PSYCHOLOGICAL CARE AND SUPPORT GUIDELINES

March 2013

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FOREWORD

The revision of this National Psychological Care and Support Guidelines come at an opportune time where the ministry seeks ensure the acceleration of the universal access of HIV care services in order to improve the health of the people of Swaziland by providing preventative services that are of high quality, relevant, accessible, Affordable, equitable and socially acceptable. For the ministry to attain all the above it realized that health care workers are pivotal to the success of the national response to HIV and AIDS given that majority of interventions are health sector based.

However, as the epidemic unfolds so is the health sector overwhelmed with the provision of care and support. Thus the ministry is decentralizing and task shifting HIV/ TB and Mental Health services to clinics, given the work load, health care workers often suffer from daily psychological trauma associated with handling of the diseases and deaths on a daily basis. The Psychological Care and Support unit of the Swaziland National AIDS Program (SNAP) is tasked with providing psychological support to health care workers.

Against this background, these guidelines will guide the Ministry and partners implementing the health sector based interventions and strategies that will be used to address recent developments, and will serve as a road map for coming years.

The focus of these guidelines is to provide technical guidance by ensuring the provision of comprehensive and quality psychological care and support services and its goal is to standardized psychological care and support interventions in the country for health care workers.

The MoH is pleased that the Public and Private sectors have participated in the acceleration and implementation of psychological care and support to health care workers both in facility and in community.

Special thanks go to NERCHA for funding the revision of these guidelines. These guidelines will be reviewed periodically to include further emerging issues.

Mr. Benedict Xaba

Honorable Minister for Health

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ACRONYMS

AIDS: Acquired immune deficiency syndrome
ANC: Antenatal care
CSO: Central Statistics office
CBT: Cognitive Behavioral Therapy
EGPAF: Elizabeth Glazer Paediatric AIDS Foundation
GHQ-12: General Health Questioner tool
HCWs: Health Care Workers
HIV: Human immunodeficiency virus
HMIS: Health management information systems
ICAP: International Centre for AIDS Care Prevention
IEC: Information. Education, communication
IPPF: International planned Parenthood Federation
M&E: Monitoring and evaluation
MSF: Medicins san frontiers
MOH: Ministry of Health
NERCHA: National Emergency Response Council on HIV and AIDS
PCS: Psychological care and support
PSCHACC: Public Service Committee on HIV and AIDS
PSI: Population Services international
RHMs: Rural Health Motivators
SRH: Sexual Reproductive Health
SNAP: Swaziland National AIDS Programme
SID: Strategic information department
TASC: The AIDS Support Centre
TB: Tuberculosis
UNAIDS: United Nations joint HIV and AIDS Programme
UNFPA: United Nations Population Fund
URC: University Research Council
VCT: Voluntary counseling and testing
WHO: World Health Organization

GLOSSARY OF TERMS

Term	Description
Anxiety	Fear or emotions that interfere with normal functioning. These include phobias, generalized anxiety disorder, panic disorder, obsessive-compulsive disorder and post traumatic stress disorder [1]
Psychological support	Providing interventions aimed at promoting psychological health, preventing psychological problems, giving psychotherapy.
Psychotherapy	refers to psychological therapeutic interaction or treatment between a trained professional and a client, patient, family, couple, or group aimed at increasing the individual's sense of his/her own well-being. Psychotherapy employs a range of techniques based on experiential relationship building, dialogue, communication and behavior change that are designed to improve the mental health of a client or patient, or to improve group relationships.
Psychosocial support	In addition to psychological support providing interventions aimed at enabling individuals and groups to live better despite limiting social situations of their lives
Burnout	the exhaustion of physical and or emotional strength as a result of prolonged stress or frustration.[2] Burnout is a psychological term for the experience of long term exhaustion and diminished interest usually in the work context. It is often construed as a result of a period of expending too much effort at work while having too little recovery.[3]
Counseling	counseling involves an interpersonal relationship between someone actively seeking help and someone willing to give help who is capable of or trained to help in a setting that permits help to be given and received
Debriefing	Interventions aimed at providing psychological support to individuals and groups who encounter emotional, mental and physical exhaustion as a result of caring for others
HCW	This includes those in the private, public and industrial health facilities. It also includes all cadres of health professionals and

