*Journal of Traumatic Stress*, Vol. 19, No. 1, February 2006, pp. 5–17 (© 2006)



# The ISTSS/Rand Guidelines on Mental Health Training of Primary Healthcare Providers for Trauma-Exposed Populations in Conflict-Affected Countries

David Eisenman
*RAND, Santa Monica, California and David Geffen School of Medicine, UCLA*

Stevan Weine
*University of Illinois*

Bonnie Green
*Georgetown University Medical School*

Joop de Jong
*Healthnet TPO*

Nadine Rayburn
*RAND, Santa Monica, California*

Peter Ventevogel
*Healthnet TPO*

Allen Keller
*Bellevue/NYU Program for Survivors of Torture*

Ferid Agani
*University of Prishtina*

*Mental health care for trauma-exposed populations in conflict-affected developing countries often is provided by primary healthcare providers (PHPs), including doctors, nurses, and lay health workers. The Task Force on International Trauma Training, through an initiative sponsored by the International Society for Traumatic Stress Studies and the RAND Corporation, has developed evidence- and consensus-based guidelines for the mental health training of PHPs in conflict-affected developing countries. This article presents the Guidelines, which provide a conceptual framework and specific principles for improving the quality of mental health training for PHPs working with trauma-exposed populations.*

Funding was provided by the RAND Corporation, the International Society for Traumatic Stress Studies, and the Jerome Frankel Foundation.

Task Force Members and Contributors: Ferid Agani, Sayed Azimi, Florence Baingana, Eduardo Cazabat, Sotheara Chimm, David Eisenman, Bonnie Green, Alison Holman, Timothy Holtz, Vincent Iacopino, Joop de Jong, Nira Kaplansky, Allen Keller, Mooli Lahad, Malik Mubbashar, Srinivasa Murthy, Lisa Meredith, Mark Van Ommeren, Daniel Mosca, Mary Ngoma, Nadine Rayburn, Daya Somasundaram, Bradley Stein, Willem Van de Put, Peter Ventevogel, Andrés Villaveces, Beverly Weidmer, Stevan Weine, Suzanne Wenzel, Ken Wells, Marlene Wong.

Correspondence concerning this article should be addressed to: David Eisenman, RAND, 1776 Main Street, PO Box 2138, Santa Monica, CA 90407. E-mail: david_eisenman@rand.org.

 DOI: 10.1002/jts.20094

Primary healthcare providers (PHPs)—including doctors, nurses, and lay health workers—are often called upon to provide mental health care to trauma survivors in developing countries affected by war or large-scale collective violence (De Jong, 2002; Mollica et al., 2004; Sphere Project, 2004; World Health Organization, 1996). This situation results from a lack of mental health professionals in many resource-poor countries (World Health Organization, 2001a) and the tendency of individuals to seek care first from their PHPs (World Health Organization, 2001b). However, PHPs face many obstacles in providing mental health services, including little or no training in mental health, limited access to psychiatric medications, and few linkages with the mental health care system, if one exists (World Health Organization, 2001a, 2001b).

Trauma mental health experts often travel worldwide to train local practitioners to recognize and respond to trauma-related mental health problems and frequently focus on PHPs for such training (Weine et al., 2002). However, multiple shortcomings have been identified in the practice of providing this trauma mental health training, including a lack of integration with general mental health training, limited evidence-based content, absence of outcome assessments, failure to link to health and community resources, and questionable cultural relevancy (Mollica et al., 2004; Summerfield, 1999; Van Ommeren, Saxena, & Saraceno, 2005). The identification of these shortcomings raises important questions about how mental health training for PHPs should be conceptualized, designed, implemented, and evaluated. The work described in this article aims to address these questions.

In November 1999, the Board of Directors of the International Society for Traumatic Stress Studies (ISTSS) created the ISTSS Task Force on International Trauma Training to provide guidance on how best to respond to mental health needs after complex emergencies around the world. A major goal established for the Task Force was to advance the quality of international trauma training. The Task Force began by drafting the Guidelines for International Trauma Training, a set of principles and strategies to be used as a framework for training all categories of professional and lay health workers (Weine et al., 2002). In 2002, the ISTSS Task Force on International Trauma Training partnered with the RAND Corporation to convene an international panel to outline the application of these general Guidelines to the training, specifically, of PHPs located in conflict-affected areas, particularly those in developing countries. The Task Force effort was based on both established scientific knowledge and clinical practices of mental health, with emphasis on application that is effective, sustainable, and avoids doing harm.

The ISTSS/RAND Guidelines on Mental Health Training of Primary Healthcare Providers for Trauma Exposed Populations in Conflict Affected Countries (the Guidelines) are presented in the here. The Guidelines aim to identify areas that need to be addressed before, during, and after training implementation to ensure PHPs are instructed in how to provide high-quality mental health care. The Guidelines are intended for international and local trainers and health organizations, as well as governmental and nongovernmental organizations responsible for funding and implementing training. They are meant to provide an overview of important elements to consider in establishing principles to guide development and implementation of training curricula. Although the Guidelines are not meant to address in-depth technical training issues, they do provide references to more detailed resources. Further, in developing the Guidelines, the Task Force chose to focus only on care for adults at this time, because training practitioners to provide pediatric and adolescent mental health care requires its own focused effort and expertise (La Greca, Silverman, Vernberg, & Roberts, 2002; Wolfe & Nayak, 2003; Yule, Stuvland, Baingana, & Smith, 2003).

