform parents about the confidentiality of information and respect the privacy of individuals.
- 6- Manage communication and dialogue among parents and provide some guidance by the community worker.
- 7- Create an atmosphere of communication and familiarity among the present persons.
- 8- Direct parents through the library that contains the stories, brochures and books.
- 9- Inform parents about activities for children such as "games, drawing, clay"
- 10- Run the DVD that contains the topics of mental health.
- 11- Organize entry and exit from the therapy sessions.

### Time needed / Frequency:

- Time during which the parents are waiting in the waiting room.

### Tools and materials needed:

- \* Brochures containing meaningful topics.
- \* Library for parents and children containing books for parents and children's stories.
- \* Tools for the activities of children "drawing, play dough, games, paint"
- \* DVD includes topics related to mental health.
- \* TV + DVD.



**Difficulties/challenges:**

- \* Initial fears of parents about the nature of the service in the center and the concept of mental health.
- \* The impact of social and cultural factors on the present persons.
- \* Fear of parents to meet with people they know or people related to them in the waiting room especially for the new parents.

**Do's and Don'ts: tips and hints from experience:****Do:**

- 1- Respect the opinions of the present people and their fears and understand and accept their problems
- 2- Support and guide parents through guidelines

**Do not do:**

- 3- Do not make fun of the parents' and children's capabilities
- 4- Do not discriminate according to the economic situation, social status, nationality, religion and sect
- 5- Avoid speaking about personal matters with parents and children.
- 6- Do not dive in the private information of services recipients with other parents.





## 24. Psycho-education sessions targeting parents/ parental training.

### **Definition for this activity:**

*Training parents on specific topics related to their child's difficulties.*

### **Objective:**

- To strengthen the theoretical and practical knowledge of parents related to their child's problems and resources.
- To listen and respond to the parents' needs demands and concerns.

### **Expected results:**

- \* Parents are empowered with knowledge and skills that help them understand and better manage their children's difficulties.
- \* Parents are accompanied to manage their own questioning and doubts concerning their child's situation.

### **Target group:**

- Parents of children benefiting from the center's services and whose situation has already been diagnosed by the team.
- 10-15 persons per group in case of group modality.

### **Implementing persons:**

- \* Therapists (OT, PT, ST, psychologist, psychomotor therapist) based on the needs assessed among the targeted parents. All therapists don't do the training at the same time. They intervene each one alone or by pair.
- \* Community workers.

### **Steps for implementation:**

#### ***These steps can be done:***

- 1- After the diagnosis of the child's situation and before the beginning of treatment
- 2- During the treatment to have the parents actively involved as partners in the treatment process
- 3- At the end of the treatment during the phase out process to make sure parents are empowered to continue working independently with their child after the ending of the treatment.

#### ***Psycho-education sessions can be done:***

- 1- Individually, or in group with parents having children with same types of problems.
- 2- Through separate sessions each one based on specific needs, or through a developed program including several progressive sessions.
- 3- At home or in the center .
- 4- Implemented by a specialist or by a community worker under the supervision of a specialist concerning content of the session.

#### ***In case of having an organized training program including several sessions :***

- 1- List parents of children having same type of problems.
- 2- Define the parents' needs at level of knowledge and practices based on the parents' questions, the children's diagnosis and needs, the counterproductive behavior noticed among parents, etc.
- 3- Design by the whole multidisciplinary team a curriculum allowing a progressive acquisition of information and skills with a global and multidisciplinary approach.
- 4- Implement the training sessions.
- 5- Evaluate the results.

#### ***In case of separate psycho-education sessions given by the community worker to a group or to one family:***

- 1- Define parents' need, main messages to be transmitted to parents and key information/skills to be acquired by them during the sessions.
- 2- Design the content and methodology for the session

- 3- Specialists support and validate at all steps of the preparation process
- 4- During all sessions, discuss with parents and give time to exchange experience if in group.
- 5- Debrief by the community workers and with the specialists to discuss necessary adjustments of the messages and method of the sessions based on how the session went.
- 6- Follow how the recommendations given to parents are adopted by parents through the individual sessions or at home by the community workers.

**Time needed / Frequency:**

- A minimum of 1h30 for the session. Sessions dates are flexible depending on parents' availability. In case of a curriculum, sessions can be once per month. In other cases, depending on needs.

**Means of verification:**

**In the case of an organized training program.**

**An assessment form is presented and filled anonymously by the parents in order to:**

- Evaluate parents skills and knowledge.
- Evaluate the content of the session and take into consideration parents suggestions.