[1] Marine, A. Ruotsalaine, J.H. Serra, C. Verbeek, J.H. 2009. Preventing Occupational stress in healthcare workers

[2] Felton,J.S. Burnout as a clinical entity – its importance in health care workers

[3] Embriaco, N. Papazian, L. Kentish-Barnes, N. Pochard, F. & Azoulay, E. Burnout Syndrome among critical care healthcare workers

	support staff who are in the health sector
Promotion	promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.
Rehabilitation	Assisting individuals and groups attain their highest level of independence within their community.
Mental health	An individual's ability to negotiate the daily challenges and social interactions of life, without experiencing undue emotional or behavioural incapacity
Themed week	An intervention implemented in a predetermined week identified for raising awareness on a topic of concern
Lay counselor	Any person who had undergone a training on counseling ; these can be intervention based counselors such as HIV counselors, Adherence counselors.

CHAPTER 1

BACKGROUND

1.1 COUNTRY PROFILE

Swaziland still leads with high prevalence rates of HIV and AIDS in her population. With a population of just over a million (1,018,449), the prevalence of HIV among those aged 15 to 49 years was estimated at 26 percent. The HIV prevalence is higher among females compared to males which are 22 percent and 15 percent respectively (CSO 2007). The generalized HIV epidemic has reduced the life expectancy of the Swazi population to 49 years of age (WHO, UNFPA, UNAIDS, IPPF 2011)[4]. Such a high HIV prevalence is accompanied by high disease burden with increasing numbers of people who are chronically and terminally ill.

The country is strengthening provision of integrated HIV/AIDS and SRH interventions which increase access to prevention of HIV infection. In addition to this the TB and HIV co-infection further exacerbates the situation. The advent of HIV and AIDS changed the scene in health care service provision where curative efforts were rewarded with recovery of patients who were on treatment for short periods. Now what happens is many are chronically ill and frequently seek services when they are very ill with lowered immunity and need for prolonged health care support. These form the majority of patients in health facilities and as such the environment in facilities changed in terms of the wellness and symptoms of patients presenting for services. This meant that health care workers worked in a different environment where their efforts are not quickly rewarded with total recovery.

The country's HIV situation:

- 19% prevalence among the 2 years and older
- 26% among sexually active adults (31% for women and 19% for men) (CSO 2007)
- 41.1% among antenatal care clients (2010 HIV ANC Serosurveillance)

Massive efforts and resources were put in place for HIV prevention, care and support as well as impact mitigation. ART was introduced and rolled out such that all hospitals, health centres, PHUs and clinics provide this service. In total 110 health facilities are providing ART. This saw government developing partnerships with international organizations to increase access to services. These partnerships included human resources, medicines and supplies as well as infrastructural changes. However challenges with human resources in the health sector have also persisted. Turnover remains high among HCWs and this has taken its toll on the remaining staff complement. Tiredness, burnout and dealing with inordinate amounts of trauma and

[4] WHO, UNFPA, UNAIDS, IPPF 2011. Linking SRH and HIV/AIDS. Gateways to integration: A case study from Swaziland.

grief because of the high mortality rates associated with HIV and AIDS are some of the observed effects. It has also been estimated that 45% of HCWs worldwide have latent TB infection because of their proximity to TB patients in their care (van der Walt 2012:8)[5]. Realizing the plight of health workers the MOH established the Psychological Care and Support unit under SNAP as part of Care for the Carers program. Four Psychologists were subsequently deployed to the four regions to enable HCWs to access their services.

1.2 THE HEALTH CARE SYSTEM

The health care system within which all HIV and AIDS health sector based interventions are implemented include government health facilities, mission or faith based and privately owned health facilities. The following table shows the different types of health facilities in Swaziland.

