Dominica: Hurricane Maria Response

Mental Health and Psychosocial Support Program Report
October 2017 – March 2018
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Background

Hurricane Maria emergency response

The Commonwealth of Dominica is a Caribbean island with an area of 750km$^2$ and a population of approximately 70,000 people.\(^1\) On the 18\(^{th}\) of September 2017, the country was hit by Hurricane Maria, a category five storm which brought extreme winds of 260 km/h and severe rainfall. Thirty-one fatalities were reported and 37 people were reported missing. The storm caused severe flooding and landslides, and damaged an estimated 90% of the buildings on the island, leaving thousands homeless and without access to employment or education.\(^2,3,4\)

International Medical Corps (IMC) was among the first of the humanitarian agencies to provide emergency response services following the hurricane, establishing programs focused on: Health; Water, Sanitation and Hygiene; and Mental Health and Psychosocial Support (MHPSS). This report describes the IMC MHPSS Program, detailing program activities, partner engagement and outcomes.

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\(^1\) 2011 Commonwealth of Dominica Census.
\(^2\) United Nations (2017). Dominica: Hurricane Maria Situation Report No. 7 (as of 19 October 2017)
\(^3\) United Nations (2017). Dominica: Hurricane Maria Situation Report No. 6 (as of 14 October 2017)
MHPSS Program Objectives

The MHPSS Program had four key objectives:

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<th>Objective 1:</th>
<th>Assess MHPSS needs and resources</th>
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<td>Objective 2:</td>
<td>Establish a coordination mechanism for MHPSS activities</td>
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<td>Objective 3:</td>
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<td>Objective 4:</td>
<td>Increase awareness and use of international best-practice guidelines on MHPSS in emergencies</td>
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This report documents the activities and outcomes associated with each objective.

Assessing MHPSS needs and resources

- A rapid MHPSS assessment was conducted in October 2017 to understand the needs of communities affected by Hurricane Maria, identify existing services and resources, and generate recommendations to inform program design. This section summarizes the assessment findings. The full report is available online.\(^5\)
- The assessment tools were adapted from the UNHCR/WHO MHPSS Assessment Toolkit and included an assessment of available MHPSS services (4Ws mapping exercise), community needs and current sources of distress.\(^6\)
- Data were collected through review of key documents, interviews with key informants, and group discussions with community members and representatives of state and non-state organizations involved in MHPSS activities (Figure 3).

Figure 2 Images of damage sustained during Hurricane Maria

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Participants reported high levels of distress among affected communities relating to: basic needs (e.g. lack of food, water, shelter, security, and possessions); social issues (e.g. disruption to normal activities, loss of livelihood, disruption to usual support services); and psychological stressors (e.g. anxiety, hopelessness, disillusionment, resentment, guilt, feelings of loss and bereavement, perceived lack of emotional support). Several groups were identified as being particularly vulnerable following the disaster, including shelter residents, children, older people, people with disabilities, and the Kalinago population.  

Prior to the assessment, there was no MHPSS technical coordination group and there had not been any MHPSS coordination meetings or MHPSS service mapping activity. Multiple agencies were independently carrying out MHPSS activities, but these were not centrally coordinated and there was no documentation of what activities were

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7 The Kalinago Territory on the North East of the island was severely affected by the hurricane. Rates of employment and mean income in the region tend to be lower than the national mean, and Kalinago people have historically faced a degree of social discrimination.
being conducted or of which geographical locations were receiving support.

- As part of the assessment, IMC conducted an MHPSS ‘4Ws’ mapping exercise to document current MHPSS activities being conducted in Dominica. The 4Ws Matrix is available in the published assessment report. The exercise identified a rich network of local Non-Governmental Organizations (NGOs) that were engaged in MHPSS activities, though none of those interviewed were aware of the IASC MHPSS Best Practice Guidelines for MHPSS in Emergency Situations.

- The assessment found evidence that some of the activities being conducted were not consistent with best practice guidance, with several groups conducting single-session psychological debriefing (including Critical Incident Stress Debriefing), an approach that is discouraged by the WHO (World Health Organization) due to evidence that it may hinder recovery and increase the risk of Post-Traumatic Stress Disorder (PTSD).\(^8\,^9\)

- The assessment report concluded with seven recommendations for actions to be jointly undertaken by MHPSS actors to improve the response (Panel 1).

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MHPSS Rapid Assessment: Recommendations for Practice

- Improve **coordination and mapping** for mental health and psychosocial support activities.
- Improve **local capacity to respond** to the mental health and psychosocial support needs of the affected population (e.g. through PFA training and support for caregivers).
- Promote international **best practice guidelines** and evidence-based approaches to MHPSS in emergencies.
- Improve **awareness of common psychological reactions** to distressing events, positive coping strategies, and sources of support.
- Support **community initiatives**, self-help and social-support groups, in accordance with IASC and PAHO guidance for MHPSS in Emergency Situations.
- **Advocate for at-risk groups** and support existing social services.
- Host an inter-agency MHPSS panel discussion to **share lessons learned** and develop recommendations for future emergencies.