**In cases of individual/separated sessions: noted in the child's file.**

**Tools and materials needed:**

- \* Evaluation form sheets.
- \* Visual supports.

**Difficulties/challenges:**

- \* Parents might attend one of the sessions and skip others.
- \* Lack of parents' participation and motivation.
- \* Parents might misunderstand some of the information given.

**Do's and Don'ts: tips and hints from experience:**

- 1- Have very practical messages in the training sessions.
- 2- Build trust with parents.
- 3- Support the parents and take time to listen to their concerns.
- 4- When parents have difficulties to accept the child's diagnosis, take time to listen to them, to their complaints, and help them express their need for support. Parents need time to accept child's disability and need accompaniment and support during this process.
- 5- In group sessions, help parents to gain each other's confidence and feel comfortable to ask anything they want in front of each others.
- 6- Make sure the room setting is well organized and welcoming.
- 7- Use visual and practical supports to facilitate the information integration.
- 8- When in group sessions observe all the group members and engage them all during the sessions.
- 9- Distribute relevant brochures, booklets, guidelines that the parents can take home and use in their daily life as a reference.

**For example of form to prepare training for parents, please refer to toolbox doc#20**

## 25. Co-parents sessions.

### **Definition for this activity:**

*Therapy sessions attended by parents.*

### **Objective:**

- To train parents on specific techniques that they can use at home with their child.
- To support parents to acknowledge their child's abilities and difficulties.
- To observe and give feedback to parents on their interactional modalities with their child.

### **Expected results:**

- \* Parents are more aware about what their child can do and what is difficult for him/her to achieve.
- \* Parents acquire skills to interact and play with their child through observation and modeling.
- \* The whole therapy duration can be reduced because parents learn to work in an independent way with their child.

### **Target group:**

- Parents of children benefiting from occupational therapy, psychomotor therapy, speech therapy or physiotherapy sessions.

### **Implementing persons:**

- \* Therapists and community workers.

### **Steps for implementation:**

- 1- Decide which child and his/her parents would benefit from co-parents sessions.
- 2- Decide what activities you would like to implement during the parents presence and how you are going to involve them.
- 3- Explain to the parents the objective of having them in these sessions
- 4- Explain to the child that his/her parent will attend the session, or all the sessions and explain why.
- 5- Before the session, explain to parents what they are expected to do: observe without interfering, participate spontaneously, repeat exercises, etc.
- 6- During the session, explain to the parents and child what you are doing.
- 7- At the end of the session, make a small recapitulation of the session, and if needed, ask the parents to repeat exercises at home.

### **Time needed / Frequency:**

- 45 minutes per session. Frequency of sessions depends on the objective and the situation. Parents can attend all the sessions in some cases or specific sessions in other cases.

### **Means of verification:**

Individual therapeutic session form mentions the presence of parents.

### **Tools and materials needed:**

- \* Tools and materials used for a regular session.

### **Difficulties/challenges:**

- \* Some children don't accept to have their parents in the session or are disturbed by the presence of the parents.
- \* For some children having the parents in the session can be counterproductive if the effect of having the parent in the session is not controlled or "used" in an efficient way by the specialist. Some parents ask a lot of questions during the sessions and this may impact the child's attention. Explain to parents that it is better to keep their questions until the end of the session.

**Do's and Don'ts: tips and hints from experience:**

- 1- Have clear objective when asking parents to attend the sessions and select activities accordingly.
- 2- Distribute relevant brochures, booklets, guidelines that the parents can take home and use in their daily life as a reference.
- 3- Never impose a co-parent session to a child or a parent.



## 26. Mothers' support group.

### **Definition for this activity:**

*Providing an open-discussion space for a group of mothers, united around a common need concerning their children .*

### **Objective:**

- To build a strong mother-to-mother interaction, through sharing emotional experiences.
- To exchange information between participants.
- To provide specific psycho-education.

### **Expected results:**

- \* Mothers are empowered to adjust their skills of managing their children's difficulties.
- \* Mothers can detect their children's improvements.
- \* Mothers are resilient to external stress factors.
- \* Mothers can identify their needs and seek internal resources.
- \* Mothers knowledge about specific disorders is improved.
- \* Mothers become socially integrated and can spread awareness around them.

### **Target group:**

- Mothers of children with similar diagnoses (Autism spectrum disorder, Intellectual difficulty, etc) meeting without their children.
- A maximum of 8 mothers per group.

### **Implementing persons:**

- \* Psychotherapist.