Table 1: Types of health facilities

Health facility type	Operational definition
National referral	Refers to private, non-mission owned hospitals. They are three namely: Mbabane government hospital, TB hospital, and Psychiatric hospital
Regional hospitals	All hospitals who receive referrals from lower facilities (health centres and clinics) regardless of ownership. They are five in total, inclusive of sub regional hospitals. These are; Good Shepherd hospital, Hlathikhulu hospital, RFM, Mankayane, and Piggs Peak
Hospital	They include private hospitals namely; Manzini clinic, Mbabane clinic, Medisun clinic, Ubombo Ranches (ILLOVO) clinic
Health Centres	They are five; Dvokolwako health centre, Matsanjeni health centre, Mkhuzweni health centre, Nhlangano health centre, Sithobela Rural health centre.
Public Health units	They are eight; Hlathikhulu, King Sobhuza II, Mankayane, Matsanjeni, Mbabane, Nhlangano, Piggs Peak, and Siteki public health units.
Specialized clinics	Refers to clinics that offer specialized services such as dental, eye care etc. They are 29
Clinics with maternity	These are clinics with delivery wings and often have capacity to provide emergency deliveries
Clinics without maternity	These are clinics that do not have delivery wings

*Source: Service availability mapping 2010

The Health care system is organized into four levels comprising of three national referral hospitals, five regional hospitals, primary health care facilities (health centres, public health units and clinics with and without maternity, and community based care (RHM's, faith-based health care providers, TBA's, volunteers and traditional practitioners). It is at the clinics and Public Health Units that the health service delivery

[5] Van der Walt,M. 2012. Caring for the Health Care Workers. Health Nursing Matters. Vol 3, no. 3.

interfaces with the community[6]. It is estimated that 85% of the population of the country live within a radius of 8km from a health facility (MOH policy 2007). Services provided in the health sector include preventive, promotive, curative and rehabilitative services.

Administration of the health care system is decentralized into the four regions which are led by Regional Health management Teams (RHMTs).

HCWs comprise of different cadres which are as follows:

- Medical cadre
- Nursing cadre
- Paramedic cadre
- Support staff

The total number of HCWs in the health sector is 7546 according to the SAM 2010 as shown in the following table.

Table 2: Number of HCWs in Swaziland

	CADRE	NUMBER	PERCENTAGE (%)
1	Doctors	241	3.2
2	Nurses	1449	19.2
3	Nursing assistants	462	6.1
4	Paramedical	422	5.6
5	Support staff	4972	65.9
	Total	7546	100

*Source: SAM 2010

1.3 PSYCHOLOGICAL CARE AND SUPPORT FOR HCWs

An assessment was conducted in 2010 to inform the PCS programme and it documented that HCWs suffered high levels of stress with this being more among nurses and nursing assistants. The trends of stress suffered across cadres were similar which justifies similar interventions (Assessment Report 2010)[7]. The experience of work related stress was described by over 20% of HCWs as pronounced compared to stress from other causes and correlates. This assessment showed that the causes of work related stress and its correlates require HCWs to be supported to cope.

[6] MOH 2010 Service Availability Mapping

[7] SNAP. 2010. Assessment of the prevalence of work related stress and correlates among Health care workers in Swaziland.

The PCS program started as part of the VCT programme at SNAP after an observation of burn out among HCWs. As HIV and AIDS interventions were scaled up the needs for PCS services increased such that the demand for PCS service no longer just catered for those in VCT but all health care workers as it was realized that with the maturing of the epidemic HIV and AIDS patients were in all departments of health care facilities. A wellness programme for HCWs was established which collaborates with the PCS program.

The program is housed in SNAP and therefore technically guided under Public Health. It works in liaison with the Wellness programme which falls under the Undersecretary Human Resources.

1.4 RATIONALE AND OBJECTIVES

The PCS guideline aim to provide technical guidance by ensuring the provision of comprehensive and quality psychological care and support services

Goal:

- Ensure standardised psychological care and support interventions in the country for health care workers.

The objectives of the guidelines are as follows:

- To articulate the position of PCS program within the Public Health
- To provide technical guidance to PCS service providers in Swaziland

CHAPTER 2

GUIDING PRINCIPLES AND ETHICAL CONSIDERATIONS

Provision of PCS services will be guided by the following principles:

2.1 Comprehensive PCS services: Promotive, preventive, curative and rehabilitative PCS services will be provided to individual and groups of HCWs.