The Guidelines consider two forms of collective violence, as defined by the World Health Organization: (1) wars, terrorism, and other violent political conflicts that occur within or between states and (2) state-perpetrated violence such as genocide, repression, disappearances, torture, and other human rights abuses (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). In developing the Guidelines, the Task Force determined that PHPs include not only doctors

and nurses, but also lay health workers, who provide much of the primary healthcare in some developing countries. A PHP is defined as any clinician or healthcare practitioner formally engaged in the provision or delivery of comprehensive healthcare services or treatments in the outpatient primary healthcare setting.

The Task Force recognizes that implementing all of the Guidelines' recommendations will not be possible in all contexts. However, instead of prioritizing some recommendations over others, the Task Force believes trainers, trainees, and their communities share the responsibility to prioritize the recommendations collaboratively.

## PROCESS

The ISTSS Task Force on International Trauma Training and the RAND Corporation collaborated to form a working group of mental health professionals, practitioners, research scientists, and global health policymakers with expertise in primary care–based mental health. Potential participants were identified through consultation with and recommendations from members of the Task Force, the ISTSS Board of Directors, and senior researchers at RAND. Discussion with working group members and a review of the literature yielded additional potential participants. Selection of participants attempted to achieve balance among the domains of expertise, training, and experience; among regions of the globe; between developing and developed countries; and between genders.

Recommendations for the Guidelines were based on (1) existing scientific evidence of efficacy or effectiveness, (2) conceptual rationale supported by a broad consensus, and (3) feasibility in primary care settings. Wherever possible, evidence-based recommendations were sought. The Task Force performed a systematic search of the MEDLINE, PsychInfo, PILOTS, and Social Science Abstracts databases. Internet searches were conducted to identify gray literature (that is, publications issued by governments, academia, business, or industry and not published in peer-reviewed journals), and international experts identified unpublished reports. In the absence of empirical data, recommendations were based on the consensus of the participating experts.

### Consensus Process

In July 2003, the Task Force began by systematically assembling the empirical evidence regarding management of psychological trauma in primary care settings. On November 3–4, 2003, Task Force members met at RAND in Santa Monica, California, agreed on the scope of work, developed and refined a conceptual framework for the writing of the Guidelines, further assembled and integrated the empirical evidence, created preliminary draft statements of each component of the Guidelines, and discussed the statements. After that meeting, the Task Force chair and authors prepared the text of the Guidelines, submitted it to the remaining Task Force members for critical review, and revised the drafts on the basis of those reviews.

In the second year, the Task Force disseminated the Guidelines to more than 50 professionals worldwide and requested their feedback. These individuals represented 32 service, academic, nongovernmental, and governmental organizations involved in training worldwide. The Task Force leaders subsequently reconvened to review the feedback and to revise the Guidelines accordingly. The final draft of the Guidelines was reviewed and approved by the entire Task Force and the ISTSS Board of Directors.

### Conceptual Framework

The Task Force developed and refined a conceptual framework for the design and implementation of mental health training for PHPs that guided the creation of the Guidelines (Figure 1). This framework describes the elements of an effective training program for PHPs that will improve their delivery of mental health care.

Designing a training program requires specifying both the content and the strategies for implementation in a given context. As Figure 1 indicates, *Evidence-Based Curricular Elements, Values and Beliefs*, and *Contexts and Systems* inform the content. *Values and Beliefs*, *Contexts and*

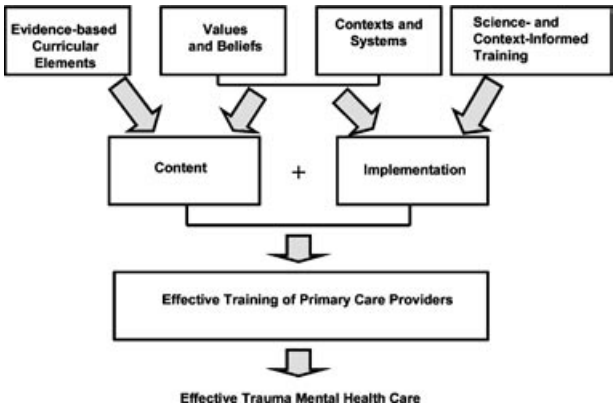


***Figure 1.*** Conceptual framework for design and implementation of effective trauma mental health training.

*Systems*, and *Science- and Context-Informed Training* inform the implementation. The role of each of these dimensions is explained fully in the Guidelines. However, in brief, implicit and explicit **Values and Beliefs** underlie any training. The Guidelines propose values the Task Force considered particularly important for training PHPs. Understanding the community, sociopolitical, and temporal dimensions of **Contexts and Systems** will improve both content and implementation. **Evidence-Based Curricular** elements derived from the body of empirical and experiential evidence form the basis of the training curriculum. **Science- and Context-Informed Training** refers to the body of evidence that informs the implementation strategy.

The issue of temporal context (which is considered in **Contexts and Systems**) merits further explanation. Training may occur during any phase of a crisis (e.g., the acute or postemergency phase). Training delivered during the acute phase of a crisis runs the risk of having limited relevance to the long-term mental health needs of the individuals, communities, and organizations involved (Weiss, Saraceno, Saxena, & Van Ommeren, 2003). The design of both acute-phase and postemergency-phase training programs must consider how they relate to long-term processes and goals. Because of the increasing consensus regarding the value of phase-specific training agendas, the Guidelines address the importance of temporal context.

# THE GUIDELINES

## Values and Beliefs

The content and implementation of a training curriculum are based on both implicit and explicit values and beliefs. These values and beliefs must be understood, shared, and, if necessary, negotiated with the trainees. The Guidelines emphasize specific values that the Task Force agreed are important to guide PHPs' relationships with their patients, professions, institutions, and communities.

