Teaching Foundational Helping Skills: An EQUIP Competency-Based Training Manual for Trainers and Supervisors

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# INTRODUCTION

This manual is a resource from the WHO / UNICEF Ensuring Quality in Psychosocial and Mental Health Helping Skills (EQUIP) project. It is for trainers and supervisors to teach foundational helping skills using the EQUIP competency-based approach to anyone involved in helping roles. This includes anyone whose role is to support people and foster wellbeing, such as specialist and non-specialist health and social care professionals, community workers, case managers, volunteers, teachers, mentors, coaches, community leaders, religious counselors and many others.

The manual is divided into three sections.

**Section 1** gives background information on foundational helping skills, competency-based training, and use of the EQUIP competency-based approach. Trainers and supervisors are encouraged to read this section to prepare for delivering competency-based trainings or supervision.

**Section 2** covers how to prepare for and set-up this EQUIP foundational helping skills training.

**Section 3** includes 8 modules covering 15 different foundational skills which are used to deliver competency-based trainings. This foundational helping skills manual is intended to be used alongside other resources available through the EQUIP platform ([equipcompetency.org](http://www.equipcompetency.org)).

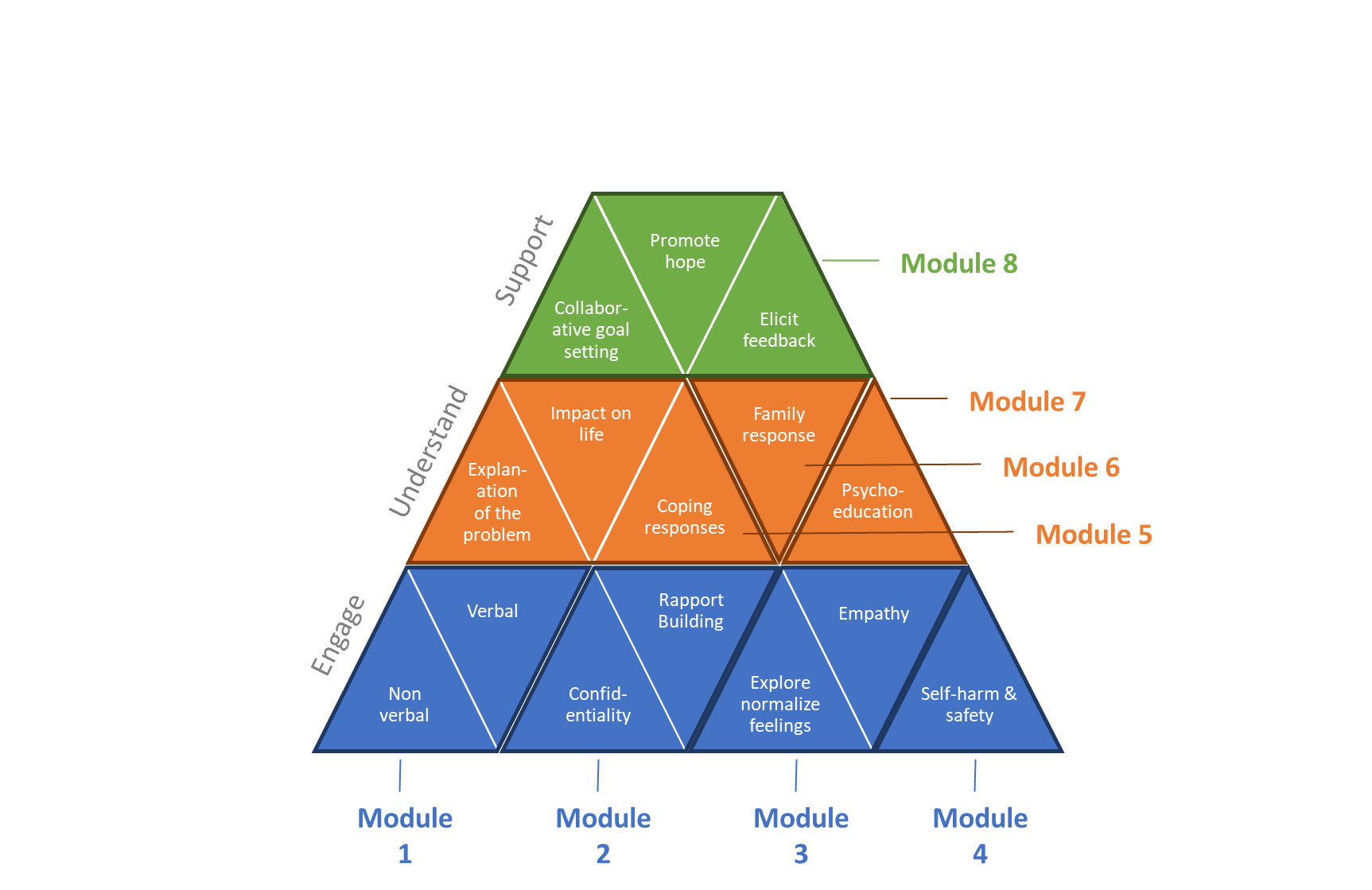


Figure 1. Pyramid of foundational helping skills and associated modules in this training.