2.2 **Human rights:** PCS services will be provided in a non judgmental human right based approach. PCS service providers have the duty to avoid discrimination, abuse or exploitation of people on grounds of race, age, sex, class, gender, religion or behaviour.

2.3 Privacy: record keeping and sessions will be structured in a way that ensures privacy of individuals and groups is respected. No unauthorized individuals will be able to access client records and information and sessions will be held where they will not be overheard.

2.4 Confidentiality: clients' information will be kept confidential and will not be shared with others without the clients' written consent. There will be shared confidentiality among health professionals who provide care to the client.

2.5 **Beneficence:** Service providers of PCS services have an obligation to ensure that their actions cause no harm to clients; to strive at all times to be of maximum benefit to client;

2.6 **Non-Maleficence:** PCS service providers must ensure to do good and avoid doing harm to others; they bear the duty of care, to protect the weak and vulnerable; the duty of advocacy; defending the rights of the weak and vulnerable, or incompetent.

2.7 The principle of respect: PCS service providers have the following responsibilities to ensure respect of their clients:

- The duty to respect the rights, autonomy and dignity of other people
- The duty to promote their well-being and autonomy
- The duty of truthfulness, honesty and sincerity

2.8 **Collaborating with multidisciplinary health professionals**[8]: PCS service providers shall when necessary meet with other health professionals to ensure quality service provision for clients

[8] Gross, R. Rabinowitz, J. Feldman, D. Boerma, W. Primary Health Care physicians' treatment of psychosocial problems: Implications for social work. Health & Social work: 1992, 21(2), 89-95

CHAPTER 3

ACHIEVEMENTS AND GAPS

Since the beginning of implementation of services there has been numerous achievements as indicated below.

ACHIEVEMENTS

i. PCS has been included in the NSF 2009 - 2014, Multisectoral HIV and AIDS Policy and National Health Sector Strategy
ii. Provision of PCS to VCT centres in whole country has grown to 99.9%
iii. Initiation of exchange visits to impact on the psychological wellbeing of VCT providers
iv. Implementation of interventions such as debriefing, individual counseling whenever clients were referred
v. MOH having psychologists providing PCS to HCWs – one of the few countries that are actually caring for the HCWs
vi. Providing PCS to public sector through PSCHACC when requested
vii. Collaborating with partners e.g. EGPAF, URC, MSF, ICAP, PSI, TASC, Hospice at Home, World Vision & churches
viii. Setting up a PCS programme that other programmes learn from
ix. Providing PCS to RHMs
x. Providing PCS to SOS mothers and in some situations the children
xi. Development of training manual, guidelines, assessment tools
xii. Established offices of Psychologist per region

GAPS

While notable achievements were made, there are challenges that the programme still faces. These are as follows:

i. Limited resources
    a. Transport to reach health facilities
    b. Human resources (only 4 psychologists nationally)
    c. The budget remains limited
ii. Limited advocacy to enable uptake of services (sensitization, lack of IEC materials)
iii. Weak coordination in PCS service provision
iv. Partner supported sites (affecting planned PCS activities, coverage and comprehensiveness)
v. Poor collaboration of MOH and supporting partners. The link with psychosocial officer in organizations of supporting partners remains weak
vi. Linkage with mental health programme weak

vii. No defined debriefing mechanisms for those providing PCS
viii. Limited programme development. As such no officer at national level coordinating PCS
ix. Capacity building – no capacity building in the form of refresher courses for psychologists
x. Lack of a psychologist structure in MOH, therefore no M&E, PCS services not provided for in HMIS (SID)

CHAPTER 4

COORDINATION OF PCS SERVICES

The Ministry of Health, by virtue of its technical mandate leads coordination and management of the PCS programme and service provision. While the programme falls under SNAP, it is one of the pillars of the Wellness Programme of the Ministry of Health which falls in the Under Secretary's portfolio in the MOH (Human resources). A national PCS Coordinator under SNAP will lead programming, while in the region the PCS programming at this level will be led by the Regional Psychologists.