### **Steps for implementation:**

- 1- Set the group rules and have everyone's approval on them (keeping confidentiality, not acting-out).
- 2- Introduce the group's goals to everyone.
- 3- Encourage members to build trust through transparent exchange of thoughts.
- 4- Allow the mothers to lead the discussions, and observe the interaction.
- 5- Moderate when needed to clarify misconceptions.
- 6- When needed, remind the group of the rules regarding turn taking, respecting each other's opinion, etc.
- 7- Prepare the closure through recapitulating information shared during the session.
- 8- Set the date for next appointment.

### **Time needed / Frequency:**

- One hour thirty minutes.
- 1 session per month per group.

### **Means of verification:**

- Logs of sessions.

### **Tools and materials needed:**

- \* Tools and materials used for a regular session.

### **Difficulties/challenges:**

- \* Absence of some mothers: some mothers have difficulty to be committed.
- \* Trust exchange was difficult at first for some mothers.

**Do's and Don'ts: tips and hints from experience:**

- 1- Make sure the room setting is organized to receive the mothers.
- 2- Make rituals during the sessions.
- 3- Build trust with/between the mothers.
- 4- Give the mothers the opportunities to speak freely.
- 5- Meeting with mothers over coffee and tea helped the ambiance to be more calm and friendly.
- 6- Engage every member equally.
- 7- Don't judge.
- 8- Don't be misled by the culture differences.

## 27. Parents Committees.

### **Definition for this activity:**

*Supporting the creation of parents committees representing the parents of children who receive mental health services at the center and some of the people wishing to join the committees.*

### **Objective:**

- Raising awareness of parents committees on mental health issues and other topics needed by parents
- Empowering parents with skills and techniques to deal with children going through difficulties.
- Building the capacity of parents to advocate for children's issues.
- Enhancing their capacity to self-support each other and support the other parents in the community.

### **Expected results:**

- \* Parents are represented by the committee before the center administration, other committees and the local community.
- \* Parents who are members in the committee are able to exchange experiences among themselves, understand each other despite differences in background and support each other in everyday life.
- \* Parents who are members of the Committee are able to claim and advocate for the rights of their children
- \* Parents who are members of the committee are able to support and assist other parents in the community particularly in the center.
- \* Parents who are members of the committee are participants and active in the community and in the center: helping the team of the center in logistic and other matters at conferences and trainings, preparation of banners to share information to support new parents in the center.

### **Target group:**

- Parents whose children receive mental health services at the center.
- Parents who have a desire to work within parents committees.
- The committee includes 10 to 15 members.

### **Implementing persons:**

- \* Community workers have the ability to plan activities, programs and manage a group.

### **Steps for implementation:**

- 1- The desire of parents to establish a committee to carry out activities that serve the interests of their children.
- 2- Desire of the center to have parents committees.
- 3- Present the idea to the administration of the centre and the team.
- 4- Choose two community workers to work and follow up with the committee.
- 5- The two community workers do the process of coordination between the committee and the team; and between the committee and administration of the center.
- 6- Determine training topics after doing a study on needs through interviews or focus groups with the committee.
- 7- Train parents on topics on mental health / advocacy / negotiation in order to raise the level of their knowledge and information.
- 8- Help parents meet regularly to organize their own activities as a committee.
- 9- Support parents in the planning of programs and activities that relate to their children, such as the planning of the activity on the occasion of "World Day of Awareness on Autism".
- 10- Ask the committee to participate in the annual assessment of the centre's services and needs assessments.
- 11- Invite parents to participate in special conferences on mental health and share their experiences.
- 12- Request for assistance from the committee in the preparation of the big activities at the center.
- 13- Request for the assistance of the committee members to support new parents or assessing the center's activities.



**Time needed / Frequency:**

- Meeting the committee once a month, the duration of the meeting is between an hour and an hour and a half.
- Trainings twice a month or three times a month depending on the trainings and events so that the time of events does not exceed 3 hours.

**Means of verification:**

- Assessment forms of trainings.
- Minutes of meetings.
- Documenting trainings.

**Tools and materials needed:**

- \* Training tools: LCD - Flip Chart - Folders.
- \* Stationery.
- \* booklets and brochures on mental health topics.

**Difficulties/challenges:**

- \* Differences in the intellectual and awareness levels among parents.
- \* The impact of social and cultural factors on members.
- \* Reservation by the parents to talk about their personal experiences about the topics that are suggested.
- \* Some parents bring their children to the meeting which disrupts on the rest of the members, especially by children with difficulties.
- \* Lack of funding for some of the things that are agreed on which contribute to delaying the implementation.
- \* Difficulty in coordinating with the parents committees from other institutions; and obstacles created by other committees in the agreements and implementation of certain things.