# SECTION 1

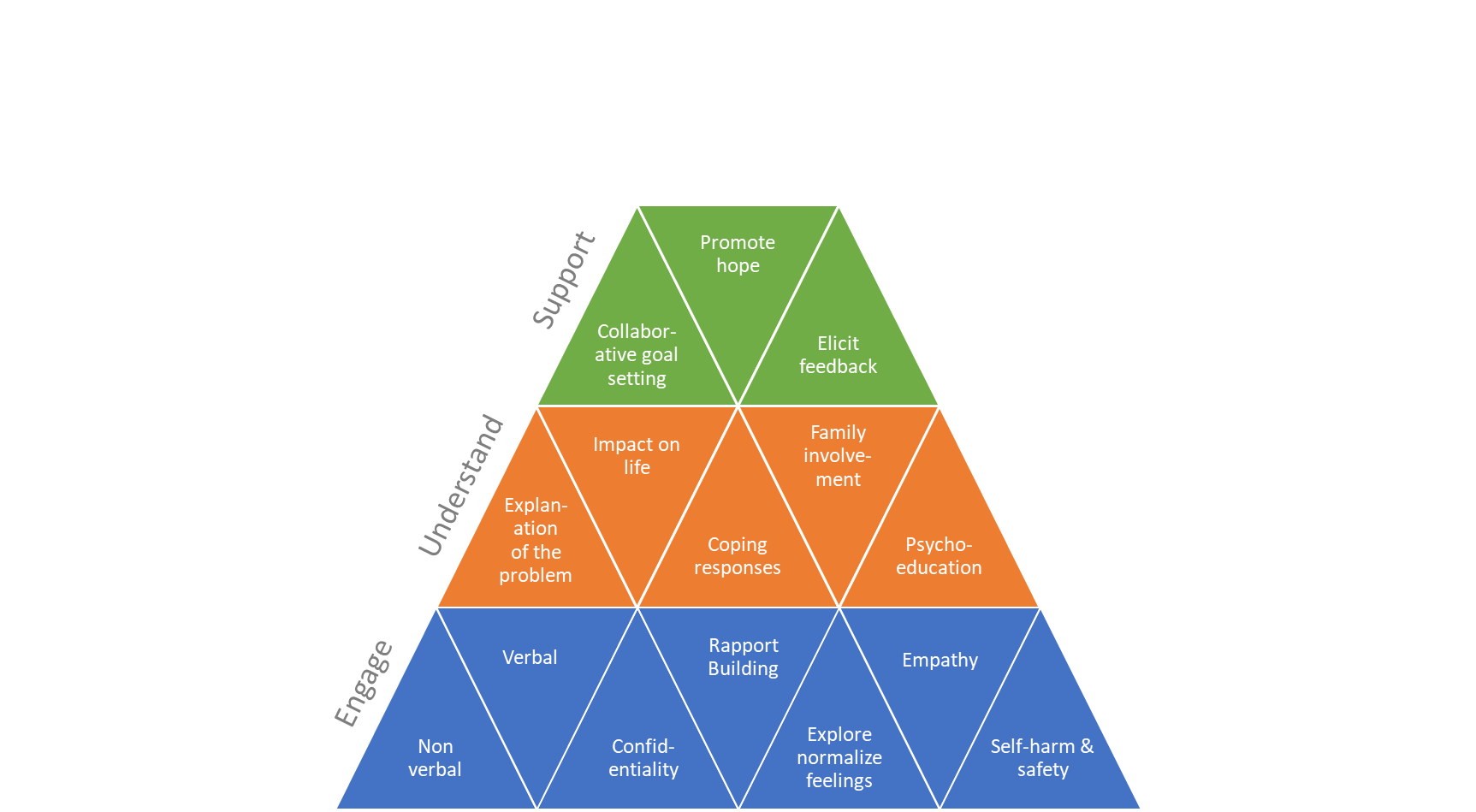
This section covers the following learning objectives:

* Objective 1: What are foundational helping skills?
* Objective 2: What are competencies and what is the EQUIP competency-based approach to teaching foundational helping skills?
* Objective 3: Introduction to using the EQUIP resources.
* Objective 4: How can this foundational helping skills training be used in an existing training or course.

## Overview of EQUIP competency-based approach to training in foundational helping skills

### What are foundational helping skills?

Foundational helping skills are also known as basic helping skills. They involve core behaviors that helpers use to strengthen the relationship with the people they are helping and support their emotional well-being. Foundational helpings skills are essential skills for helpers in health and community services. Use of these skills encourages helpers to take a positive and supportive approach. Foundational helping skills are recognized as core competencies in EQUIP. Figure 2 provides a visual illustration of the EQUIP core competencies. Each of the individual competencies is described in detail in Section 2.



The bottom tier (represented in blue) shows the core competencies that are used to **engage** others when acting in a helping role.

The next two tiers represent the foundational helping skills necessary when helping a person with a health, mental health or social problem. The middle tier (orange) includes the skills to **understand** the problem while the third tier (green) includes skills to provide **support**.

Foundational helping skills can be accompanied by more specific skills required for specific psychological interventions or other techniques.

### What are competencies?

A competency is the “observable ability of a person, integrating knowledge, skills, and attitudes in their performance of tasks. Competencies are durable, trainable and, through the expression of behaviours, measurable.” (Mills, 2020). Thus, competencies can be seen and observed.

A competency-based approach to training and supervision involves assessing a trainee’s competencies to customise training and supervision to make them more centred on trainees’ needs. Training and supervising in this way are likely to increase the competency of trainees and accordingly are likely to improve quality of care.

### What is EQUIP?

The EQUIP initiative provides resources to support competency-based training and competency assessment for training mental health and psychosocial helping skills. These resources can also be used for “benchmarking” or setting the level of competency required before delivering help. The EQUIP platform (<https://equipcompetency.org/en-gb>) provides access to these resources.

### How can you use an EQUIP competency-based approach to teaching foundational helping skills?

In the EQUIP approach, trainees’ competencies are observed during interactions with help-seekers or in structured role plays. This manual outlines an approach for facilitators to use brief structured role plays to observe skills throughout training to check if trainees are able to demonstrate foundational helping skill competencies. If certain skills are not demonstrated, additional time can be spent to address gaps. This means that some modules may be covered quickly because trainees already have a competency, or achieve a satisfactory level of competency, whereas other modules may require additional time.



Step 1 Step 2 Step 3 Step 4 Step 5

Step 1. Begin foundational helping skills training Step 2. Use role-plays during training Step 3. Rate role plays with competency assessment tool Step 4. Use feedback and make modifications to training to address competency gaps Step 5. Continue use of role plays until trainees meet satisfactory levels of competency.

This EQUIP foundational helping skills competency-based training builds on trainees’ existing strengths and allows the facilitator to customise the curriculum to meet the trainees’ needs and reach training goals. This style of training increases engagement, enhances trainees’ skills and offers adaptability and flexibility that support the facilitator and trainees to work well together. It can be carried out either in-person or remotely.