***Collaboration***. Effective training involves interaction and collaboration, not only with the PHPs themselves, but also with local governments, communities, nongovernmental organizations, and, when available, mental health specialty care providers. Collaboration is important for assessing the need for services, PHPs' specific training needs, the available resources, and for developing training activities that fit with local practice patterns, resources, and incentives. Local collaboration to assess community needs and resources allows program design to be based on what is locally important and what is available (Soriano, 1995; Witkin & Altschuld, 1995). Collaboration and local ownership of the training help ensure that it fits the social and cultural contexts and facilitates the sustainability of the knowledge and skills imparted (Carballo, 2003). Collaborating with local officials and authorities is important in negotiating appropriate compensation for PHPs who participate in trauma training and identifying opportunities for recognition and accreditation of training by local formal entities or systems. Work with health authorities on the provincial and national levels might be needed to put mental health issues on the policy agenda and obtain policy support for the training activities (Ventevogel et al., 2002).

***Multidisciplinary participation***. Trauma is a multifaceted problem that is best understood through the perspectives and contributions of multiple disciplines. Individual and collective experience of trauma is shaped by culture, economics, history, gender, religion, historical and social change, and politics. The consequences of trauma are

not only emotional and psychosocial (e.g., posttraumatic stress disorder, depression, substance abuse), but also economic, social, and physical. Professionals in the fields of health, religion, social sciences (anthropology, history), and other disciplines may help trainers understand how the particular traumas experienced by a people affect the physical, mental, and social dimensions of health and their interrelations. Including traditional healers is vital to enhancing the development of a culturally appropriate curriculum (De Jong, 2002; Fairbank, Friedman, de Jong, Green, & Solomon, 2003).

***Family and community***. A multicontextual view of trauma includes the family, community, and society. Trauma affects not only the individual victim but also the entire family. PHPs who care for victims of trauma are obliged to consider the needs of the whole family and are encouraged to provide family members with support, guidance, treatment, and information, as culturally appropriate. The consensus of the Task Force is also that families be considered in terms of their strengths and the resources they provide to their communities and cultures: Mobilizing support from family members is an important component of "psychological first aid."

Community context must also be incorporated into training, including the values, culture, needs, meanings, and strengths that are embedded in the community. Training programs can recognize PHPs' usual roles in their communities and, where possible, seek to enhance that community involvement in ways that promote higher quality mental health care.

***Human rights***. The Task Force recommends that training programs encompass a human rights framework. The Universal Declaration of Human Rights enunciates a set of international standards regarding fundamental rights of individuals and communities, particularly in relation to the appropriate behavior of governments and ruling authorities (United Nations, 1983). A human rights framework can inform the roles and responsibilities of PHPs in several areas: (1) documentation of traumatic events and their medical and mental health sequelae, (2) advocacy by PHPs or other responsible persons on behalf of victims of human rights violations, and (3) identification of links to other helping professionals' systems (e.g., legal or social).

## Contexts and Systems

The design and implementation of training for PHPs in trauma mental health must consider the contextual and systems factors that may influence the effectiveness of such training.

***Cultural context***. Effective training incorporates an understanding of how local culture influences survivors' experiences of trauma, suffering, recovery, and resources, including the idioms used to express distress (de Jong, 2002; de Jong et al., 2005; Green et al., 2003). Collaborating with local partners in the early stages of preparation can help identify cultural factors and processes that affect the appropriateness, acceptability, feasibility, and effectiveness of training. For example, because of strict gender segregation (*purda*) in eastern Afghanistan, separate training sessions for male and female participants were necessary (Ventevogel & Kortmann, 2004b).

***Community and systems context***. Training is likely to be more effective if it incorporates an understanding of local health, social, and economic factors and their influence on the need for and characteristics of the training. It is important to understand the perceived or evaluated need for mental health services in the community and the perceived or evaluated need for training among PHPs. Understanding how the training will complement and supplement existing resources and expertise improves the chances for success and prevents both duplication of services and crippling of existing service provision (for instance, among traditional healers). Integrating or embedding trauma training within existing systems of healthcare delivery—be they formal or traditional health services—promotes sustainability. A multidisciplinary model that integrates PHPs, mental health services, and other services, such as social welfare, is optimal (Cohen, 2001). Enlisting the support of traditional healers has been effective in developing and

implementing other primary care initiatives (Bishaw, 1990; Green, Zokwe, & Dupree, 1995).

***Human rights context.*** Understanding local PHPs' position in relation to previous or ongoing human rights violations and the aims and activities of local and international human rights organizations is important for developing training programs. It is also critical to learn and incorporate which specific PHP activities (e.g., forensic documentation) could be helpful in promoting human rights work in their country and region, and what knowledge and resources might be available to PHPs. For example, documenting a patient's location when he stepped on a landmine provides information that can be used later to inform mine clearing teams (Stover, Keller, Cobey, & Sopheap, 1994). International and local human rights organizations can provide important information to trainers regarding human rights violations in a particular country or region where training is to occur. Encouraging PHPs to establish direct contacts with other local health professionals as well as national and international human rights organizations rather than working alone may also help ensure their safety.

***Temporal context.*** Critical to training is imparting an understanding of the phases of a complex emergency and the position of the training and mental health services in this temporal framework. Training may occur in any phase of an emergency and, thus, needs to be particularly sensitive to the needs and problems associated with that phase. For example, training that occurs during the acute phase of a crisis must emphasize the need to balance the more prevalent psychological and social health needs of the majority of individuals with the less prevalent but possibly more urgent needs for psychiatric care among persons who have chronic mental illnesses who have been deprived of medications, or for whom the traumas have precipitated an acute exacerbation (Silove, Ekblad, & Mollica, 2000). In contrast, long-term issues of primary care–based mental health care (e.g., long-term management of psychiatric medications and substance abuse) demand greater attention in the postemergency phase. Regardless of the phase of a crisis during which training occurs, a successful training program clarifies the role of crisis care in the overall mental health service framework or the long-term mental health services goals for that community. Even when conducted during the acute phase of a crisis, training programs are most useful when they contribute to the long-term development of primary care–based mental health services.