**Do's and Don'ts: tips and hints from experience:****Do:**

- 1- Respect the privacy of the members of the committee and individual differences.
- 2- Ensure confidentiality and privacy
- 3- Explain the role of the committee and the services offered by the center.
- 4- Reassure members of the committee, make them feel safe and consider them as team partners
- 5- Provide them with information in direct and indirect ways.
- 6- Build a trust relationship
- 7- Respect the views of present persons and their fears
- 8- Understand their problems and accept them
- 9- Select dates fit the schedules of parents.
- 10- Involve the committee in the planning, implementation and decisions specific to the center

**Do not do:**

- 11- Do not overload parents with matters surpassing their circumstances and ability.

**For an example of form to document parents committees meeting minutes, please refer to toolbox doc#21**



## **28. Coordination with the child's KG, school, educational center, animation center, etc.**

### **Definition for this activity:**

*Coordination with schools, KGs, clubs and other educational and social centers to integrate or follow up on a child inside the center within a clear educational intervention plan.*

### **Objective:**

- Creating a coordination channel with the inclusive educational institutions and a joint action plan to facilitate the process of educational intervention for a child taking services in the center.

### **Expected results:**

- \* Teachers or animators working with the child are supported by the mental health team to facilitate the inclusion of the child in activities.
- \* Follow-up on an agreed upon child program within the institution (kindergarten, school ...), a systematic action plan, and a clear distribution of roles.
- \* Child participation in classroom activities and group activities enhanced within the educational plan
- \* Attitudes on issues related to psychological problems and disabilities are improving.

### **Target group:**

- Children between 3 and 18 years, followed up by the center and integrated in social, educational and youth centers.

### **Implementing persons:**

- \* Coordinator.
- \* Community worker.
- \* Specialists when needed.

### **Steps for implementation:**

- 1- Prepare list of people in charge in kindergartens, schools and animation centers, and their phone numbers and e-mails.
- 2- Supply lists of children intended to be followed up within these centers to facilitate coordination with the person in charge of the process.
- 3- Conduct regular meetings between the community worker or the specialist and teachers / animators to support, guide and find solutions to the problems of the child; and develop a plan to work with the child within a the class or animation center.

### **During the meeting:**

- 1- Define the child's situation in a simple way,
- 2- Explain the work done with the child at the center (the types of treatments, objectives)
- 3- Focus on the child's abilities
- 4- Listen to teachers and understand their difficulties and fears
- 5- Give practical advice and develop a joint action plan between the mental health center and kindergarten – school – animation center.

### **Time needed / Frequency:**

- From 20 minutes to 30 minutes.
- Twice per year for the director of the school.
- 1 to 2 times per month according to the need with the person in charge in school, kindergarten, and psychosocial activities center.

### **Means of verification:**

- Minutes of the meeting.
- Filling out the basic information of the child in the child's file.

**Tools and materials needed:**

- \* List of children that are intended to be followed up in KG and school...
- \* Booklets, brochures related to child's difficulties and the good ways of dealing with the child.

**Difficulties/challenges:**

- \* Lack of conviction of school principal, the center or the person in charge.
- \* Prior attitudes on some issues, especially learning disabilities.
- \* Time constraints and the difficulty of coordination due to preoccupation of one of the parties.
- \* The large number of institutions that coordinate randomly and which constitute a bad example of the process of coordination for the director.

**Do's and Don'ts: tips and hints from experience:****Do:**

- 1- Deal delicately and do not let the other person feel that he/she is compelled.
- 2- Always remind about the importance of the coordination process and how it will reflect positively on the interest of the children.
- 3- Make sure to always take into account the time remaining
- 4- Bring some brochures, posters, booklets and any other materials that give an idea about the nature of the work.
- 5- When you change the CW in charge of the coordination with this institution/center, you should visit the institution and inform them about the new person.

**Do not do:**

- 6- Do not exaggerate in the coordination process so as not to constitute a burden on the other party.
- 7- Avoid periods of administrative pressures, like the days of distributing certificates and final exams and graduation periods ...
- 8- Do not enter the classrooms or halls without requesting permission.
- 9- Avoid repetition, redundancy and over-explanation.

## 29. Activities implemented by the team in Kindergarten / school for a specific child.

### Definition for this activity:

*Providing complementary support and rehabilitation services within schools and KGs for children having psychological difficulties or other rehabilitative needs, through individual support in the classroom and / or through the activities with the classmates.*

### Objective:

- Improving adjustment and integration of the child educationally, socially and psychologically within the school and kindergarten.