Research has shown that an EQUIP foundational helping skills competency-based training leads to improved competencies among trainees and reduces the possibility that they display harmful behaviours.

The EQUIP foundational helping skills competency-based training:

* *Is modular***:** facilitators determine the number and flow of modules. Facilitators can use the suggested training plan or select fewer or additional modules based on trainee or programme needs.
* *Uses results of competency assessments***:** during training, at close of training day(s) and at the end of training, to guide the facilitator’s decision-making on how much time to spend on modules and what activities best match the needs of the trainees.
* *Incorporates time for feedback***:** to ensure the use of supportive, tailored feedback to coach trainees to reach their goals.
* *Uses multiple role-plays:* to practice skills and focus on areas where trainees need to improve, such as at the beginning of each training day and on the last day of training. The amount of role play practice may vary, and is based on competency assessment results, facilitator observations and trainee requests.

### Assessing foundational helping skill competencies during role-plays using the Enhancing Assessment of Common Therapeutic Factors (ENACT) competency assessment tool

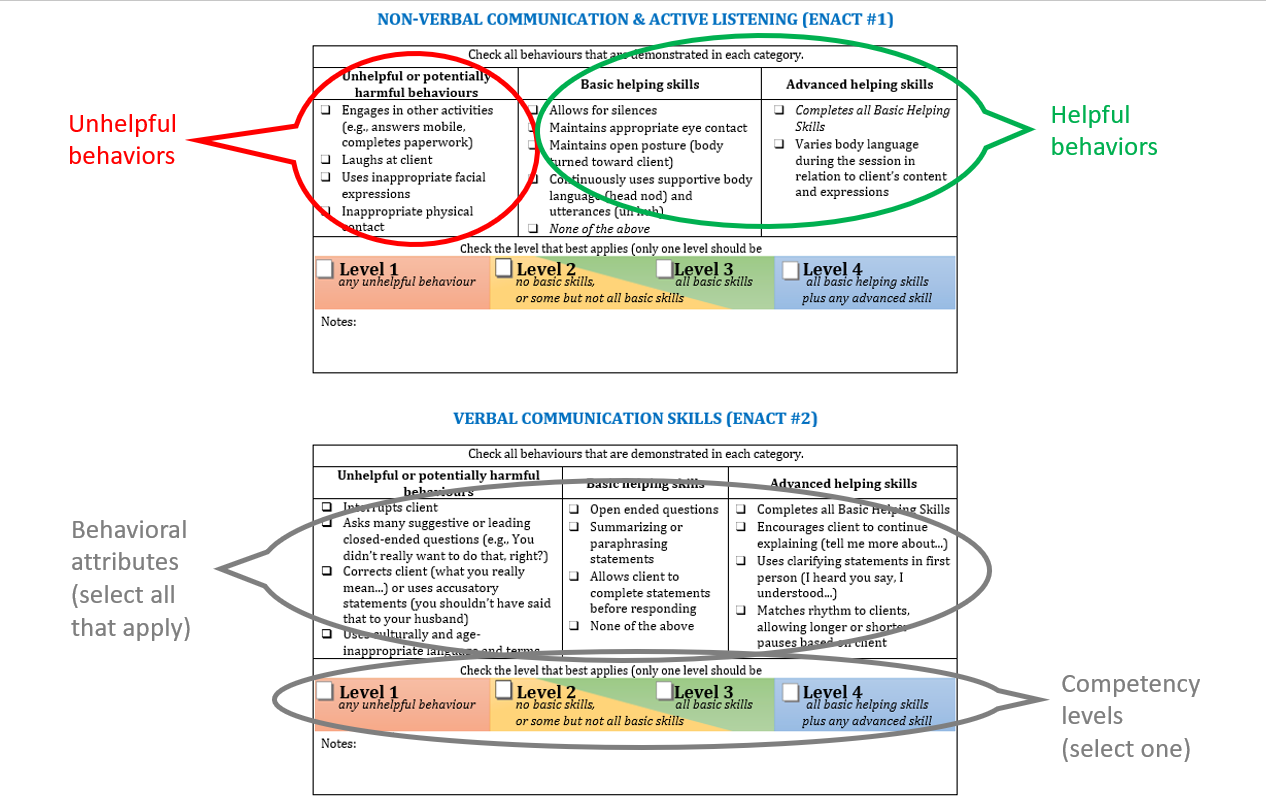
In this EQUIP foundational helping skills competency-based training, facilitators use the ENhancing Assessment of Common Therapeutic factors (ENACT) tool, which is a competency assessment tool for foundational helping skills with adults. This manual guides you through the process of using the ENACT tool during training of foundational helping skills.

###### What is the ENACT tool?

* The ENACT tool assesses trainees’ levels in the foundational helping skills taught in this training.
* Each foundational helping skills module includes a “unhelpful and helpful behaviours” table, based on the ENACT tool.
* ENACT is used with structured role-plays.
* The ENACT tool is reprinted throughout this training manual and in Annex X. It is also available on the EQUIP platform to use online or for download as a PDF: <https://equipcompetency.org/en-gb>

###### Scoring ENACT

ENACT is designed to record behaviors (unhelpful and helpful) and score each competency on a Level of 1 to 4 (see **Figure X**). Level 1 is unhelpful behaviours. Demonstrating any of these behaviours automatically means the trainee is at this level. It is particularly important to correct these during training and supervision. Level 2 is some, or none, but not all basic skills. Someone can score a Level 3 if they display all the basic helping skills, and a Level 4 if they display all basic skills plus an advanced helping skill.



The EQUIP platform includes features that mean users can score competency assessment tools (including the ENACT tool) online and easily analyse and display the results using the automatically displaying visualisations. This can help facilitators track progress for the whole group and to provide individual feedback to trainees. The platform can be used on a computer, tablet and mobile phone and is also available offline. More information on the EQUIP platform and how to use it can be found here: <https://equipcompetency.org/en-gb>.