## Evidence-Based Curricular Elements

The core curricular elements encompass knowledge and skills that can be learned and appropriately applied by PHPs. Although covering each of these areas may not always be possible, it is hoped that trainers will prioritize on the basis of considerations discussed in the sections Values and Beliefs and Contexts and Systems.

## Knowledge

Training conveys information about mental health that is specific to trauma as well as more general mental health information.

***Mental health literacy.*** The Task Force identified mental health literacy as an important component of training programs. Mental health literacy includes a basic understanding of symptoms and modifiable risk factors for mental illness as well as a belief in the ability to treat mental illnesses and in the seeking of help. Because mental disorders often carry a stigma, even among PHPs, it is recommended that training programs seek to demystify and destigmatize mental disorders early on. PHPs must be able to address stigma concerns in themselves and among the persons they care for as well as the communities in which those individuals reside.

***Confidentiality and trust.*** Confidentiality is a critical concept to address in training because it is key to establishing trusting and therapeutic relationships, especially when trauma has eroded individuals' ability to trust. However, cultural differences in the definition of confidentiality also demand that PHPs be instructed to consider cultural

context, for example, when deciding the appropriateness of sharing information with a patient's family.

***The dimensions of trauma***. Descriptions of the types of trauma encountered in war, refugee situations, and domestic settings, including gender-specific trauma exposures, and their consequences are useful. Certain types of trauma exposures, such as rape, including that of boys and men, are considered shameful in many cultures. Elucidating such traumas for PHPs who may have little knowledge of their nature or prevalence is helpful.

***Common mental health symptoms and disorders associated with trauma***. Didactic material can include the common mental health symptoms and illnesses associated with trauma that are likely to be seen in primary care settings, including depression, posttraumatic stress disorder, anxiety disorders, and substance abuse (Baron, Jensen, & de Jong, 2003; Ventevogel & Kortmann, 2004b). PHPs need to be educated about common positive and negative psychological responses to trauma as well as the fact that some degree of distress is normal and resolves in most persons (Ballenger et al., 2004). Specific material can include diagnostic criteria, common presenting symptoms and concerns, and factors that allow differential diagnoses between medical and mental illnesses and among mental illnesses. Additional points to emphasize include the fact that mental illness and mental health problems are among the most common diseases worldwide, that over the course of an individual's lifetime they can affect all areas of functioning, and that these illnesses can and do occur independently of any antecedent trauma.

***Interaction of general health and mental health***. Training can emphasize the interaction of physical and mental health. Trauma exposure has negative physical and mental health consequences that are interdependent and can exacerbate one another (Schnurr & Green, 2004). For example, physical manifestations of trauma, such as severe musculoskeletal pain from beatings, can result in persistent reminders of trauma and ensuing psychological symptoms, and the shame from rape may be an obstacle to human immunodeficiency virus testing. Another point to emphasize is that mental disorders are similar to other health disorders and often accompany them, and that preexisting mental health and medical conditions may worsen if individuals are under extreme stress.

***Treatments***. Training can cover the types of medications used for mental disorders in general and trauma-related disorders in particular, the way they work, their side effects, the evidence base for the most efficacious treatments, and common issues and problems in prescribing the medications and in encouraging patients to give them an appropriate trial (Sphere Project, 2004). Other issues to address include concerns about the stigma of using such medications and psychotherapeutic approaches to depression and posttraumatic stress disorder, such as cognitive-behavioral therapy (Foa, Keane, & Friedman, 2000). It is also important that PHPs are taught about the existence of clinical guidelines, including those of ISTSS (Foa et al., 2000), and techniques to keep up with changes in those and other guidelines as they evolve (National Institute for Health and Clinical Excellence, 2005; Ursano et al., 2004).

***Burnout***. Vicarious traumatization and burnout are relatively common but can be prevented or mitigated through the transfer of skills and identification of helping resources.

Vicarious traumatization is the transformation of or change in a helper's inner experience as a result of responsibility for and empathic engagement with traumatized clients (Saakvitne, Gamble, Pearlman, & Lev, 2000). PHPs who have a large caseload of very needy clients, particularly those who have painful and overwhelming circumstances that are difficult to hear about, may lose their ability to empathize with these individuals or begin to experience the symptoms their clients present (e.g., dreaming about circumstances described by patients).

Burnout is a real possibility when PHPs are overburdened with ill patients who have suffered extreme stress or trauma, particularly when resources are inadequate. PHPs who have been traumatized by wars or violence may be at particularly high risk for burnout. Information to

incorporate includes identification of the warning signs, prevention, and coping.

## Skills

Skills that are readily learned and easily practiced in the primary care setting are optimal for inclusion in training programs (World Health Organization, 1996). Such training can enhance skills that are already part of the PHP's general repertoire.

***Listening skills***. Effective listening skills are an important aspect of any provider-patient encounter. Because they increase the likelihood of addressing the most important problems, they are critical in validating the patient's symptoms and making appropriate diagnoses (Lipkin, Putnam, & Lazare, 1995).

***Communication skills***. Effective communication includes clear explanations of health problems, shared decision making about treatment options, addressing of any concerns the patient may raise, and ability to solve problems (Lipkin et al., 1995). Relationships characterized by higher levels of communication result in better adherence to treatment regimens and better health outcomes (Hulsman, Ros, Winnubst, & Bensing, 1999; Roter et al., 1998; Stewart, 1995).