Panel 1 Recommendations from Rapid MHPSS Assessment

- International Medical Corps designed an MHPSS Program to address the first four recommendations, focusing on improving MHPSS coordination, building local capacity to respond to MHPSS needs, promoting international best practice guidelines, and improving awareness of common psychological reactions and sources of support in emergency settings. These activities were prioritized based on the available resources and the ongoing activities of other agencies.
- The assessment findings were disseminated to relevant national and international actors via email and were published on ReliefWeb at the request of the United Nations Office for the Coordination of Humanitarian Affairs (OCHA).
Coordination of MHPSS response activities

- In October 2017, International Medical Corps established a Working Group to improve the coordination of MHPSS and Gender-Based Violence (GBV) activities (Panel 2).

### MHPSS/GBV Working Group Objectives

1. To ensure an effective, coordinated and focused inter-agency response to the MHPSS/GBV needs of the Dominican population affected by Hurricane Maria
2. To make information available about which actors are conducting which activities in which locations, identify gaps, and enable appropriate referrals
3. To identify gaps in the MHPSS/GBV response and facilitate coordinated action
4. To promote adherence to internationally-recognized best practice guidelines for MHPSS in emergencies and inter-agency recommendations
5. To strengthen the knowledge-base on MHPSS/GBV needs and activities in Dominica
6. To promote the leadership of the government, and encourage the representation of diverse MHPSS and GBV partners and stakeholders, including government partners, UN agencies, international and local Non-Governmental Organizations (NGOs)
7. To improve the transparency of MHPSS activities through structured documentation, and to draw lessons for future responses

The *Terms of Reference* document drafted and approved by the Working Group is available in Appendix 1.

- As of February 2018, the Working Group has 29 member organizations, including Government Bodies, Local NGOs, Faith-Based Organizations, International NGOs (INGOs), private MHPSS Providers, and UN Agencies (Panel 3).
- Working Group coordination meetings were held bi-weekly and chaired by International Medical Corps. In this role, International Medical Corps collaborated with IOM to design a section on Psychosocial Issues for the Data Tracking Matrix survey conducted periodically with shelter residents.
- The chairing role was phased over to the Ministry of Social Services, Family and Gender Affairs in March 2018.
MHPSS/GBV Working Group Member Organizations

Government bodies
- Bureau of Gender Affairs
- Department of Child Protection
- HIV Unit
- National Drug Prevention Unit
- School Counsellor Network
- Social Welfare at Princess Margaret Hospital
- Welfare Department at Social Services

UN Agencies
- IOM
- OCHA
- UNFPA
- UNICEF

Local NGOs
- CARIMAN
- Dominica National Council of Women
- Dominica Planned Parenthood Association
- East Dominica Children's Federation
- Fouche La Vie
- NGO Coalition for the Protection of Women and Children
- West Dominica Children's Federation

Faith-Based Organizations
- The Franciscan Institute
- Lifeline Ministries
- Samaritan's Purse
- Seventh Day Adventists

International NGOs /Agencies
- Communicating with Disaster Affected Communities Network (CDAC-N)
- International Federation of the Red Cross
- International Medical Corps
- IsraAID

Private MHPSS Providers
- Dominica Psychological Society
- Premium Home and Residential Care Services
Improving local capacity to respond to MHPSS needs

Psychological First Aid (PFA) training for community leaders

Training overview

PFA is an approach to providing practical and emotional support to people who have recently experienced a distressing event.\(^{10}\) It is recommended by the World Health Organization as an important part of supporting communities impacted by humanitarian emergencies.

International Medical Corps collaborated with the Dominica Psychological Society and IsraAID to design a one-day interactive workshop for community leaders in PFA. The curriculum was based on the WHO PFA Guide for Fieldworkers. Panel 4 presents an overview of the course.

Fifteen full-day participatory workshops were implemented with 212 community leaders between December 2017 and February 2018. The workshops were led by the IMC MHPSS Program Manager and a Clinical Psychologist from the Dominica Psychological Society. Psychosocial Specialists from IsraAID co-facilitated three of the trainings.

On completion of the course, each participant received a copy of the WHO PFA Guide for Fieldworkers, a hand-out listing useful resources for further learning (Appendix 2), and a certificate of completion.

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Psychological First Aid
An interactive one-day workshop for community leaders

Course Outline

Section 1
• Registration and pre-training survey
• Introductions
• WHO Psychological First Aid Guide for Field Workers
• Understanding different reactions to distressing events
• Risk factors and protective factors
• Coping styles and strategies

Refreshment break

Section 2
• What is Psychological First Aid (PFA)?
• Who, when and where of PFA
• Risk factors, protective factors, and resilience
• Recognizing signs of distress and signs of mental disorder
• World Health Organization PFA Action Principles: Prepare, Look, Listen and Link

Lunch Break

Section 3
• Good communication skills
• Ethical considerations
• Caring for yourself and your team members
• Recap and reflections

Close - post-training surveys, evaluations, and award of certificates

Panel 4 Psychological First Aid: Course Outline
Training participants

- Participants were recruited through local government councils throughout the island, with the aim of achieving broad geographical coverage. Based on population size, councils were invited to nominate between three and ten community leaders (e.g. village council members, health workers, teachers, fire officers, police officers, religious leaders, leaders of community groups, and local NGO staff). One exception was a dedicated workshop held for health workers at Portsmouth Hospital, which was conducted at the request of the Community Health Nurse.