###### How and when is ENACT used?

* ENACT can be used in role plays to assess single competencies (e.g. non-verbal communication only assessed in one role play) and multiple competencies (e.g. one role play in which a trainee is assessed on a collection or all of the ENACT competencies). This training encourages the use of both approaches.
* This manual provides guidance on using role plays and the ENACT tool to assess competencies during training (e.g. at the end of each module) and at the end of training.
* The facilitator reviews the results of the ENACT competency assessments to provide feedback and coaching to trainees and to plan activities and time for working on areas for improvement.

### Role-plays

Assessing trainees using role-plays is an integral part of a competency-based training. Section 3 of this manual outlines the role-plays and how they are integrated into the training. These can be adapted for context. It is also possible to use ENACT in real-world settings either through direct observation or recordings.

### Providing Feedback

Personalised ongoing feedback is at the heart of an EQUIP competency-based approach. Feedback means to provide specific, supportive, personalised information on a trainee’s performance or progress throughout training and supervision so that they can improve and reach their competency goals.

Using the EQUIP platform (<https://equipcompetency.org/en-gb>) to assess trainees’ competency supports the feedback process. The platform automatically displays results that can help you to identify your trainees’ strengths and areas for improvement. These displays can then be used when providing feedback.

Key principles for delivering feedback:

* Individual feedback
  1. Focus on areas of strength before addressing any areas for improvement.
  2. When focusing on areas of improvement provide concrete ways in which the trainee can improve and opportunities to practise.
  3. Always end the feedback session with something positive.
* Group feedback

The above principles for individual feedback generally also apply in groups, although we would strongly discourage identifying individuals when feeding back on areas for improvement. Instead focus on the trends across the group that have been witnessed.

More detailed information and ideas on providing feedback can be found in Annex X and on the EQUIP platform (https://equipcompetency.org/en-gb).

# SECTION 2:

This section covers the following learning objectives:

* Objective 1: Identify who can be a foundational helping skills facilitator.
* Objective 2: How to prepare for and run this foundational helping skills training.
* Objective 3: How to adapt this training.
* Objective 4: How this training can be used in an existing training or course.

## Who can use this training manual?

### Who can train in foundational helping skills?

Facilitators can come from any background where foundational helping skills may be relevant. People delivering a foundational helping skills training should have experience and knowledge in using foundational helping skills. Additionally, they should have experience training or supervising others.

### Your role as a facilitator

A facilitator’s main responsibilities are to:

* Plan and deliver training activities, considering previous experience and training needs of trainees.
* Teach trainees to develop foundational helping skills and to use them safely and competently.
* Help trainees feel confident in their ability to use foundational helping skills, including through constructive feedback.

### Course duration and structure

This training is designed to last 3 days (24 hours including breaks) when delivered by 2 facilitators to 12 participants. However, as a competency-based training the time taken could be shorter or longer dependent upon how trainees perform in competency assessments during the training. The aim of the training is for participants to reach a basic level of competency in foundational helping skills. As a minimum, facilitators should take the time to address any harmful behaviours identified in the scheduled individual feedback sessions at the end of the training.

The table below outlines a suggested foundational helping skills training agenda**.** The training is modular and does not need to be held on consecutive days.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Day 1** | **Day 2** | **Day 3** |
| **9:00 – 12:30**  (3hrs 15 mins + 15 min break) | * Welcome and introduction * Ground rules * Module 1 * Module 1 role plays and informal assessment * (Module 1 group feedback) | * Welcome to Day 2 (5 min) * ***Group feedback on informal assessments from day 1 and review or relevant material (90 mins)*** * Module 4 * Module 4 role plays and informal assessment * (Module 4 group feedback) * Module 5 | * Welcome to Day 3 (5 min) * ***Group feedback on informal assessments from day 2 and review or relevant material (90 mins)*** * Module 7 * Module 7 role plays and informal assessment * (Module 7 group feedback) * Module 8 |
| **12:30-1:30** | Lunch | Lunch | Lunch |
| **1:30-5:00**  (3hrs 15mins + 15 min break) | * Energizer * Module 2 * Module 2 role plays and informal assessment * (Module 2 group feedback) * Module 3 * Module 3 role plays and informal assessment * *(*Module 3 group feedback) | * Energizer * Module 5 role plays and informal assessment * (Module 5 group feedback) * Module 6 * Module 6 role plays and informal assessment * *(Module 6 group feedback)* | * Energizer * Module 8 role plays and informal assessment * (Module 8 group feedback) * ***Group feedback on informal assessments from day 3 and review or relevant material (60 mins)*** * End of training role plays plus individual feedback (2hours 30mins for a group of 12 with two facilitators as both raters and actors) * Close training |

### Facilitator-to-trainee ratio

This training has been designed to be delivered by 2 facilitators to a group of 12 participants. This could be adapted based on the number of facilitators and time you have available. The key consideration is the time it takes to run individual role plays and competency assessments with participants at the end of the training.

## Preparing for this training

### Planning checklist with tasks for training organizers and facilitators

* Select a suitable and accessible venue.
* Select at least two co-facilitators and prepare together. Advance planning and communication is essential. This includes deciding on overall length and schedule of the training as well as practicing demonstrations, agreeing adaptations and deciding who will present what sections. If you do not have a co-facilitator, think through how to adapt the training.
* Identify trainees. Provide them with key information about the training.
* Decide on the size of the training. The training as laid out in this manual has been designed to be led by 2 facilitators and have 12 trainees. This can be adapted based on available resources.
* Prepare all materials (see the materials checklist below).
* If using interpreters, give them any information or materials that may help them in their role. Organize and test all interpretation equipment.
* Set up the training room:
  + to encourage participation and comfort (e.g. trainee chairs in a U-shape with facilitators at the front)
  + for minimal disruption
  + to keep track of time (e.g. place a clock that is visible to all) and
  + if applicable, to show slides (i.e. set up a computer and projector), or for interpretation

### Materials checklist: what to bring to each day of the training

**Essential materials:**

* This manual
* Print outs of the ENACT tool or relevant ENACT items to rate throughout or at the end of training / a mobile, tablet or laptop If using the online version of ENACT.
* Flipchart / chalkboard / whiteboard and markers.
* Pens/ pencils and paper for trainees who want to take notes.
* Nametags.
* Clock (if the training room does not already have one that is visible to everyone).