### Expected results:

- \* The level of participation of the child in classroom and non-classroom activities is improved.
- \* The child's performance during the exams and overall academic performance is improved.
- \* Self-confidence and self-esteem and social behavior (sharing, accept the challenge, being part of a group, respecting the turn) are improved.
- \* The child follows up on the school track, similar to the rest of the children.
- \* The capabilities of the educator to deal with the child and integrating him/her in the group are developed.
- \* The capabilities of the educator to modify classroom activities to suit the child and the rest of the pupils are developed.

### Target group:

- Children with psychological and learning difficulties from the age of 3 to 18 years old and are followed up within the center.
- Other children in the class- group depending on the objective of the activity and the agreement with the educator- animator.

### Implementing persons:

- \* Community worker.
- \* Specialists monitor the action plan.

### Steps for implementation:

- 1- Put the appropriate intervention plan with the participation of the team, specialists and community workers.
- 2- Inform the child and his/her family about the action plan and take their consent.
- 3- Inform the school administration and educators of the class about the action plan and what is required for implementation.
- 4- Prepare the tools and activities needed for the activity.
- 5- Implement the activity according to plan.
- 6- Remind the child and those who participated with him/her at the end of each session of what has been implemented and what will be implemented next time.
- 7- Take the opinion of the child after the activity has been completed (recommendations- Notes).
- 8- Record what has been implemented in the child's file and the steps for the next session.
- 9- Inform the school supervisor/director or educators of the class on what has been implemented, thank him/her and remind him/her about the next session.

### Time needed / Frequency:

- 20 to 40 minutes every session, weekly or as needed.

### Means of verification:

- Report from the CW who implements the activity.
- Pictures.

**Tools and materials needed:**

\* Cards - pens - colors - papers - shapes - games – clay...

**Difficulties/challenges:**

- \* Unresponsiveness/distraction of the rest of the pupils.
- \* Noise during activity.
- \* Absence of the concerned child.
- \* Non responsiveness of the school.

**Do's and Don'ts: tips and hints from experience:****Do:**

- 1- Inform parents about everything that is being implemented in the school.
- 2- Involve parents in some of the activities as needed.
- 3- Commit to the agreed time and the time that works with the child and the school.
- 4- Remind the school consistently about the importance of what is being implemented.
- 5- If you want to take pictures, ask for prior permission from the institution/center.

**Do not do:**

- 6- Do not bind the child in the activity in case he/she refuses it.
- 7- Avoid being more than 2 in the intervention team so as not to complicate the work progress in the classroom.

**Examples illustrating the activities**

A child has hyperactivity; the community worker visits him/her during a previously planned activity with the educator of the class. The community worker participates in the activity to facilitate the participation of the child, explaining the activity to him/her and helping him/her control his/her movement, accept losing and winning, and understand the rules.

## 30. Evaluation of child's progress.

### Definition for this activity:

*An assessment of the child's psychological well-being progress and the development of his/her skills at different levels: daily living skills, motor and communication skills, etc. after he/she went through one or more types of treatment within the care process.*

### Objective:

- Determine the extent of the child's progress after a period of care by the multidisciplinary team.
- Modify the treatment plan or end the care process.

### Expected results:

- \* To get a clear picture of the child's progress based on the following criteria: decrease of the symptoms, improvement in his/her psychological well-being, improvement of his autonomy and improvement of his/her relationship with others.
- \* The decision of how to modify or terminate the action plan based on the progress he/she achieves.

### Target group:

- Children provided treatment services by the team.

### Implementing persons:

- \* Therapists and community workers in charge of following up on the child and his/her family.

### Steps for implementation:

- 1- Each therapist working with the child assesses the child's progress in the field of treatment he/she is applying using specific tools to his field of treatment.
- 2- The community worker assesses the child's progress based on his/her observation at home, at school and during sessions; and takes the opinion of the parents concerning their observations of the child's progress in his/her everyday life.
- 3- All involved team members present and discuss the child's progress assessment during the team weekly meeting based on the specific assessments that were done to take the appropriate decision to stop treatment or to modify the treatment plan. For example, the improvements and difficulties at level of behavior, communication and ability to express oneself, to focus, to transfer skills acquired at the center to the home and in everyday life are discussed.
- 4- Set a meeting with the child's parents to share information about child's situation progress and the decision taken for the steps intended to be implemented and take into account the priorities of parents.

### Time needed / Frequency:

- One or two sessions for evaluation by each therapist or community worker working with the child and the time needed to meet.
- The evaluation happens after 6 months or a year for the start-up, or when team members notice important development or lack of development for the child.