- A total of 212 individuals participated (36 males, 176 females). Participant numbers ranged from 10 to 19 per session.

- Participants represented 126 different organizations and 59 different villages across all eight health districts.

- Figure 7 shows the geographical coverage, demonstrating that all coasts of the island were reached (the central areas of the island are largely uninhabited mountainous regions). The largest numbers of trainees were based in the most densely populated areas of Roseau and Portsmouth. The gap in the south-east of the island in the district of St Patrick represents the Petite Savanne area, which has been uninhabited since a mandatory evacuation was enforced in 2015 due to severe damage caused by Tropical Storm Erika.
Figure 7 Geographical distribution of PFA trainees
50% of attendees were government representatives (18% local and 32% central), while 39% represented NGOs or Community-Based Organizations (CBOs; Figure 8).

Among government representatives, 31% were Village Councilors, 29% were Health Workers, 16% were Education Professionals, and 11% were Social Workers (Figure 9).
Improvements in perceived competencies

- Perceived competencies were measured on a nine-item scale, which addressed self-reported competency on skills such as: the ability to support people who have experienced disasters, the ability to recognize people in distress, and the ability to link people affected by disasters to services and information.

- Mean Perceived Competency Score increased from 74% to 91% between pre- and post-training surveys.

- The largest gains in perceived competency were for the following items:
  - Knowledge of what to say and do in order to be helpful to someone in distress (23% improvement)
  - Knowledge of things to avoid doing and saying (that could unintentionally cause harm) (22% improvement)
  - Ability to prepare for and approach a crisis situation safely (18% improvement)
  - Ability to take care of yourself when assisting people affected by crisis (18% improvement; Figure 10).

![Figure 10 Improvements in perceived competencies at the beginning (pre) and end of (post) the workshop](image)

Improvements in knowledge

- Improvements in knowledge were assessed using seven ‘true or false’ questions (e.g. “[When helping someone in distress after a disaster, you should] ask the person to recount the details of their traumatic experience.”).

- Mean helping skills scores increased from 65% to 86% between pre- and post-training surveys (Figure 11 & Figure 12).
Training evaluation
Participants were asked to complete an evaluation form at the end of the workshop. This consisted of six Likert-scale questions in which they were asked to rate their level of agreement with learning statements (e.g. “The information [presented] is useful to my work”), and three free-text questions in which they were asked to specify what they found most useful, what they learned that they will use in their work, and any suggestions that would
improve the training for future participants.

Feedback was overwhelmingly positive, with 100% of participants stating that they would recommend the training to others. All participants agreed that the information was clear and easy to understand, and that the workshop gave them knowledge and skills to apply in crisis situations. Further details are provided in Figure 14 and Figure 15.
When asked what they found most useful about the workshop, participants highlighted both the **content** and the **teaching methods**.

### Content
- Several respondents commented that the content of the workshop was “timely” and “relevant to the present situation” in Dominica. They commonly referenced the sections on **PFA Principles** (Prepare, Look, Listen and Link), **Self-care**, and the **Dos and Don’ts of PFA** as particularly useful.

  “Prepare, Look, Listen and Link is easy to remember and easy to apply”

  “Self-care: finding time to take more care of myself in order to better help others”

- When asked which aspects of the training they were most likely to use in their work,
common responses were: active listening, listening non-judgmentally, asking permission before helping, understanding the difference between sympathy and empathy, and recognizing people’s capabilities as well as their constraints.

“I learned to be a better listener... from now on my approach will be different.”

“Everything was useful, but knowing the difference between sympathy and empathy was key to me.”

“Understanding and respecting a person’s capabilities; understanding what they can do, rather than just going in to give help.”

Teaching Methods

- The most common theme was that participants valued the practical, interactive teaching methods, which they felt helped them to retain the information and would make it easier to apply the skills in real life.

“A wonderful balance was created between the theory and the practical aspects.”

“The visual aids and the activities kept my attention, kept me alert, and aided me in retaining the information.”

“The information will be easy to apply in real situations immediately.”

- Another common theme was that the manner of delivery was effective, with participants commenting that facilitators were well-informed and approachable.

“The lecturers were very knowledgeable about the topic and presented it well.”

 “[They] made everyone comfortable around each other, which made it easier to open up and share ideas.”

Suggestions for improvement

- When asked for suggestions of how the training could be improved, the majority of participants (57%) either left the section blank or stated that they could not think of any way in which the training could be improved.