**Optional materials:**

* If using PowerPoint: TOF workshop slides, computer and projector.
* Handouts of slides for trainees (if desired).
* Prepared flipcharts as needed.

## Adapting this training

In general, facilitators can change how different components of this training are delivered and can choose to train in some or all of the modules, dependent upon their needs.

Because trainings differ substantially across settings, this manual provides a suggested approach, but this can be adapted depending on time and setting. In addition to the recommended approach in this manual, EQUIP competency assessments including the ENACT tool can be used:

* Before training (pre-training) - to identify strengths and weaknesses. The training can then be tailored to address the main areas where competencies need to be developed.
* After training/in supervision (post-training): to help track changes and improvements and identify any areas that require additional support and/or training.

As mentioned before, the focus should be on trainees’ competencies and flexibly adapting the training length and approach based on ongoing competency assessments.

If training in a language other than English, make sure that you have the ENACT tool already available in your desired language. If the ENACT tool is not available in your target language it is strongly recommended that you first translate the tool. You can contact the EQUIP team for advice on and possible support with translations: [equip@who.int](mailto:equip@who.int).

## How can this training manual be used alongside an existing training or course?

Foundational helping skills can be incorporated in any training on psychosocial skills or psychological intervention, basic communication courses, provider-client relations courses, introductory courses on psychological or psychosocial techniques, practicums, clinical placements, and other settings. Many psychological intervention manuals include a training on basic helping skills. EQUIP foundational helping skills can be used to complement treatment specific manuals to support and strengthen these skills. Alternatively, the ENACT tool can be used to assess foundational helping skills in an existing course that covers similar competencies.

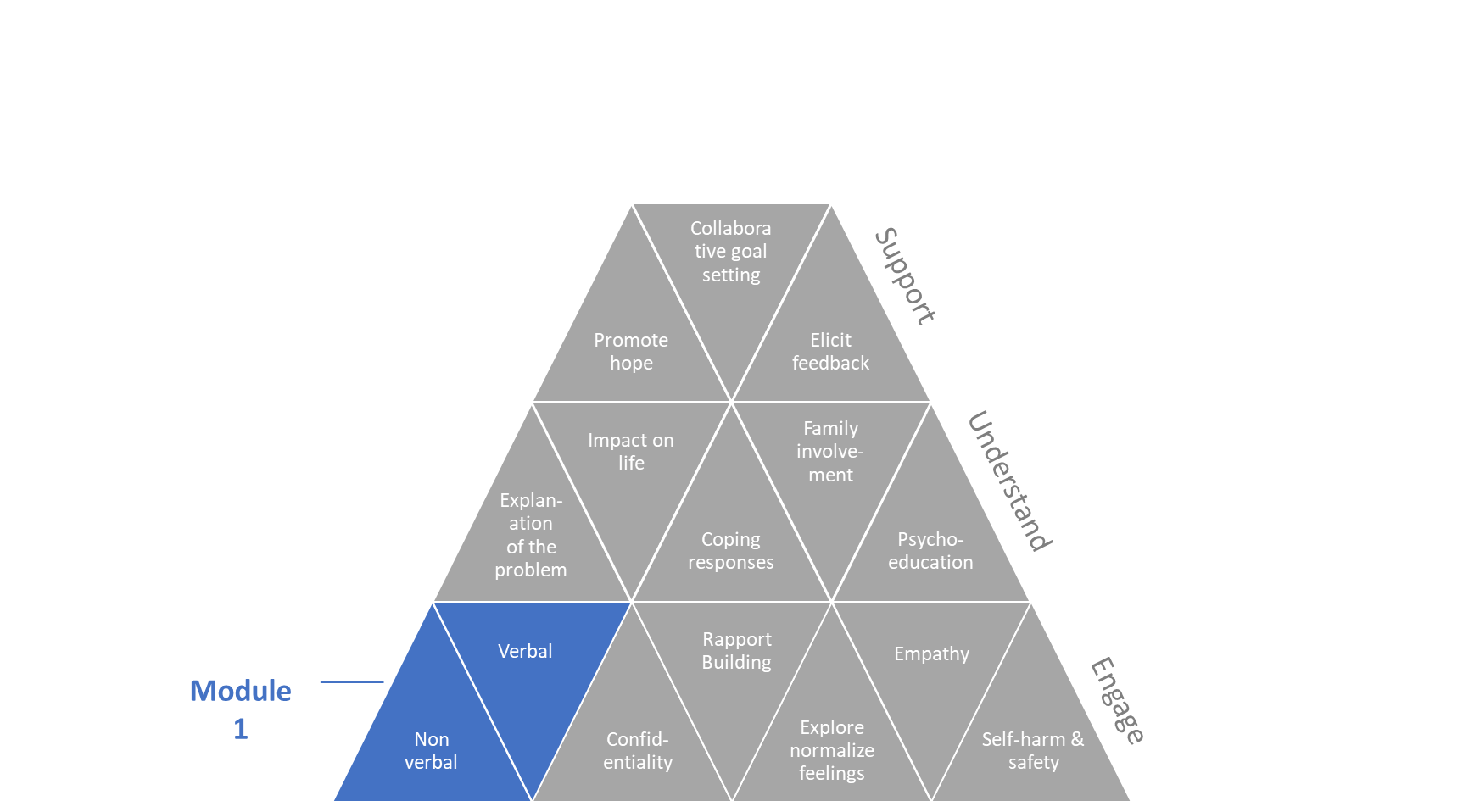
Once trainees are evaluated on their foundational helping skills competencies, a course can be tailored to areas where trainees need additional support. The idea is to train someone to the point at which they are able to display the required competencies. We recommend being flexible, if possible. Based on what competency levels trainees reach on days 1 and 2 organizations may schedule additional days of training, depending on progress. It is recommended that all foundational helping skills competency-based trainings include a minimum of half a day on the last day of training to run competency assessments covering all competencies trained and providing individual feedback, focusing particularly on any level 1 or potentially harmful behaviours.