### Means of verification:

- Filling out the part specified for the child's progress in his/her main file.

### Tools and materials needed:

- \* The child's file in various treatments.
- \* Monitoring tools and observations of community worker.
- \* The tools needed in each evaluation (games, tests...).

### Difficulties/challenges:

- \* The existence of multiple problems for the child, making it difficult to measure the child's progress.



**Do's and Don'ts: tips and hints from experience:****Do:**

- 1- Take group decision to stop treatment or follow up on it.
- 2- Inform the parents about the steps intended to be implemented.
- 3- Take the notes of community workers and parents into account in the assessment.
- 4- Modify the treatment plan according to the needs that fit the child, taking into account the priorities of parents .

## 31. Phase out process.

### Definition for this activity:

*Phase of discharge following the decision by the team to end the child's follow up.*

### Objective:

- Ending the child's follow-up in most efficient way.

### Expected results:

- \* An action plan with specific actions for ending the follow-up is designed by the team and communicated with parents.
- \* The child's family is involved in this phase to continue/sustain the results of the follow up of the child after the end of the treatment.

### Target group:

- Children who have achieved their action plan goals.
- Children whose parents are now skilled enough to work with the child on their own with some support.
- Children whose needs are not covered anymore by the types of services provided in the center, and for whom there is a possibility to receive more adapted services in another center (example: a child who can be included in a special education center, etc.).
- Children who are not improving with the services provided in the center because these services appeared as not adequate to respond to their needs.
- Children whose family is not committed to the treatment (not coming to sessions, etc.).

### Implementing persons:

- \* **The team:** the therapists and CWs involved in the child's treatment.

### Steps for implementation:

- 1- Based on the team evaluation (see chapter: evaluation), the team discusses the ending of the child follow-up.
- 2- An action plan is designed by the team to end the follow-up and to be suggested to parents. These are examples of activities that can be done during this phase.
  - \*\* Continue child's follow up for a transitional period by the community worker to support the family, for social and daily living skills interventions as well as for psycho-education sessions.
  - \*\* Network and coordinate with another center to refer the child to other types of services and orient the parents to these services which are adapted to their child's needs.
  - \*\* Have a specific number of sessions with the child aiming to finish the treatment with the child,
  - \*\* Write a report for school with recommendations, and intensify coordination with school,
  - \*\* Integrate the child in a group activity (child- parent activity, group activity for children with Down syndrome....).
  - \*\* Integrate the child's parent in the support group or the parent committee in order to support them and raise awareness on their rights (advocacy...).
- 3- Meet with the parents, discuss the evaluation results and discuss with them the reasons the team suggests to stop/finish the treatment.
- 4- Give parents detailed information about the phase out action plan.
- 5- Listen to parents' concerns and accompany them throughout the phase out process.
- 6- Give parents all information needed about other services you are referring the child to, about recommendations you gave to school through reports, etc.
- 7- Explain clearly to the child in words he can understand why the sessions will stop and what are the activities that will be done till then.

### Time needed / Frequency:

- Depending on action plan designed to finish the treatment.

**Means of verification:**

- Notes in the child's file, notes about parent's meeting.

**Tools and materials needed:**

- \* Child's file.

**Difficulties/challenges:**

- \* The end of the treatment is in some cases not only related to child's progress or child's need, but also related to administrative issues (financial problems at the center and need to decrease beneficiaries).
- \* Even in this situation, the phasing out with the child follows an action plan allowing the family to find the substitution for the services and treatment is not stopped before that.
- \* Some parents are emotionally attached to the center and it is difficult for them to accept the ending of their child's treatment.

**Do's and Don'ts: tips and hints from experience:**

- 1- Prepare the parents since the beginning of the treatment on how and when the treatment will be ended and based on which criteria.
- 2- Explain to the parents that they are always welcome to visit the center for any request/need.
- 3- Take time to discuss with parents the ending of the treatment taking in consideration their opinion about it.
- 4- Take time to explain why and how the treatment will be ended.
- 5- Recommend to the parents to continue interacting with other parents (to mitigate their stress, find peer solidarity etc) for example through the parents committees.
- 6- Organize a following up visit to the child discharged few months later discharge to ensure things are on track and the child and the family are coping with their difficulties.