“I can’t think of any... We left feeling much more knowledgeable.”

“None, it was super.”

“Everything was amazing. I learnt a lot and I had fun. Very interactive.”

“The training was excellent, just keep up the good work.”
Where suggestions were offered, the most common was that the training should be longer and/or conducted with more people (45%).

“Have it more often, maybe twice a week? I loved it”
“I recommend that this training be done on a regular basis all across the island.”
“For many more persons to get a hold of this information to better our communities.”

The remaining suggestions related to a desire for additional role-plays or demonstrations, a need for more males to participate, timing, and improving the catering and technology used.
PFA Training-of-Trainers

- In the interest of sustainability, a PFA Training-of-Trainers workshop was held in February 2018.
- All 212 PFA trainees were contacted via text message/email and invited to apply for a place by responding to the message, specifying (i) why they wanted to attend, and (ii) who they intended to train in PFA (i.e. target group and approximate number).
- Applicants were prioritized based on the number of participants they intended to train.

Training overview

The workshop consisted of four sections:

1. **Revision of training slides and activities:** This was a guided review of the training slides and participatory activities. The facilitator highlighted key points to cover on each topic and provided trainees with an opportunity to ask questions. Photographs of each participatory activity from different workshops were included to show a range of different implementation options depending on the resources available in a given setting. To maximize opportunities for learning, participants were invited to share suggestions of additional or modified activities based on their area of expertise (e.g. disability, children, youth).

2. **Facilitation Tips:** This section focused on facilitation skills, including the importance of introductions and ground rules, techniques to encourage participation, managing uncertainty, dealing with arguments, time-management, and teaching effectively as a team.

3. **Introduction to MHPSS Best Practice Guidelines:** This section introduced the IASC Guidelines for MHPSS in Emergency Settings, emphasizing the importance of designing programs that are consistent with the guidelines and the use of appropriate terminology while teaching.

4. **Orientation to training ‘Starter Packs’:** Participants were guided through the contents of their PFA Training Starter Packs, which included the print materials needed to run a training for 10 people and a USB Flash Drive containing electronic versions to be printed as needed (Panel 5).
## Panel 5 Contents of PFA Trainer Starter Pack

<table>
<thead>
<tr>
<th>PFA Facilitator’s Manual</th>
<th>PFA Field Worker Guide</th>
<th>IASC Best Practice Guidelines</th>
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<tbody>
<tr>
<td><strong>PFA Training Slides</strong></td>
<td><strong>Facilitation Tips Slides</strong></td>
<td><strong>Sample Agenda</strong></td>
</tr>
<tr>
<td>Training Video</td>
<td>Monitoring &amp; Evaluation Pack</td>
<td>Group Activity Instructions</td>
</tr>
</tbody>
</table>
Training participants

- 26 people attended the Training-of-Trainers workshop (20 females, 6 males), representing 19 villages across seven health districts (Figure 18).
- 38% of trainees represented NGOs or Faith-Based Organizations and 30% represented local government (e.g. village councils; Figure 19).

![Figure 18 PFA Trainers disaggregated by Health District](image18)

![Figure 19 PFA Trainers disaggregated by sector](image19)
Training evaluation
Participants were asked to complete an evaluation form at the end of the PFA Training-of-Trainers workshop. This consisted of:

- four Likert-scale items in which participants were asked to rate their level of agreement with learning statements such as “The workshop gave me practical skills and knowledge”.
- three free-text questions in which they were asked to specify what they found most useful about the workshop, what they learned that they will use in their work, and any suggestions that would improve the training for future participants.

Feedback was positive, with the majority of participants ‘strongly agreeing’ with all learning statements (Figure 20).

![Figure 20 PFA Training-of-Trainers: levels of agreement with the four learning statements](image)

Two participants responded “strongly disagree” to all four questions, however, their free-text comments were positive and they provided no suggestions for improvement, suggesting that this may have been a response error. As evaluation forms were submitted anonymously, it was not possible to follow-up on this.

When asked what they found most useful about the workshop, the most common theme was the inclusion of tips on effective facilitation (e.g. establishing clear ground rules, managing disagreements, dealing with uncertainty).

“[I learned] more varied ways of dealing with difficult and delicate situations and avoiding explosive situations!”
The second most common response related to the interactive facilitation style, which granted participants an opportunity to learn from each other and to form a supportive network.

“Everyone showed interest and we all came to a common agreement on everything discussed – the facilitator was brilliant.”

“Learning together with everyone in this group, and having the potential to support each other and work together.”

Other recurring responses related to the sections on using appropriate terminology (e.g. avoiding clinical terminology in non-clinical contexts), and the provision of the training Starter Pack.

“The approach to the training-of-trainers program was thorough, including useful tips and a package of training materials. The trainer was excellent and very knowledgeable.”