An annual work plan will be developed with relevant stakeholders for the PCS programme. All regional implementing partners shall implement PCS services as per regional plan extracted from the national plan in liaison with the Regional Psychologist to reduce duplication of activities and double reporting. The key stakeholders in this thematic area include government health institutions under the Ministry of Health, private sector, civil society organizations, bilateral and multilateral development partners.

A PCS technical working group will support programming and meet at least quarterly to review plans and implementation.

CHAPTER 5

PROVISION OF PSYCHOLOGICAL CARE AND SUPPORT SERVICES

5.1 PCS service provision targets to do the following:

- Promoting the psychological wellness of HCW's
- Preventing psychological problems among HCW's
- Providing psychotherapy aimed at managing psychological problems among individual and groups of HCWs,
- Providing rehabilitative psychological care and support to ensure HCWs can resume their responsibilities and positions.

5.2 Provision of PCS services is done by professionals who have undergone a standardized PCS training offered by the Ministry of Health and these professionals are as listed below:

- Psychologists
- Nurse
- Social Workers
- Lay counsellors
- Doctors

5.3 **Beneficiaries:** The beneficiaries of these services are all cadres of health care workers.

5.4 Access to PCS services will be through the following:

- **Booking:** Clients (HCWs) will access services through a booking system through wellness corners, Supervisors or directly with PCS service providers.
- **Referral:** Referral will be used to enable HCWs to obtain comprehensive care from the appropriate professional disciplines.
- **Self- referral**: Individual HCWs can make appointments for themselves for PCS service with the Regional Psychologist or any PCS service provider. These can also be from supporting partners in the region/ facility. This requires HCWs to arrange time off for this appointment.

- **Referred**
    - **Supervisors**: Referral for PCS services can also be done by supervisors for HCW who have been observed to be in need of such services. This referral will be done with the knowledge of the HCW concerned.

- **Wellness focal persons**: Referrals can be made by wellness focal persons[9] for HCWs in need of PCS services.
- **Other organizations:** Other organizations can make a confidential referral for a HCW who needs PCS services.

The national referral form will be used.

- **PCS service providers**: PCS service providers can schedule group activities and promote uptake of PCS services.
- **Call center**: HCWs can access PCS services through a call center.

Individuals access PCS services when the observations shown in annex 1 are made.

[9] Sinclair Miller, E. 1995. Treating mental Health problems of health care workers. BMJ1995; 310:742.5

CHAPTER 6

COMPREHENSIVE PCS SERVICES

6.1 Preventive and Promotive PCS

Evidence based preventive programmes and policies have been found to reduce risk factors, strengthen protective factors and decrease psychiatric symptoms and disability and onset of some psychological disorders. Prevention aims to reduce stressors and enhance resilience. For HCWs this entails the following:

i. Raising awareness about signs and symptoms of psychological distress
ii. Promoting holistic Self-care in all the five dimensions (spiritual, physical, emotional, mental and social).
iii. Increasing the coping capacity.[10]
iv. Reducing risk of psychological distress such as substance abuse
v. Improving HCW coping mechanism, effective communication among members of a HCWs team through Group meetings, debriefing sessions or team building

The following table outlines guidance on implementing preventive and promotive pcs interventions

Table 3: Preventive and promotive interventions

Intervention	**Standard requirements**	**Minimum time allocation**
Stress management retreat	Maximum of 30 participants	3 days
	Away from work setting	
	2 PCS service providers	
Debriefing	Maximum 10 participants	1 hour
	Participants of same cadre	
	Participants from same department/ facility	
	Agreed language to be used	
Sensitization on PCS related issues	Maximum of 30 participants	1 hour
Exchange visit	2 HCWs as guest to 3 HCW as host facility	2 hours
	2 PCS Service providers	
Individual	Use of relevant PCS assessment	According to tool

[10] WHO. 2004 Prevention of mental disorders. Effective interventions and policy options

assessment	tools	
Team building	Maximum 30 participants	1.5 days
	Participants from same facility/ nature of work	
	Away from work setting	
	2 PCS service providers	
Themed weeks	Evidence informed theme guided by SOPs	1 week
Training on PCS	Maximum 30 participants	3 days
	2 PCS service providers	

6.2 Treatment of psychological problems

Early identification and response to psychological problems essential to prevent depersonalization of the provider-patient relationship (Felton 1998)

In the context of where PCS services are provided and the target population a brief therapy approach is recommended.