***Assessment skills***. Assessment skills include the ability to ask about trauma exposure, help-seeking history, available resources, and social support. When asking about trauma exposure, displaying a nonjudgmental attitude and a stance that communicates the medical importance of the information, and the provider's ability to help increases the probability that the patient will share information and benefit from the communication. Use of behavioral language is usually recommended, as is a thorough assessment of types of exposure.

Training addresses the differing pathways to health seekers' current care. PHPs can benefit from knowing whether the patient has previously sought treatment for a mental health problem (including problems that have no Western counterpart or are described by particular local idioms or terms) and, if so, whether he or she benefited from the help.

Patient resources and social support, or the lack thereof, predict how well the patient will be able to manage his or her trauma and utilize the services of the PHP. Patients who have limited support and coping skills will need more support from the PHP and/or community.

***Crisis intervention***. Appropriate medical, psychological, and social intervention skills can be taught. These skills are helpful in assessing and managing acute crises related to suicidal ideation, exposure to extreme stressors, interpersonal and domestic violence, and substance abuse.

***Stress reduction***. Acute-phase stress reduction techniques include psychological first aid, a set of skills believed to limit distress and negative health behaviors (e.g., providing education about normal psychological responses to trauma and the importance of maintaining normal sleep, nutrition, and general health; establishing safety; and ensuring that basic needs are met) (Institute of Medicine, 2003; Mollica et al., 2004; Sphere Project, 2004). In post-emergency phases, training curricula can include a variety of approaches to reduce stress and promote health (e.g., those related to sleep hygiene, as well as traditional healing techniques and prayer) (World Health Organization, 1996).

***Self-care***. Basic self-care techniques, including health promotion, measured breathing, meditation, and relaxation, can help PHPs manage their own health (to reduce burnout and vicarious traumatization) and can be taught to patients. Particularly where other resources—such as psychiatric medications—are scarce, techniques that empower patients to help themselves may promote healing and carry little risk of harm. Self-care also includes attending to potential risks to the safety or well-being of PHPs who participate in human rights–related activities.

***Community resources and referrals***. The ability to access and utilize available local, regional, and national resources is an important set of skills. During the acute emergency phase, knowledge about available relief resources, including housing, financial aid, employment, and social services, is critical (Lima, Santacruz, Lozano, & Luna, 1988). Lists of local referral resources can be created collaboratively during training sessions and later posted in examination rooms.

In both acute and postemergency phases, PHPs can be trained to think broadly about the range of useful services and to explore collaborations with other service providers in the area, particularly clergy, traditional healers, and other community leaders. Because of the stigma that can surround mental health problems, outreach activities to address these problems may also be important (Cohen, 2001). For patients who are very ill or not responding to primary care treatment, referrals to a mental health professional are encouraged, if available, along with continued communication and collaboration between the PHP and mental health professional.

***Family involvement***. PHPs, particularly those who already work with families, can learn to augment family involvement in treatment. Family involvement is likely to enhance recovery and help adherence to provider recommendations. However, exceptions to the goal of family involvement need to be highlighted. These exceptions include situations in which incest or domestic violence occurs or the family is part of the trauma; another exception is the case in which exposure or disclosure of the patient's condition could result in a negative reaction from the family and be harmful to the patient (see Confidentiality and trust).

***Documenting human rights violations***. Learning when and how to document human rights violations to support legal claims can help prevent future events (Iacopino, Ozkalpipci, & Schlar, 1999). This process includes asking for details of trauma exposure as well as documenting physical, emotional, and mental health evidence of torture or abuse. Training includes information on how to document and potentially report human rights violations, especially in situations in which these violations are known or suspected to be ongoing. Documentation may occur only if agreed to by the patient. Intimidation and harassment of PHPs who document and care for victims of human rights abuses are also concerns (Iacopino, 1996). Thus, additional issues to be addressed include confidentiality and PHP and patient safety, including acknowledging and strategizing about measures to protect PHPs and patients from harassment, threats, or violence; and privacy of records, including storage locations. Linkages with other health professionals, including professional organizations, international and local human rights organizations, and international partnerships, can be important in addressing these issues (Iacopino, Kirschner, & Heisler, 1996).

## Science- and Context-Informed Training

Training programs for PHPs strive to utilize evidence-based training models and techniques. In implementing a training program, developers can draw upon available training materials, (Patel, 2003; World Health Organization, 1996, 1998), teaching guides (Cantillon, 2003; Farrow, 2003; Green, 2001; Jaques, 2003; Prideaux, 2003), curricula (Mubbashar, 1998), and reports or evaluations of previous training initiatives (Green et al., 2003; Mohit et al., 1999; Somasundaram, Van de Put, Eisenbruch, & de Jong, 1999; Ventevogel & Kortmann, 2004a).

***Selecting trainees***. The selection of appropriate candidates for training is guided by community resources, context, and culture. For instance, in countries where nurses have close, continuous relationships with primary care patients, they may be most appropriate for training (Moreno, Saravanan, Levav, Kohn, & Miranda, 2003). In countries or regions where much of the healthcare is provided by lay health workers, training programs would most appropriately be adapted for these individuals. Training programs are ideally guided by a pretraining assessment of trainees' knowledge, attitudes, and practices and then adapted to address the training needs, goals, and limitations of the identified target audiences.