When asked for suggestions for improvement, four participants suggested having a longer training session or follow-up sessions, two suggested expanding the starter-pack to include equipment such as projectors and art supplies, two suggested adding activities where trainees could practice facilitation, and two suggested having more decentralized training sessions so to improve access for rural communities.

**Discussion of training plans and collaborations**

At the end of the training, the participants spontaneously began a discussion on how best to work together to ensure that the PFA trainings continue. They considered the possibility of applying for a small grant to buy a projector, and working together to order additional print copies of the PFA Guides in bulk. One participant agreed to serve as coordinator, and another established a WhatsApp group to allow the trainees to stay in touch.
Arts-based approaches to psychosocial support for social workers

Training overview

- In collaboration with IsraAID, International Medical Corps hosted two full-day capacity-building sessions with local psychosocial care-givers focused on arts-based approaches to providing psychosocial support. The sessions were facilitated by three art-therapists working for IsraAID and were administered by IMC.
- This initiative was community-led in that it was developed in response to demand from members of the Dominica Psychological Society and Child Friendly Space Facilitators, who were keen to capitalize on the expertise of three experienced art-therapists during their time volunteering with IsraAID.
- The sessions outlined the theory underpinning the use of creative expression to bolster resilience and self-care, and combined lecture-style teaching with experiential learning through creative exercises. The workshop also highlighted ethical factors that must be considered when using the arts in a humanitarian setting.

Training participants

- **Workshop 1** (Nov 18th 2017) was attended by eight members of the Dominica Psychological Society: three psychologists and five counsellors (1 male, 7 female).
- **Workshop 2** (Jan 27th 2018) was attended by 11 participants: three members of Dominica Psychological Society and eight social workers from local NGOs working with children (1 male, 10 female).

Improvements in perceived competencies

- Perceived competencies were measured by asking participants to rate their perceived competency on a range of relevant skills using a five-point scale. Items were defined by the IsraAID facilitators based on the content of each workshop.
Workshop 1

- Mean overall Perceived Competency Score increased from 66% before the workshop to 84% at the end of the workshop.
- Figure 23 shows that the largest gains were achieved on “ability to implement art-based therapeutic approaches.” Smaller gains were achieved on the other items, which was in part due to their higher baseline ratings. These items related to general facilitation and support skills rather than art-based techniques, and the high baseline ratings are likely to reflect the fact that most participants were already experienced facilitators.

![Figure 23 Perceived competency scores before and after Workshop 1](image)

Workshop 2

- Mean overall Perceived Competency Score increased from 65% before the workshop to 89% at the end of the workshop.
- Figure 24 and Figure 25 show that, as with Workshop 1, the largest gains were achieved on items directly relating to art-based techniques, such as the ability to use the Expressive Therapies Continuum to inform choice of materials and methods.
Improvements in knowledge

- For Workshop 1 participants, knowledge scores increased from 80% before the workshop to 87.5% after the workshop.
- For Workshop 2 participants, knowledge scores increased from 67% before the workshop to 70% after the workshop.
- The item that posed the biggest challenge for both groups of participants was “Art and creativity are a good way to avoid painful emotions”, with only half of participants
giving the correct answer of ‘false’ in the post-workshop survey. This may reflect confusion regarding how the item was phrased. When this item was removed, Workshop 1 scores increased from 83% before the workshop to 97% afterwards, and Workshop 2 scores increased from 77% before the workshop to 83% afterwards.

Training evaluation

- Participants were asked to complete an evaluation form at the end of the workshop, consisting of four Likert-scale items and a free-text section.

Workshop 1

- Workshop 1 evaluation scores are presented in the figures below, with lower numbers indicating more negative ratings, and higher scores indicating more positive ratings.
In the free-text section of the evaluation form, participants were invited to provide suggestions to improve the training. Six of the eight participants used this section to request further trainings. This was part of the rationale for hosting the second workshop.

Workshop 2

Workshop 2 evaluation scores are presented in the figures below, with lower numbers indicating more negative ratings, and higher scores indicating more positive ratings.
“As a social worker this session will allow me to use this knowledge to help clients resolve issues and open up to get the help they need.” (Workshop 2 Participant)
Increasing awareness and use of MHPSS Best Practice Guidelines

The rapid MHPSS assessment conducted in October 2017 highlighted the rich network of local NGOs and CBOs involved in MHPSS activities; however, their potential impact was limited by the lack of a formal coordination mechanism and limited awareness of relevant international best practice guidelines. Staff from local NGOs and CBOs also reported that they had a limited understanding of the international humanitarian system, which limited the potential for effective collaborations and partnerships. Two full-day orientation workshops were conducted to address these training needs, and copies of the IASC Best Practice Guidelines for MHPSS in Emergency Settings were distributed to relevant agencies.

Workshop on Best Practices for MHPSS in Emergencies

The workshop was developed based on local needs, drawing on the Building a Better Response program\(^\text{11}\) and the IASC Best Practice Guidelines for MHPSS in Emergency Settings.\(^\text{12}\) The goals and learning objectives of the workshop are presented in Panel 6.