Interventions for treatment of psychological problems are;

i. **Individual counseling session**: This session empowers client to be able to deal with their psychological problems. This is a one-on-one intervention. (see Algorithm for individual counseling session attached in annexure 5)
ii. **Group counseling session**: this intervention is provided to HCW of the same cadre, same unit/clinic/department and those who had common experience of stress.
iii. **Critical incident stress debriefing (CISD):** a therapeutic session allowing free flow of feelings after a traumatic event to prevent onset of PTSD and enhance coping strategies (see annexure 3 for a debriefing tool).
iv. **Family counseling session**: this session shall be provided to clients family in appropriate manner

6.3 Rehabilitative Psychological care and support

The Rehabilitative PCS services consistently involves interdisciplinary teamwork as a condition of practice and services within a network of biological, psychological, social, environmental and political considerations in order to achieve optimal rehabilitation goals.

i. **Multidisciplinary rehabilitation**: The PCS services go beyond counseling and include medical review and medication depending on the extent of burnout

ii. **Preventing relapse**. This involves the following:

- Identification of high risk relapse factors
- Understanding relapse as both a process and as an event

Identification of signs and symptoms indicative of relapse can be facilitated by the use of a tool for assessing elements of psychological wellness (see annexure2)

CHAPTER 7

OVERVIEW OF THE MINIMUM PACKAGE OF PCS

The minimum package for PCS service is designed in three categories which can be provided to HCWs according to their eligibility

Categories	Minimal intervention
1. Prevention and Promotion	Sensitization on PCS related topic, Individual assessment, Debriefing sessions and team building
2. Treatment	Counseling sessions (Individual sessions, group sessions or CISD), training on stress management and self care
3. Rehabilitative and Prevention of Relapse	Rehabilitative counseling, relapse prevention

CHAPTER 8

MONITORING AND EVALUATION

PCS services shall be monitored , evaluated and reported in order to ensure quality service provision.

Health Management Information System (HMIS)

The Health Management Information System (HMIS) aims at improving the quality data collected by programmes in order to have it analyzed, interpreted and disseminated for better policy and programming of services at all levels.

The PCS records shall be kept confidential at all levels

At facility level, Wellness Corner, Regional Psychologist office, National PCS Office

- Client's personal profile that contains basic client information like, facility, name, age, sex, address, next of kin
- Appointment card given to the client for follow up sessions
- A daily activity registers which records daily attendance of clients. Information includes number of visit by clients
- A standard MOH client referral card
- Monthly, Quarterly and annual reports are made. This provides a summary of the type of clients served

In Swaziland, some psychological care and support indicators are included in the overall MOH HMIS at the central level and at the service delivery points. All data will be segregated by age and sex. Indicators shall include, but not limited to:

Monitoring

Indicators for the program

# of health workers reached with PCS services

# of HCWs from other organizations workers reached with PCS services

# of workers referred for PCS services

# of workers referred by PCS provider

# of trained PCS service providers

Evaluation

Survey – every 5 years

Impact evaluation

c Evaluate quality of services through questionnaire – every 5 PCS recipients to determine quality of services and areas of improvement

Setting targets e.g. Reducing percentages of HCWs with extreme stress to less that 25**%**

Goals of M&E

- To monitor, evaluate and report PCS services
- To provide quality PCS services

Monitoring

- ❑ Indicators for the program
    - ❑ # of health workers reached with PCS services
    - ❑ # of public sector workers reached with PCS services
    - ❑ # of workers referred for PCS services
    - ❑ # of workers referred by PCS provider
    - ❑ # of trained PCS service providers

Quality PCS care audits will be implemented annually.