## **ANNEXS**

**\*\* Annex 1: Detailed presentation of the organizations who participated in writing this guide.**

**\*\* Annex 2: Acronyms.**

**\*\* Annex 3: Human resources -Profile of each of the team members.**

**\*\* Annex 4: TOOLBOX List.**

## **ANNEX 1: Detailed presentation of the organizations who participated in writing this guide.**

### ***Handicap International (HI):***

In Lebanon since 1992, Handicap International has been working closely with Lebanese civil society supporting people with disabilities, providing psycho-social support to children living in Palestinian refugee camps and surroundings, ensuring relief and recovery information, strengthening local Disability People's Organizations across Lebanon and carrying out humanitarian mine and cluster bombs clearance.

HI works in Mental Health and Psychosocial sector in Palestinian camps since 2004. Main HI's activities aimed to provide psychological care for children and capacity-building on MH for care takers (animators, educators, community workers) through training and accompaniment.

A study was done in 2009, and showed the high prevalence of mental health problems among children in the South camps and the limited access to services because of lack of knowledge and awareness of the families about the existing services. Handicap International has initiated a project in 2010 aiming to improve the access to mental health rehabilitation services for CwMHP living in the Palestinian camps in North Lebanon and Tyre area. Since then, Handicap international has been supporting provision of multidisciplinary mental health rehabilitation services provided by two local partners CBRA and FGC.

### ***This has been done through:***

- *Support to different local stakeholders on identification and referral of CwMHP to appropriate service providers. Referral maps were produced to facilitate the referral process among the different stakeholders working in North and Tyre area camps.*
- *Raise the community awareness on issues related to mental health through running awareness campaigns and awareness home stations activities.*
- *Support partners financially and technically to provide quality comprehensive multidisciplinary mental health rehabilitation services to CwMHP living in North and Tyre area camps.*

Since the beginning of the year 2014, HI has increased its intervention and beside what has been done it also started to:

- *Support different stakeholders to improve their capacities to include mental health issues within their field of intervention.*
- *Raise the awareness on the situation of mental health in Lebanon generally and in the Palestinian camps specifically among local, national and international stakeholders.*
- *Mobilize the community stakeholders to contribute to the improvement of the situation of mental health in the camps.*
- *Improve partners' clinical governance and support them to have their own policies and strategies.*
- *Document on the experience and good practices of Handicap international in the field of mental health and share experiences with other local, national and international stakeholders.*

Handicap International's intervention in the field of mental health is done in partnership of two main mental health service providers : community based rehabilitation association (CBRA) covering Naher el Barid and Beddawi camps in North area, and Family Guidance Center which is part of Beit Atfal Al Somoud covering Tyre area camps and gathering.

Beside these partnerships, Handicap intervention is closely cooperating and coordinating with Ministries mainly Ministry of Public Health and Ministry of Social affairs, UNRWA, other international, national and local stakeholders.

### ***Family Guidance Center - Al Buss***

Family Guidance Center (FGC) -Al Buss is one out of 5 Family Guidance Centers run by the National Institution of Social care and Vocational Training (NISCVT) in Lebanon.

The NISCVT commonly known as Beit Atfal Assumoud is a non-governmental organization working within the Palestinian refugee community in Lebanon. It was established in 1976, after the Tal Al Zaatar massacre, to provide assistance and accommodation for surviving orphans children.

NISCVT is independent with no ties to any political faction. Services are available to the Palestinian refugees community and persons with other disadvantaged nationalities living inside the camps or close to them. Today NISCVT provides cultural, health, educational and recreational services through 12 centers in Lebanon, the "Family Guidance Centers" are one of its health services.

The "Family Guidance Center" in Al Buss camp was established in November 2007 to provide comprehensive mental health rehabilitation services to children and youth below 18 years and the caregivers who are living in the Palestinian refugee camps and gatherings in Tyre area.

A limited number of beneficiaries from other nationalities and from very poor socio-economic background from neighboring communities also receive mental health services.

The FGC work is carried out in cooperation with the NISCVT centers located in the Palestinian refugee camps across Lebanon. Referrals to the FGC are made through the help of social workers, kindergarten teachers in the refugee camps and gatherings, family members, caregivers, NGO's working with the Palestinian children and adolescents and UNRWA staff from schools and clinics.

### ***The Community-Based Rehabilitation Center***

The Community Based Rehabilitation Association (CBRA) is a non-profit developmental association located in north Lebanon and registered as a Lebanese non-governmental organization under decree 440/AD.

The CBRA is the result of merging the two projects of "Community Based Rehabilitation" that was initiated in 1997 and the "Social Association for the Rehabilitation of the Disabled" that started working in the Palestinian refugees' camps, North Lebanon, in 1990. CBRA works with all segments of the society, individuals and institutions, to achieve its goals. It works in the fields of disability and rehabilitation with the Palestinian communities and refugee camps in Northern Lebanon as well as with the surrounding Lebanese communities around the camps in Northern Lebanon.