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11 http://www.buildingabetterresponse.org/
Section 1. The International Humanitarian Architecture

Aim
To provide a general introduction to the international humanitarian system.

Learning Objectives
By the end of Section 1, participants will:

- Understand the humanitarian imperative and the four principles of humanitarian action
- Recognise key actors in emergency response and understand their roles
- Understand key coordination mechanisms for humanitarian response

Section 2. The IASC MHPSS Best Practice Guidelines

Aim
To provide an orientation to the IASC Guidelines on MHPSS in emergencies.

Learning Objectives
By the end of Section 2, participants will:

- Understand the rationale for MHPSS Best Practice Guidelines for emergencies
- Be equipped to implement the guidelines in their work
- Be equipped to advocate for best practices in their work settings.

Panel 6 Workshop on Best Practice Guidelines for MHPSS in Emergency Settings: Aims and learning objectives

Training participants
- Invitations were sent to leaders of local NGOs and CBOs, members of the Dominica Psychological Society, PFA Trainees, members of the MHPSS/GBV Working Group, and
government staff from Social Services, the Psychiatric Unit, the Health Promotion Unit and the Office of Disaster Management.

- In total, 44 individuals participated (36 females, 8 males).
- 43% represented local NGOs, 39% represented government agencies (Social Welfare, Bureau of Gender Affairs, the HIV Unit, the Fire Service, the Acute Psychiatric Unit, local village councils and disaster committees), 11% worked in education (teachers or guidance counsellors), and 7% represented Faith-Based Organizations.

![Figure 29 Training participants disaggregated by organization type (FBO= Faith-Based Organization)](image)

- Participants received printed copies of the presentation slides and of the IASC Guidelines for MHPSS in Emergency Settings.

**Evaluation**

Participants were asked to complete an evaluation form at the end of the workshop. This consisted of six Likert-scale items in which participants were asked to rate their level of agreement with learning statements, and three free-text questions in which they were asked to specify what they found most useful about the workshop, to identify any topics on which they would like further clarification, and to provide suggestions on how the training could be improved.

Figure 30 and Figure 31 show the responses to each of the learning statements. All participants agreed with all learning statements, with 93% “strongly agreeing” that they would recommend the workshop to others.
When participants were asked what they found most useful about the workshop, the most common response related to understanding the rationale for the Best Practice Guidelines and their content. Several commented that it was extremely helpful to be made aware of the available resources, materials and trainings.

The second most common theme was gaining an understanding of the broader humanitarian system and the principles of humanitarian action. In particular, participants highlighted the value of the interactive discussions in which international principles and practices were compared with examples from the local response in Dominica.

“The guidelines and examples paired with participants’ real-life experiences.”
Several participants highlighted the value of a group activity in which participants were asked to create a visual representation of the different actors in a given emergency response, their responsibilities, and the relationships between them. They reported that the activity brought to life some of the complexities of effective coordination between multiple actors and sectors during emergencies.

“We actually had to think through the activity and we realized that it’s not as easy as we think.”

When asked if there were any topics that they would like clarified further, a recurring theme was that people would like more information on why psychological debriefing is not recommended by the WHO, and several requested further training on PFA and other practical alternatives. To address these requests, materials on the most recent evidence on psychological debriefing, and the list of local individuals that had been trained as PFA Trainers were emailed to participants after the training.

When asked how the training could be improved for future participants, the most common response was that they would like a longer session or more follow-up trainings.

“Can’t wait for more”

“Spread the knowledge”

Other suggestions included adding more group activities, advertising the workshop more widely, and hosting the training in a wheelchair-accessible venue.\(^\text{13}\)

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\(^\text{13}\) Unfortunately, due to the extensive damage to buildings during the hurricane, the range of available venues was severely limited.
150 copies of the IASC Best Practice Guidelines on MHPSS in Emergency Settings were distributed to staff from organizations engaged in MHPSS activities. Panel 7 lists the organizations reached.

### Recipients of IASC MHPSS Best Practice Guidelines

#### Government agencies
- Acute Psychiatric Unit
- Bath Estate Disaster Committee
- Bureau of Gender Affairs
- Kalinago Council
- Dept. Of Local Gov't
- Fire Service
- La Plaine Disaster Committee
- Layou Village Council
- Marigot Village Council
- Massacre Improvement Committee
- Mero Disaster Committee
- HIV Unit
- Social Welfare Division
- St. Joseph Village Council
- Trafalgar Village Council
- Vieille Case Village Council

#### NGOs
- Achievement Learning Centre
- Alliance Francaise
- Antillean Inc.
- Aywasi Development Foundation
- Bath Estate Development Committee
- Bureau of Gender Affairs
- Cancer Society
- CariMAN
- Caritas Antilles
- Child Friendly Spaces
- Dominica Association of Persons with Disabilities
- Dominica Psychological Society
- Dominica Red Cross
- East Dominica Children's Federation
- Girl Guides Association
- The Social Centre
- St. Vincent de Paul
- Lifeline Ministries
- Operation Youth Quake
- PACIS (Parents Advocating for the Inclusion of Children with Special Needs)