# SECTION 3

# Foundational helping skills: Tier 1 - ENGAGING

# **Module 1:** Non-verbal and verbal communication skills (ENACT #1, 2)

1. Objective 1: Define non-verbal and verbal communication and why it is important
2. Objective 2: Identify behaviours that express non-verbal communication and verbal in your context
3. Objective 3: Distinguish between helpful and unhelpful behaviours for non-verbal and verbal communication



This module is divided into two sessions – Session 1: non-verbal communication and Session 2: verbal communication.

**The module will cover the following**:

* What is non-verbal and verbal communication?
* How do you express non-verbal and verbal communication?
* Why are non-verbal and verbal communication important for health and well-being?

**Structure of the module**:

Session 1: Non-verbal communication

* Introducing the concept
* Exercise 1: Facilitators demonstrate “unhelpful” non-verbal communication
* Exercise 2: Distinguishing between unhelpful and helpful non-verbal communication
* Group activity: Individual pairs demonstrate “unhelpful” non-verbal communication (optional)
* Group activity 1: Individual pairs practise “helpful” non- verbal communication
* Review of concept and learning points

Session 2: Verbal communication

* Introducing the concept
* Exercise 1: Facilitators demonstrate “unhelpful” verbal communication
* Exercise 2: Distinguishing between unhelpful and helpful verbal communication
* Group activity 1: Individual pairs practise “helpful” verbal communication
* Review of concept and learning points

**Materials** (optional): Facilitators can distribute the “Unhelpful and helpful non-verbal and verbal communication” tables as handouts for trainees.

**Instructions:** One facilitator introduces the concept, and then both facilitators deliver the activities following this introduction. Facilitators take notes on the brainstorming activities and add suggestions to the tables of unhelpful and helpful non-verbal and verbal communication at the end of the module.

**Facilitator tells trainees:** “In the following activities, you will be brainstorming some different ideas. I will write the behaviours you identify in our list of non-verbal/verbal communication.”

## Session 1: Non-verbal communication

## Introducing the concept

***Note: Below is a sample text to cover the concepts and points above. Facilitators may adapt the language to the context as necessary, but must ensure that the points are adequately covered.***

### What is non-verbal communication?

This is a foundational helping skill that helps to build warm, trusting interactions and relationships. Helpful non-verbal communication skills show a person using the service that you are supportively listening and actively engaging with them.

Non-verbal communication involves a variety of culturally appropriate behaviours, such as:

* Sitting with an open posture
* Culturally acceptable body gestures (e.g., leaning in and nodding your head, appropriate eye contact)
* Using non-verbal utterances such as “hmmm” or “uh-huh”.”

**Optional:**Provide a mnemonic or other learning summary technique.

* Example of a mnemonic (acronym) for non-verbal communication: **PAUSE**: **P**osture, **A**ttention, **U**h-huh mhm, **S**upport, **E**ye-contact.

## Exercise: Demonstration of unhelpful non-verbal communication

***Note to facilitators:*** *The demonstration of unhelpful behaviours will support learning, while also offering an ice-breaker activity and allowing the trainees to loosen up.* It replaces actual conversation with repetition of a word. This has been done to ensure a focus on behaviours. *Have fun!* If you have not done this activity before, be sure to watch the demonstration videos on the EQUIP platform for non-verbal communication. The video demonstrates the process to do this.

**Learning objective: to have trainees start to identify unhelpful non-verbal communication by displaying these followed by a discussion.**

**Instructions:** This activity has two parts.

1. The facilitators demonstrate “unhelpful” non-verbal communication for the trainees to observe.
2. The group then discusses the behaviours that the facilitators have demonstrated (and others suggested by the trainees), listing examples of non-verbal communication. *Be sure to explain this process to your trainees.*
3. ***Demonstration***

Facilitators should refer to video recordings on EQUIP Platform and/or use demonstrations and activities appropriate to the context and setting.

* Facilitators use the names of food items in an “unhelpful” demonstration (the demonstration lasts 2–3 minutes).
  + Each facilitator picks the name of a food item to use during the demonstration. Only the name of the food item will be used to interact with the other person, and no other words (e.g., the “helper” repeatedly uses the word “cookie,” while the “person using the service” repeatedly uses the word “milk”). Because the facilitators are repeatedly using the same words, the trainees can focus on their display of non-verbal behaviours rather than be distracted by an actual discussion.
  + Facilitator 1 plays the helper. Begin by repeatedly using the name of a food item (e.g., “cookie”) in place of real words.
    - For example, Facilitator 1 says: “Cookie, cookie cookie. Cookie cookie?”, instead of “Hello, tell me your problems, why are you here?”
  + Facilitator 1: Use a variety of the non-verbal behaviours listed below, while repeating the name of your chosen food item.
* Look at your phone.
* Show irritation or impatience with the person.
* Avoid eye contact.
* Cross your arms.
* Roll your eyes.
  + Facilitator 2 plays the person using the service.
  + Facilitator 2 attempts to talk with the “helper”, but similarly, only uses the name of a selected (different) food item (e.g., milk) repeatedly.
* For example, Facilitator 2 says: “Milk. Milk… milk”, instead of “I had a tough day… I missed work.”

1. ***Group discussion***

* Discuss with the group what behaviours they saw, and which of these behaviours were unhelpful or helpful. Some prompts are suggested below.
  + Ask the group:
    - “What could you tell about the helper’s attitude, even though she was only using a food word to communicate?”
    - “What did the helper do with her body?”
    - “Where was the helper looking?”
    - “How did the person respond?”
    - “What might happen if you used these behaviours in your work?”
* Facilitator 2 (the “person”) can also describe how they felt with Facilitator 1 (the “helper”).
* List the different behaviours the group points out.
* Briefly summarise the behaviours shown in the demonstration, including any that were brainstormed by the trainees – reminding the group that these are behaviours that you want to avoid engaging in.