CBRA's vision is the following: all persons with disabilities in the Palestinian refugee camps northern Lebanon enjoy their human rights under a comprehensive social justice in the local community. CBRA's mission is to enable the local community to adopt and advocate for the rights of persons with disabilities in order for them to participate in the decision-making and to have an active role within their communities.

## **ANNEX 2: Acronyms.**

<b><i>CBRA</i></b>	Community Based Rehabilitation Association
<b><i>CW</i></b>	Community worker
<b><i>CwMHP</i></b>	Children with Mental Health Problems
<b><i>FGC</i></b>	Family Guidance Center
<b><i>HI</i></b>	Handicap International
<b><i>MH</i></b>	Mental Health
<b><i>WHO</i></b>	World Health Organization



### **Annex 3: Human resources -Profile of each of the team members.**

**Administrative director:** a person responsible for the daily functioning of the center and the follow-up of the overall progress of the project. This person is involved in the planning and evaluation process at level of the center, and in networking in the community and coordinating with other centers. This person should preferably have a social work background, trained on mental health, as well as familiar with the culture of the targeted population. He/she should take part in the team meetings, as an important link between the centre, other service providers, and the community.

**Clinical psychologist:** a person with a certified university degree in Psychology (a minimum of a master's degree). Experience/additional training in testing are needed in order to screen and assess neuropsychological, cognitive and affective disorders.

**Community Worker:** designates the Mental Health Community Worker. It is a person from the community recruited by the center to be part of the mental health team and who undergoes a capacity building program. Community workers are trained by the team's specialists on basic concepts of mental health and disability, child development, mental health problems, family dynamics, etc. They also undergo on the job training on therapeutic techniques related to the different disciplines (cf. task shifting). They can also attend training outside the center organized by other stakeholders and need to have knowledge on services provided by the center and services provided by other centers in the area. Skills required to implement the community worker's tasks are: communication skills (active listening, etc.), organizational skills, observation skills, skills to support parents, skills to work with children under the supervision of the specialists. They also need to have respectful and ethical attitude and ability to manage conflicts.

**Coordinator:** a person responsible for coordinating the work of the community workers and the team practical organizational issues. This person should preferably have a social work background, trained on mental health, as well as familiar with the culture of the targeted population.

**Occupational therapist:** person with certified university degree, preferably master's degree, in occupational therapy. Additional training in standardized tests is recommended, as well as in specific rehabilitation techniques.

**Physiotherapist:** a person with certified university degree (licence) in physiotherapy.

Psychiatrist: a certified medical doctor specialized in Psychiatry

Psychomotor Therapist: a person with certified university degree in Psychomotor Therapy, preferably a master's degree. Continuous training on treatment techniques is recommended.

**Psychiatrist:** a certified medical doctor specialized in Psychiatry.

**Psychomotor Therapist:** a person with certified university degree in Psychomotor Therapy, preferably a master's degree. Continuous training on treatment techniques is recommended.

**Psychotherapist:** a person with certified university degree in Clinical psychology (a minimum of a master's degree) and who has underwent psychotherapeutic training in a specific approach. Continuous training on treatment techniques is recommended. Experience/additional training in testing are needed in order to screen and assess neuropsychological, cognitive and affective disorders.

**Speech and Language therapist:** a person with certified university degree (master's) in Speech and Language Therapy. Knowledge of the language, dialect, and culture of targeted children and families is recommended. Continuous training on treatment techniques is recommended.

## **Annex 4: TOOLBOX List.**

- 1- Elements to include in the job description for community Workers.
- 2- Elements to include in the job description of specialists.
- 3- Main topics to be included in the training of the community workers.
- 4- Example of improvement action plan for the community worker.
- 5- Team meeting minutes form.
- 6- Form for taking picture consent.
- 7- The Children Cases Notes form.
- 8- Example for setting quality monitoring criteria in the project.
- 9- Example for quality of service management action plan.
- 10- Example for the person centered approach action plan.
- 11- Service request form.
- 12- Example of a family and social questionnaire .
- 13- Example of a child' needs assessment form.
- 14- Community worker and case coordination action plan form.
- 15- Example for an individual action plan form.
- 16- Example for a group action plan form.
- 17- Example for a group work documentation form.
- 18- Form for the documentation of the therapeutic sessions done by the community worker in the center.
- 19- Two formats to document home visits.
- 20- Parents' training preparation form.
- 21- Parents committee's meeting minutes form.