***Selecting trainers***. Important considerations for training programs are the identification of appropriate trainers and an appropriate trainer/student ratio. The specific skills required by a trainer depend on the content of the curriculum and the characteristics of the participants. Matching trainers and trainees in terms of disciplines and professional backgrounds can facilitate learning. For example, trainers who work with physicians require a broad understanding of medications, as well as skills in differential diagnosis and other areas, whereas those working with nurses might benefit from stronger educational and group skills, and those working with lay workers might need skills in community outreach and education.

***Multifaceted training methods***. Training programs can employ a range of learning approaches. Evidence supports the effectiveness of multifaceted approaches (Kroenke, Taylor-Vaisey, Dietrich, & Oxman, 2000). A variety of methods are recommended, both because different information is best learned in different ways, and because people differ in the ways they best take in new information. Training may include lectures, case examples, interactive role play, experiential and other types of exercises, and review of written manuals and flowcharts. Interactive programs that include participant activity and provide the opportunity to practice skills have been found to be more effective in training PHPs than didactic sessions (Davis et al., 1999). Including a field component of supervised clinical experience is also recommended (de Jong, 1996; de Jong, Ford, & Kleber, 1999). Research also suggests that this supervised clinical training is most successful when held near trainees' worksites (Schneider, 1971; Soumerai, 1998).

***Training resources***. Trainees require effective training and reference materials in their own language. The adaptation of training materials to meet local needs is also important (Eisenbruch, de Jong, & van de Put, 2004). Materials may include manuals, flowcharts summarizing the main principles, decision trees outlining the appropriate treatment of common conditions, laminated pocket cards, and other handouts.

***Maintaining training and supervision***. Built into an effective training program are plans for periodic reinforcement and review of the evidence base and a search for new evidence.

Reinforcement can be accomplished either through sustained involvement of trainers over time (for instance, using an open-ended model of a "consultation" agreement with the training team) or supervision by mental health specialists (Baron, Jensen, & de Jong, 2003; Cohen, 2001; Kroenke et al., 2000). Depending on the nature and context of the program, various types of involvement may be appropriate: ongoing expert and/or peer supervision, periodic booster training sessions, opportunities to communicate with trainers and/or other resource providers via electronic means, and distribution of manuals or booklets. The content and timing of booster sessions can be tailored to the setting and the evolving needs of the providers and population, following the recommendations articulated for training in general. For example, in Afghanistan, District Health Supervisors are designated to maintain PHPs' mental health skills by assessing ongoing training needs, developing refresher courses, and keeping mental health on the agenda of PHPs (Ventevogel & Kortmann, 2004b).

***Monitoring and evaluation***. Training programs should be accountable for monitoring training progress and outcomes and modifying programs on the basis of the results. Monitoring can include assessment of changes in participants' pretraining knowledge, attitudes, and practices as a function of training; collection of data pertaining to the process of training (e.g., trainee participation, comprehension of materials); and solicitation of trainee feedback throughout the program.

Changes in service provision can be measured by using few additional resources (Baingana, 2003). When the resources and infrastructure for research are available, clinical outcomes associated with training, such as number of patients identified and treated (or referred to the PHP for treatment); changes in symptom levels, quality of life, and functioning; and patient satisfaction should be measured. Monitoring and evaluation can be used to assess the outcome of a mental health intervention program on the basis

of a set of goals, objectives, activities, and performance indicators derived from the conceptual framework. All of these monitoring and evaluation steps can be framed in terms of constructs and variables that are prioritized with the help of the local community. The data can then be used to make appropriate adjustments to the training program and publicized to advance overall learning and promote "best practices" in trauma and mental health training. Selecting a format recommended for organizing and presenting the results of curriculum development and training interventions before implementation of training will improve the credibility of the empirical evidence for such programs (Reznich & Anderson, 2001).

## CONCLUSIONS

These Guidelines are intended to advance the conceptualization and application of mental health training activities for PHPs in conflict-affected developing countries. Although research to date has emphasized application over conceptualization, the latter is equally essential to improve training. For example, conceptualization includes considering how training changes in various contexts, including cultural, community, systems, human rights, and temporal contexts.

Although the Guidelines present an evidence- and consensus-based statement of what the Task Force believes to be important elements of effective training, not all of the recommendations will be easy or even possible to implement in all contexts. The Task Force recognizes that extrinsic factors such as the availability of resources will influence which elements of the Guidelines can be followed. It is also aware of the intense daily demands on PHPs working in low-resource settings and chaotic environments. Decisions made collaboratively by trainees, local trainers, and international trainers regarding selection and adaptation of these elements will lead to better training outcomes. Moreover, the development of international training is a process: Research applications of these Guidelines are also needed to specify and improve the Guidelines in relation to particular contexts.

## REFERENCES

Baingana, F. (2003). Mental health and conflict. Report no. 13. Retrieved March 8, 2005, from http://wbln0018.worldbank.org/ESSD/sdvext.nsf/67Search/?SearchView&w=67&Query=mental%20health%20and%20conflict

Ballenger, J. C., Davidson, J. R., Lecrubier, Y., Nutt, D. J., Marshall, R. D., Nemeroff, C. B., et al. (2004). Consensus statement update on posttraumatic stress disorder from the international consensus group on depression and anxiety. Journal of Clinical Psychiatry, 65(Suppl. 1), 55–62.

Baron, N., Jensen, S. B., & de Jong, J. T. V. M. (2003). Refugees and internally displaced people. In B. Green, M. Friedman, J. De Jong, S. Solomon, T. Keane, J. Fairbank, et al. (Eds.), Trauma interventions in war and peace: Prevention, practice, and policy (pp. 243–270). New York: Kluwer Academic/Plenum.

Bishaw, M. (1990). Attitudes of modern and traditional medical practitioners toward cooperation. Ethiopian Medical Journal, 28, 63–72.