## Exercise: Distinguishing between helpful and unhelpful non-verbal communication

**Learning objective and summary: to have trainees start to identify helpful and unhelpful non-verbal communication by displaying helpful communication patterns followed by a discussion.**

**Instructions:** This activity has two parts.

1. The facilitators demonstrate “helpful” verbal communication for the trainees to observe.
2. The group then discusses the behaviours that the facilitators have demonstrated (and others suggested by the trainees) and compares them with the previous demonstration. List helpful behaviours for non-verbal communication. *Be sure to explain this process to your trainees as needed.*

***1. Demonstration, outline of concepts and sample prompts***

Facilitators may refer to the sample recordings on EQUIP Platform and adapt them to the context and setting.

* Facilitators use the same food words as in the previous demonstration, e.g., if Facilitator 1 picked “cookie”, continue to use “cookie”.
* Facilitators use the food words as part of a “helpful” demonstration. Again, they use only the name of the food item to interact with one another, and no other words (e.g., the “helper” repeatedly uses the word “cookie”, while the “person” repeatedly uses the word “milk”). With the facilitators repeatedly using only the names of food items, the trainees can focus on the non-verbal behaviours they display, rather than be distracted by an actual discussion.
* The demonstration lasts 2–3 minutes.
  + Facilitator 1 plays the helper. Use the same food word repeatedly in place of real words. For example, “Cookie, cookie cookie?” instead of “Hello, thank you for coming today. How are you?”.
  + Facilitator 1: Use a variety of the non-verbal behaviours listed below, while also using the name of your chosen food item.
* Make sure to maintain an upright but not rigid posture.
* Use appropriate eye contact with the person.
* Use appropriate gestures such as open hands or nodding your head when the person is talking.
* Use utterances such as “mhmm” or “uh-huh”.
* Leave a short pause before responding to the person, etc.
  + Facilitator 2 attempts to talk with the “helper”. Again, use only the selected word (e.g., “milk”) repeatedly.
    - For example, Facilitator 2 says: “Milk. Milk… milk”, instead of “Hello. I had a tough day… I missed work”.

***2. Group discussion***

Discuss with the group what behaviours they saw, and which of them were helpful or unhelpful. Some prompts are suggested below:

*“What could you tell about the helper’s attitude, even though they were only using a food word?”*

*“What was different about their body language compared with the previous demonstration?”*

*“Where was the helper looking?”*

*“How did the person respond?”*

*“If you used these behaviours in your work, what might change?”*

* Facilitator 2 (the “person”) can also describe how they felt with Facilitator 1 (the “helper”).
* List (e.g., on a flipchart, sticky notes or a blackboard/whiteboard) the different behaviours that the group identifies (this can continue on from the previous activity).
* Briefly summarise the behaviours shown in the demonstration, including any that were brainstormed by the trainees.

## Group activity: Individual pairs demonstrate “unhelpful” non-verbal communication (optional)

**Materials needed:** Timer (clock, watch, other) and bell and/or other “alarm” for timekeeping.

**Learning objective and summary:** for trainees to experience what unhelpful non-verbal communication feels like and then discuss in order to better prepare them for engaging in helpful behaviours.

**Instructions:** Have fun! This activity has two parts:

1. Trainees demonstrate “unhelpful” non-verbal communication. This will help them to loosen up and also to explore what it feels like to be on the receiving end if their “helper” is unhelpful.
2. Then, discuss behaviours that the trainees showed and felt, listing any additional unhelpful behaviours for non-verbal communication. *Be sure to explain this process to your trainees as needed.*

**1. Role-play**

* Divide the group into pairs.
* Ask pairs to each take a turn playing the helper and the person. They will both use only the names of a food item repeatedly. To save time, they can use the same words that the facilitators used previously.
* When playing the helper, trainees should act like an “unhelpful” helper, using behaviours identified in the “unhelpful” demonstration.
* Inform the group that you will signal (e.g., with a bell, a hand clap, etc.) when the pairs should switch roles *[e.g., at 2 minutes]* andwhen the activity is over *[e.g., at 4 minutes]*.

1. **Discussion**

* Discuss with the group how they felt as the helper and how they felt as the person.
  + “As the helper, how did you think the person felt?”
  + “As the person, how did the helper’s body language make you feel?”
  + **Remind that these are behaviours you want to avoid.**
* Take notes and add points as needed to the table of “unhelpful” non-verbal communication behaviours at the end of the module.

## Group activity: Individual pairs practise “helpful” non-verbal communication

**Materials needed:** Timer (clock, watch, other) and bell and/or other alarm for timekeeping.

**Instructions:** Have fun!This activity has two parts:

1. Trainees demonstrate “helpful” non-verbal communication. This will help them to loosen up and explore what it feels like to be on the receiving end if their “helper” is helpful.
2. Then, discuss behaviours that the trainees showed and felt, listing any additional behaviours that are helpful for non-verbal communication. *Be sure to explain this process to your trainees as needed.*

Facilitators explain to the group, e.g.“Now you will demonstrate helpful behaviours, to learn how effective helpful non-verbal communication can be and why we should avoid using unhelpful non-verbal communication in our daily interactions.”

**1. Role-play**

* Ask the pairs to each take a turn playing the helper and the person. They will both use only the names of food items repeatedly. To save time, they can use the same words as they did previously.
* When playing the helper, trainees should act like a “helpful” helper, using behaviours identified in the “helpful” demonstration.
* Inform the group that you will signal (e.g., with a bell, hand clap, etc.) when the pairs should switch roles *[e.g., at 2 minutes]* and when the activity is over *[e.g., at 4 minutes]*.

**2. Discussion**

* Discus*s* with the group how they felt as the helper and how they felt as the person.
  + “As the helper, how did you think the person felt?”
  + “As the person, how did the helper’s body language make you feel?”
  + “How was it different from the unhelpful role-play? Did it feel better? Why?”
* Take notes and add points as needed to the table of “helpful” non-verbal communication behaviours at the end of the module.