Evaluation

- ❑ Survey – every 5 years
- ❑ Impact evaluation
- ❑ Evaluate quality of services through questionnaire – every 5 PCS recipients to determine quality of services and areas of improvement.

Reporting

- ❑ All reports shall consist of narrative, financial, statistical

- ❑ Monthly
- ❑ Quarterly
- ❑ Annual

Need to develop MER tools in line with the indicators and national documents.

ANNEX 1: Checklist for referral for supervisor and individual

Box :PSYCHOLOGICAL SYMPTOMS

a**) Physical**
•Exhaustion
•More frequent, longer lasting, sickness (e.g. colds and flu)
•Muscle tension
•Headaches
•Fast heart rate and respiration
•Accident prone
•Energy and motivation levels are low
b**) Emotional**
•Impatience and irritability
•Withdrawn
•Forgetfulness
•Inability to feel joy
•Feelings of inadequacy, helplessness, and guilt
•Loss of sensitivity to clients
•Sadness
•Denial of stress symptoms
c) Social
•Withdrawn
•Stop hobbies and other activities outside of work
•Destructive behaviors like drinking and drug abuse
•Lack of interest in friends and social activities that may have been important to the person in the past
d) Spiritual
•Begin to question faith – the purpose of it, the strength of it
•Loss of meaning to life
•May stop attending church meetings
•Spiritual emptiness
e) Work-related
•Withdrawn from clients
•Do not show empathy to clients (causing more stress).
•Perform poorly, this could possibly be dangerous to you and the clients
•Not punctual
•Neglect duties
•Cannot concentrate on work

Symptoms must be persistent and present for at least two weeks

Annex 2: Elements of psychological assessment

Table	Elements of a psychological assessment
Beliefs and adjustment to situation/ illness	Major fears or worries (do they seem out of proportion?)
Current symptoms e.g. depression, anxiety	Duration and severity Relationship to physical illness (ie preceded or followed onset of physical condition
Cognitive function	Orientation, level of consciousness, concentration and memory
Risk	Any active thoughts of self harm Threatening or abusive behavior
Biological symptoms	Likely relationship to physical illness (symptoms such as insomnia, anorexia and weight loss attributable to the illness?)
Level of functioning	In relation to responsibility
Known current stressors or important past events	For example recent bereavement or a history of abuse
Previous history	Previous contact with PCS or psychiatric services
Alcohol intake	Evidence of harmful or hazardous drinking
Drugs	Evidence of illicit drug taking

*Adapted from Royal College of Psychiatrists & Royal College of physicians 2003. The psychological care of medical patients. A practical guide.

Annex 3: Psychological Debriefing Session Form

PSYCHOLOGICAL DEBRIEFING SESSION FORM

1. What are the positives/achievements you have encountered during your service delivery?

……
……
……
……..

2. What are the negatives/ challenges you have encountered during your service delivery?

---

3. What stressors do you come across at your workplace and outside your workplace?

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4. What stress symptoms do you observe when you are stressed?

---

5. How do you manage your stress?

---

6. Do you have any support structure? If yes, elaborate.

---

7. Impression got by facilitator (Psychologist, Site manager , Supervisor, etc)

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8. Recommendations / Future plan

Annex 4: Individual counseling Form

A. Socio Demographic Detail

Date:…… File number:……..

Name:……. Surname: ……..

Sex:…….. Nationality:……..

Age: …….. Marital Status:

Date of birth: …… Number of children:……

Contact Numbers: ……. …….

Postal address: …….

By whom were you referred: …….

Have you ever made use of counseling services: (circle one) Yes/ No

If yes, when? ……. Why?

B. Personal History

What is your birth order?

……..

As far as you know, how was your mother's pregnancy/delivery?

…….....

Did you have any serious illnesses/injuries during your childhood?

……

……...

C. Medical history

Name of your doctor…… contact number……

Are you receiving any medical treatment at present?

.....

If any, provide particulars……..

Condition	When	nature	Period of treatment	Consequences for present health
Operations				
Serious illness				
Accidents				
Chronic Illnesses				
Cancer, Epilepsy				

Mental History

Have you had any problems with your mental health in the past?