Cantillon, P. (2003). Teaching large groups. British Medical Journal, 326, 437–439.

Carballo, M. (2003). Report of an evaluation of a Harvard Trauma Program project funded by the World Bank Post Conflict Unit in the canton of Travnik, Bosnia and Herzegovina. Geneva: International Center for Migration and Health.

Cohen, A. (2001). The effectiveness of mental health services in primary care: The view from the developing world. Geneva: World Health Organization.

Davis, D., O'Brien, M., Freemantle, N., Wolf, F., Mazmanian, P., & Taylor-Vaisey, A. (1999). Impact of formal continuing medical education: Do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or healthcare outcomes? Journal of the American Medical Association, 282, 867–874.

de Jong, J. T. V. M. (1996). A comprehensive public mental health programme in Guinea-Bissau: A useful model for African, Asian and Latin American Countries. Psychological Medicine, 26, 97–108.

de Jong, J. T. V. M. (Ed.). (2002). Trauma, war and violence: Public mental health in socio-cultural context. New York: Plenum-Kluwer.

de Jong, J. T. V. M., & Clarke, L. (Eds.). (1996). Mental health of refugees. Geneva: WHO. Retrieved September 1, 2005, from http://whqlibdoc.who.int/hq/1996/a49374.pdf

de Jong, J. T. V. M., Komproe, I. H., Spinazzola, J., van der Kolk, B., & van Ommeren, M. (2005). DESNOS in four post conflict

settings: Cross-cultural construct equivalence. Journal of Traumatic Stress, 18, 13–23.

de Jong, J. T. V. M., Komproe, I., & Van Ommeren, M. (2003). Common mental disorders in postconflict settings. Lancet, 361, 2128–2130.

de Jong, K., Ford, N., & Kleber, R. (1999). Mental health care for refugees from Kosovo: The experience of Medecins sans Frontières. Lancet, 353, 1616–1617.

Eisenbruch, M., de Jong, J. T. V. M., & van de Put, W. (2004). Bringing order out of chaos: A culturally competent approach to managing the problems of refugees and victims of organized violence. Journal of Traumatic Stress, 17, 123–131.

Fairbank, J. A., Friedman, M. J., de Jong, J. T. V. M., Green, B. L., & Solomon, S. (2003). Intervention options for society, communities, families, and individuals. In B. Green, M. Friedman, J. De Jong, S. Solomon, T. Keane, J. Fairbank, et al. (Eds.), Trauma interventions in war and peace: Prevention, practice, and policy (pp. 57–72). New York, Boston, Dordrecht, London, and Moscow: Kluwer Academic/Plenum.

Farrow, R. (2003). Creating teaching materials. British Medical Journal, 326, 921–923.

Foa, E. B., Keane, T. M., & Friedman, M. J. (2000). Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies. New York: Guilford.

Green, B., Friedman, M. J., de Jong, J. T. V. M., Solomon, S., Keane, T., Fairbank, J. A., et al. (2003). Trauma interventions in war and peace: Prevention, practice, and policy. New York: Kluwer Academic/Plenum.

Green, E. C., Zokwe, B., & Dupree, J. D. (1995). The experience of an AIDS prevention program focused on South African traditional healers. Social Science & Medicine, 40, 503–515.

Green, M. L. (2001). Identifying, appraising, and implementing medical education curricula: A guide for medical educators. Annals of Internal Medicine, 135, 889–896.

Hulsman, R. L., Ros, W. J., Winnubst, J. A., & Bensing, J. M. (1999). Teaching clinically experienced physicians communication skills: A review of evaluation studies. Medical Education, 33, 655–668.

Iacopino, V. (1996). Turkish physicians coerced to conceal systematic torture. Lancet, 348, 1500.

Iacopino, V., Kirschner, R., & Heisler, M. (1996). Torture in Turkey and its unwilling accomplices. Boston: Physicians for Human Rights.

Iacopino, V., Ozkalpipci, O., & Schlar, C. (1999). The Istanbul Protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment. Geneva: Office of the United Nations High Commissioner for Human Rights.

Institute of Medicine. (2003). Preparing for the psychological consequences of terrorism: A public health strategy. Washington, DC: The National Academies Press.

Jaques, D. (2003). ABC of learning and teaching in medicine: Teaching small groups. British Medical Journal, 326, 492–494.

Kroenke, K., Taylor-Vaisey, A., Dietrich, A. J., & Oxman, T. E. (2000). Interventions to improve provider diagnosis and treatment of mental disorders in primary care: A critical review of the literature. Psychosomatics, 41, 39–52.

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A., & Lozano, R. (2002). World report on violence and health. Geneva: World Health Organization.

La Greca, A. M., Silverman, W. K., Vernberg, E. M., & Roberts, M. C. (Eds.). (2002). Helping children cope with disasters and terrorism. Washington, DC: American Psychological Association.

Lima, B. R., Santacruz, H., Lozano, J., & Luna, J. (1988). Planning for health/mental health integration in emergencies. In M. Lystad (Ed.), Mental health responses to mass emergencies. New York: Brunner/Mazel.

Lipkin, M., Putnam, S., & Lazare, A. (Eds.). (1995). The medical interview. New York: Springer-Verlag.

Mohit, A., Saeed, K., Shahmohammadi, D., Bolhari, J., Bina, M., Gater, R., et al. (1999). Mental health manpower development in Afghanistan: A report on a training course for primary healthcare physicians. Eastern Mediterranean Health Journal, 5, 373–377.

Mollica, R., Lopes-Cardozo, B., Osofsky, H., Raphael, B., Ager, A., & Salama, P. (2004). Mental health in complex emergencies. Lancet, 364, 2058–2067.