#### Educational Institutions
- Dominica State College
- Goodwill Secondary School
- Guidance Counsellors
- Paix Bouche Primary School
- Roseau Library
- San Saveur Primary School
- Social Centre

#### FBOs
- Catholic Church
- Seventh Day Adventist Church
- Dominica District Church of the Nazarene
Promotion of psychosocial support services

The Rapid Assessment and discussions within the MHPSS/GBV Working Group and other coordination meetings indicated that there was a need to improve awareness among community members about the available psychosocial support services in Dominica. A poster of helpline numbers was therefore designed to be displayed in health facilities, village councils, churches and other public areas (Figure 33).

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400 copies were printed in A2 size for distribution, and an electronic version was shared with working group members for distribution on social media and for reprinting as required.
Program summary

Key achievements

- Established a central coordination mechanism for MHPSS response activities
- Trained 212 community leaders nationwide in Psychological First Aid
- Trained and equipped 26 psychosocial workers to continue running Psychological First Aid workshops after program close
- Distributed 500 WHO PFA Field Worker Guides to relevant actors
- Distributed 30 WHO PFA Facilitator Manuals to relevant actors
- Built the capacity of 16 local MHPSS providers through workshops on art-based techniques for psychosocial support
- Trained 44 key actors from NGOs, government bodies, education institutions and faith-based organizations in international best practices for MHPSS in emergencies
- Distributed 150 copies of the IASC Best Practice Guidelines to relevant organizations
- Developed and distributed 400 national helpline posters to raise awareness of available MHPSS services

Program strengths

- Program activities were designed based on a thorough assessment and mapping of local needs and resources.
- Broad geographical coverage was achieved, particularly for the PFA training, with at least one community leader trained from almost all towns and villages nationwide.
- Content of trainings was considered relevant and useful by trainees, with 100% of trainees surveyed stating that they would recommend the workshops to others.
- Trainees reported that the interactive training methods used were engaging and helpful in consolidating learning and demonstrating real-life applicability.
- Multi-sectoral approach and engagement of both governmental and non-governmental actors increased the reach and impact of the program.
- Focus on local capacity-building and distribution of evidence-informed training materials and best practice guidance increased the likelihood of longer-term impact and sustainability.

Lessons and recommendations for future programming

- It is recommended that the MHPSS Working Group continues to meet regularly to coordinate relevant activities and to promote best practices. Working Group members are prepared to continue to collaborate under the leadership of the Ministry of Social Services, in partnership with local and international NGOs.
- The most consistent piece of feedback from trainees was the desire for further training, both in terms of follow-up sessions and reaching a wider audience. Given the
interest and demand that has been generated by this program, and a growing recognition among community members of the potential impact of emergencies on psychosocial wellbeing, **it is recommended that MHPSS capacity-building activities continue.** This will support the current response and improve preparedness as the 2018 hurricane season approaches. For example, those that have been trained as PFA trainers are equipped to continue delivering PFA training throughout the island. This may be coordinated through the MHPSS Working Group.

- A disproportionate number of females were represented in trainings, and the need to have more males trained in MHPSS was a recurring theme in participant feedback. **Future programs should make a special effort to recruit males,** for example, by engaging organizations that have a higher proportion of male staff where MHPSS skills are highly relevant, such as the police and fire services.
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Appendix 1. MHPSS/GBV Working Group Terms of Reference

Mental Health and Psychosocial Support & Gender Based Violence (MHPSS & GBV) Working Group

TERMS OF REFERENCE

I. INTRODUCTION AND BACKGROUND

On the 18th of September 2017, the island of Dominica was hit by Hurricane Maria, a category five storm which brought extreme winds of 260 km/h and heavy rainfall. 14 31 fatalities have been reported and 37 people are still missing. 15 The storm caused severe flooding and landslides, and damaged an estimated 90% of the buildings on the island, leaving thousands without safe homes or access to clean water. 16 Coordination groups have been activated in the following areas: Shelter; Information Management; Water, Sanitation and Hygiene (WASH); Education and Protection; Food Security; Health; Logistics; and Early Recovery. Emergencies increase the risk of diverse social and psychological problems, amplify pre-existing problems, and often erode traditional protective community support structures. Given the widespread destruction on the island of Dominica, and its impact on health, livelihoods, and general wellbeing of the Dominican population, an MHPSS Working Group has been established to provide a collaborative forum for the coordination of MHPSS services, activities and assessments, and to advocate for best practices.

The term ‘psychosocial’ denotes the interconnection between psychological and social processes, and the fact that each continually interacts with and influences the other. 17 In this TOR, the composite term ‘Mental Health and Psychosocial Support’ (MHPSS) is used to describe any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorders.