……..

Have you ever seen a psychiatrist before?

……

Have you been admitted in a psychiatric hospital before?

……

D. Presenting complaints

What are the main problems that have made you seek counseling?

……
……
……

How long have you been experiencing these symptoms?

……
……

What factors are maintaining these symptoms?

……
……

How have you been coping with these symptoms/stressors?

……
……

What is the chronological account of these symptoms?

……
……
……

E. Premorbid Personality

Before this happened, how would you describe yourself?

……
……
How would other people describe you?
……
……
What sort of things do you like to do to relax?
……
……
Do you like to be around other people or do you prefer your own company?
……..
Are you religious? .....
Do you have any ambitions or plans?
……
……

F. Alcohol and Drug History

Do you smoke? How many? Since when?
……
……
Do you drink any alcohol? How much?
……
……
Have you been drinking any more or less recently?
……
……
Have you ever taken any drugs? If yes, elaborate.
……
……
……

G. MSE

Brief Mental Status Exam (MSE) Form

1. Appearance	☐ *casual dress, normal grooming and hygiene* ☐ *other (describe):*
2. Attitude	☐ *calm and cooperative* ☐ *other (describe):*
3. Behavior	☐ *no unusual movements or psychomotor changes* ☐ *other (describe):*
4. Speech	☐ *normal rate/tone/volume w/out pressure* ☐ *other (describe):*
5. Affect	☐ *reactive and mood congruent* ☐ *normal range* ☐ *labile* ☐ *depressed* ☐ *tearful* ☐ *constricted* ☐ *blunted* ☐ *flat* ☐ *other (describe):*
6. Mood	☐ *euthymic* ☐ *anxious* ☐ *irritable* ☐ *depressed* ☐ *elevated* ☐ *other (describe):*
7. Thought Processes	☐ *goal-directed and logical* ☐ *disorganized* ☐ *other (describe):*
8. Thought Content	**Suicidal** ideation: ☐ *None* ☐ *passive* ☐ *active* If *active*: yes / no plan ☐ ☐ intent ☐ ☐ means ☐ ☐ **Homicidal** ideation: ☐ *None* ☐ *passive* ☐ *active* If *active*: yes / no plan ☐ ☐ intent ☐ ☐ means ☐ ☐
	☐ *delusions* ☐ *obsessions/ compulsions* ☐ *phobias* ☐ *other (describe):*
9. Perception	☐ *no hallucinations or delusions during interview* ☐ *other (describe):*
10. Orientation	*Oriented:* ☐ *time* ☐ *place* ☐ *person* ☐ *self* ☐ *other (describe):*
11. Memory/ Concentration	☐ *short term intact* ☐ *long term intact* ☐ *other (describe):* ☐ *distractable/ inattentive*
12. Insight/Judgement	☐ *good* ☐ *fair* ☐ *poor*

H. Process notes

Date: …… Session: ……..

Referral: Circle one. Yes/ No

Return date: …….. Time: ……..

Annex 5: Trauma Debriefing Form

A. The fact Phase- Description of what the participants heard, saw, and did during the incident

……
……
……
……
……

B. The thought phase- at what point did you realize that this was not a normal situation? What did you think at that time?

……
……
……
……
……

- Reaction Phase- Describe your feelings at the scene, now, and in past situations. What was the worst part for you?

……
……
……
……
……

C. Symptom phase - Expression of participant's stress response syndromes

What symptoms let you know that this was different from other situations?

……
……

What was your most intense reaction at the scene?

……
……

What were your reactions later?

……
……

What's not going away?

……
……

D. Teaching Phase - Team discusses stress response syndrome and normal signs, symptoms, and emotional reactions.

……
……
……
……

E. Re- entry Phase - Wrap up loose ends, answers additional questions, provides final reassurances, establish a plan of action.

What was your moment of strength?

……
……
……

What did you feel good about in yourself?

……
……
……

What was positive about your response?

……
……
……

What will be valuable in the future?

……
……
……

F.

Attendance Register

Name	Designation	Contact	Signature

Annex 5: Counseling Algorithm