Moreno, P., Saravanan, Y., Levav, I., Kohn, R., & Miranda, C. T. (2003). Evaluation of the PAHO/WHO training program on the detection and treatment of depression for primary care nurses in Panama. Acta Psychiatrica Scandinavica, 108, 61–65.

Mubbashar, M. (1998). Mental health in primary care: Training manual for primary care physicians, general practitioners and specialists in other disciplines of medicine. Rawalpindi, Pakistan: Institute of Psychiatry WHO Collaborating Centre at Rawalpindi General Hospital.

National Institute for Health and Clinical Excellence. (2005). The management of post traumatic stress disorder in primary and secondary care. London: NICE.

Patel, V. (2003). Where there is no psychiatrist: A mental health care manual. London: Gaskell.

Prideaux, D. (2003). ABC of learning and teaching in medicine: Curriculum design. British Medical Journal, 326, 268–270.

Reznich, C. B., & Anderson, W. A. (2001). A suggested outline for writing curriculum development journal articles: The IDCRD format. Teaching and Learning in Medicine, 13, 4–8.

Roter, D., Rosenbaum, J., de Negri, B., Renaud, D., DiPrete-Brown, L., & Hernandez, O. (1998). The effects of a continuing medical education programme in interpersonal communication skills on doctor practice and patient satisfaction in trinidad and tobago. Medical Education, 32, 181–189.

Saakvitne, K. W., Gamble, S., Pearlman, L. A., & Lev, B. T. (2000). Risking connection: A training curriculum for working with survivors of childhood abuse. Baltimore: Sidran.

Schneider, B. (1971). Preparing general practitioners for community mental health work. Hospital and Community Psychiatry, 22, 346–347.

Schnurr, P. P., & Green, B. L. (Eds.). (2004). Trauma and health: Physical health consequences of exposure to extreme stress. Washington, DC: American Psychological Association.

Silove, D., Ekblad, S., & Mollica, R. (2000). The rights of severely mentally ill in postconflict societies. Lancet, 355, 1548–1549.

Somasundaram, D. J., Van de Put, W. A., Eisenbruch, M., & de Jong, J. T. (1999). Starting mental health services in Cambodia. Social Science and Medicine, 48, 1029–1046.

Soriano, F. I. (1995). Conducting needs assessments: A multidisciplinary approach. Thousand Oaks, CA: Sage.

Soumerai, S. B. (1998). Principles and uses of academic detailing to improve the management of psychiatric disorders. Internal Journal of Psychiatry in Medicine, 28, 81–96.

Sphere Project. (2004). Sphere handbook. Retrieved February 1, 2005, from http://www.sphereproject.org/handbook/index.htm

Stewart, M. A. (1995). Effective physician-patient communication and health outcomes: A review. Canadian Medical Association Journal, 152, 1423–1433.

Stover, E., Keller, A. S., Cobey, J., & Sopheap, S. (1994). The medical and social consequences of land mines in Cambodia. Journal of the American Medical Association, 272, 331–336.

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. Social Science & Medicine, 48, 1449–1462.

United Nations. (1983). The universal declaration of human rights. London: Amnesty International, British Section.

Ursano, R. J., Bell, C. C., Eth, S., Friedman, M., Norwood, A. E., Pfefferbaum, B., et al. (2004). Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. American Journal of Psychiatry, 161(Suppl. 11), 3–31.

Van Ommeren, M., Saxena, S., & Saraceno, B. (2005). Mental and social health during and after acute emergencies: Emerging consensus? Bulletin of the World Health Organization, 83, 71–76.

Ventevogel, P., Azimi, S., Jalal, S., & Kortmann, F. (2002). Mental health care reform in Afghanistan. Journal of Ayub College Abbottabad, 14, 1–3.

Ventevogel, P., & Kortmann, F. (2004a). Developing basic mental health modules for healthcare workers in Afghanistan. Intervention, 2, 43–54.

Ventevogel, P., & Kortmann, F. (2004b). Mental health care in primary healthcare: Experiences from eastern Afghanistan. Developing Mental Health, 2, 5–8.

Weine, S., Danieli, Y., Silove, D., Van Ommeren, M., Fairbank, J. A., & Saul, J. (2002). Guidelines for international training in mental health and psychosocial interventions for trauma exposed populations in clinical and community settings. Psychiatry, 65, 156–164.

Weiss, M. G., Saraceno, B., Saxena, S., & Van Ommeren, M. (2003). Mental health in the aftermath of disasters: Consensus and controversy. Journal of Nervous and Mental Disease, 191, 611–615.

Witkin, B. R., & Altschuld, J. W. (1995). Planning and conducting needs assessments: A practical guide. Thousand Oaks, CA: Sage.

Wolfe, D., & Nayak, M. (2003). Child abuse in peacetime. In B. L. Green, M. Friedman, J. De Jong, S. Solomon, T. Keane, J. A. Fairbank, et al. (Eds.), Trauma interventions in war and peace (pp. 75–105). New York: Kluwer.

World Health Organization. (1996). Mental health of refugees. Geneva: Author.

World Health Organization. (1998). Mental disorders in primary care: A WHO educational package. Geneva: Author.

World Health Organization. (2001a). Atlas: Mental health resources in the world. Geneva: Author.

World Health Organization. (2001b). World health report 2001—mental health: New understanding, new hope. Geneva: Author.

Yule, W., Stuvland, R., Baingana, F., & Smith, P. (2003). Children in armed conflict. In B. L. Green, M. Friedman, J. de Jong, S. Solomon, T. Keane, J. A. Fairbank, et al. (Eds.), Trauma interventions in war and peace (pp. 217–242). New York: Kluwer.