II. WORKING GROUP OBJECTIVES

- To ensure an effective, coordinated and focused inter-agency response to the MHPSS/GBV needs of the Dominican population affected by Hurricane Maria
- To make information available about which actors are conducting which activities in which locations, identify gaps, and enable appropriate referrals
- To identify gaps in the MHPSS/GBV response and facilitate coordinated action
- To promote adherence to internationally-recognized best practice guidelines for MHPSS

17 Inter-Agency Standing Committee (2013). Mental Health and Psychosocial Support in Emergency Settings: What Should Camp Coordination and Camp Management Actors Know?
in emergencies and inter-agency recommendations

- To strengthen the knowledge-base on MHPSS/GBV needs and activities in Dominica
- To promote the leadership of the government, and encourage the representation of diverse MHPSS and GBV partners and stakeholders, including government partners, UN agencies, international and local Non-Governmental Organizations (NGOs)
- To improve the transparency of MHPSS activities through structured documentation, and to draw lessons for future responses.

III. SCOPE OF ACTIVITIES

1. General Coordination

- Hold regular working group meetings as a forum to coordinate activities, exchange information, provide updates, and disseminate work plans and progress
- Coordinate with Health, Education, Protection and other inter-agency and inter-sectoral working groups to ensure that MHPSS and GBV priorities are represented
- Maintain communication with focal points and ministries, encouraging the active involvement of relevant actors and ministries in the working group
- Promote MHPSS and gender issues as cross-cutting themes among various sectors, and promote the integration of related cross-cutting issues within the MHPSS/GBV activities (e.g. age, gender, disability).

2. ASSESSMENT, ANALYSIS AND INFORMATION-SHARING

- Conduct a mapping exercise of actors engaged in MHPSS/GBV activities, including the formal mental health system, civil society actors such as NGOs and community-based organizations (4Ws mapping - Who is doing What, When, and Where?)
- Coordinate dissemination of assessment findings among group members and share with other relevant inter-agency and inter-sector working groups
- Collate, document and share lessons learned among working group members
- Disseminate relevant information and useful resources to working group members
- Encourage members to report on achievements and challenges

3. TECHNICAL SUPPORT & CAPACITY BUILDING

- Provide a platform for sharing technical support among members
- Support the capacity building of member partners, beneficiaries, national authorities and civil society organizations

ROLES AND RESPONSIBILITIES

1. Leadership

The MHPSS working group will be chaired by International Medical Corps and the Bureau of
Gender Affairs. The chairs will be responsible for:

- Acting as focal points for the MHPSS working group and representing the working group at relevant coordination platforms
- Acting as the link between the MHPSS working group and the health coordination group and other inter-agency and inter-sectoral working groups, communicating relevant information back to the MHPSS working group
- Facilitating regular MHPSS meetings and preparation of relevant documents.

2. Membership

Members of the MHPSS/GBV working group commit to regular participation in working group meetings, activities and initiatives. Participating members will be responsible for:

- Briefing their organization on the orientation, recommendations, and decisions of the MHPSS working group
- Active contribution of relevant experiences and information from their organizations
- Effectively coordinating their programs and activities, avoiding duplication and working towards good practice standards within their own organizations
- Serving as advocates and representing the working group when participating in inter-agency and inter-sectoral activities.

All organizations and ministries working on MHPSS and GBV in Dominica are invited to participate.

MEETINGS

The MHPSS Working Group will meet every two weeks. In agreement with Working Group members, the chairs may schedule alternative dates in special circumstances, and ad hoc meetings may be called as necessary.
Appendix 2. Trainee resource sheet

Useful Resources on Mental Health and Psychosocial Support in Emergency Settings

Resources on Psychological First Aid

- National Traumatic Stress Network & National Center for PTSD (US) PFA Materials [http://www.nctsn.org/nctsn_assets/pdfs/pfa/2/PsyFirstAid.pdf](http://www.nctsn.org/nctsn_assets/pdfs/pfa/2/PsyFirstAid.pdf)
- Johns Hopkins RAPID model of PFA – free online training course [https://www.coursera.org/learn/psychological-first-aid](https://www.coursera.org/learn/psychological-first-aid)

Mental Health Innovation Network

- The Mental Health Innovation Network (MHIN) is an online community of Mental Health professionals with lots of excellent resources, including a full video course on mhGAP.
- You can sign up here [http://mhinnovation.net/](http://mhinnovation.net/) and explore the training materials by clicking on the Resources tab, and then the Training button on the left.

mhpss.net

- A global platform for sharing resources and for building knowledge related to mental health and psychosocial support both in emergency settings and in situations of chronic hardship. The network functions as an online community of practice for mental health and psychosocial support in challenging humanitarian and development contexts.

Disaster Ready Website

- The Disaster Ready website offer useful online courses on relevant topics such as humanitarian principles, crisis management, and caring for vulnerable groups: [https://www.disasterready.org/humanitarianism-courses#diversity-mainstreaming](https://www.disasterready.org/humanitarianism-courses#diversity-mainstreaming)

Pan-American Health Organization publication