## Session 2: Verbal communication

## Introducing the concept

***Note: Below is a sample text to cover the concepts and points above. Facilitators may adapt the language to the context as necessary, but must ensure that the points are adequately covered.***

### What is verbal communication?

This is a foundational helping skill that helps to build warm, trusting interactions and relationships. Helpful verbal communication skills support clear, respectful communication.

Verbal communication can be used in a variety of culturally appropriate behaviours, including in the following examples:

* **Introduce yourself and ask the person what they like to be called:**
  + “Hi, my name is Mr John Officer, but you can call me John. What is your name? Should I call you Person or Ms Person?”
* **Use open-ended questions:**
  + Ask questions that leave room for the person to thoughtfully respond and explore their feelings (e.g. “How do you feel?”), rather than closed-ended (Yes/No) questions e.g. “Are you sad?” (“Yes/No”).
* **Change closed-ended questions to open-ended questions:**
  + Change “Did you feel sad?” to “How did you feel?”
  + Change “Why did you say that?” to “How do you feel about your response?”
  + Change “Can you ask your wife?” to “Would you feel comfortable asking your wife?”
  + Change “Is it hard for you?” to “Would you describe reasons why this is hard for you?”
* **Offer reflective statements that summarise what the person has said:**
  + “I heard you say you felt sad that you could not get out of bed. How do you feel when you do manage to get out of bed?”
* **Allow time and space for the person to share their thoughts.**
  + When a person shares with us, we might feel compelled to respond immediately, or comment on what they have said while they are speaking.
    - For example, a person might say, “I was so happy…” and we might want to immediately respond, for instance, “That is so great, you were happy! I’m glad to hear it.”
    - If we pause, we might learn more. For example, the person says, “I was so happy…” *[facilitator allows silent pause for a few seconds]* “…I thought I had won the lottery. But it turns out my thumb was covering a number, and I did not win.”
* **When are closed-ended questions helpful?**
  + Although we should use open-ended questions as much as possible, especially when discussing feelings, there are also times when it is helpful to ask some closed-ended questions. When would it be helpful to ask closed-ended questions?
    - The facilitator brainstorms with the group times when closed-ended questions might be helpful.
  + **Examples of when closed-ended questions are helpful:** 
    - When confirming something in a summarising or clarifying statement. For example: “You said that, when this happened, you were alone and none of your family members were there to help. Is that correct?”
    - To confirm details that are important for planning care. For example: “Is that clinic in a location that you can get to every Tuesday morning?”
    - When a person is providing a lot of detail, some of which might be contradictory, and you need to focus on a specific piece of information. For example: “It sounds like you’ve tried a lot of different things to manage your pain. Did you complete the full three months of physical therapy?”
* **Optional:**Provide a mnemonic or another learning summary technique.
  + Example of a mnemonic (acronym) for verbal communication: **SPEAK:** **Summarise**, **P**ace, r**E**flect, **A**s**K** open-ended questions.

## Exercise: Facilitators demonstrate “unhelpful” verbal communication

***Note to facilitators:*** *The demonstration of unhelpful behaviours will support learning, while also offering an ice-breaker activity and allowing the trainees to loosen up. Have fun!*

**Instructions:** This activity has two parts:

1. The facilitators demonstrate “unhelpful” verbal communication for the trainees to observe.
2. The group then discusses the behaviours that the facilitators have demonstrated (and others suggested by the trainees), listing unhelpful behaviours in verbal communication. These can be added to the table of unhelpful and helpful behaviours at the end of the module. *Be sure to explain this process to your trainees as needed.*

**** 1. Demonstration, outline of concepts and sample prompts**

Facilitators should refer to the sample recordings on EQUIP Platform and/or use demonstrations adapted to the context and setting.

* Prompt the group to come up with typical scenarios for a “bad day”.
  + Ask trainees to brainstorm events that make up a “bad day” in their experience (e.g. getting stuck in traffic, losing their Internet connection, waking up late, stepping in mud, a disagreement with a friend, family member or co-worker/boss).
  + Select 2–3 of these scenarios.
* Facilitators demonstrate 2–3 “bad day” scenarios in a demonstration of “unhelpful” verbal communication.
  + The demonstration lasts 2–3 minutes,
  + Facilitator 1 plays the helper, and Facilitator 2 plays the person. When the “helper” asks, the “person” attempts to explain their bad day to them.
    - Facilitator 1 begins the demonstration. Ask the person to talk about their day.
    - As the person starts to speak about their bad day, continually interrupt them.
    - Ask mostly closed-ended (Yes/No) questions that might elicit a defensive response, e.g. “Why didn’t you wake up on time? Why didn’t you plan to leave earlier?”
    - Give direct advice or solutions, e.g. “You should leave earlier for work. You shouldn’t argue with your husband.”

***2. Group discussion***

* Discuss with the group what behaviours they saw, and which were unhelpful or helpful. Some prompts are suggested below:
  + “What sort of things did the helper say? How did those things affect the person?”
  + “What sort of questions did the helper ask?”
  + “Was the person able to explain her thoughts and feelings? Why or why not?”
  + “What might happen if you used these behaviours while trying to support another person?”
* Facilitator 2 (the person) can also describe how they felt with Facilitator 1 (the helper).
* List (on a flipchart, sticky notes, blackboard/whiteboard, etc.) the different behaviours that the group identifies (this can continue on from the previous activity).
* Briefly summarise the behaviours shown in the demonstration, including any brainstormed by the trainees. Add them to the table of unhelpful and helpful behaviours for verbal communication at the end of the module.

## Exercise: Distinguishing between helpful and unhelpful verbal communication

**Instructions:** This activity has two parts:

1. The facilitators demonstrate “helpful” verbal communication for the trainees to observe.
2. The group then discusses the behaviours that the facilitators have demonstrated (and others suggested by the trainees), listing helpful behaviours for verbal communication. *Be sure to explain this process to the trainees.*

****1. Demonstration, outline of concepts and sample prompts**

Facilitators may refer to the sample recordings provided with these materials and adapt the role-play to the context and setting.

**Instructions:**

* Facilitators use the same “bad day” scenarios as in the previous demonstration (e.g. if for the first demonstration the group chose, “The person woke up late, missed the bus and missed an important meeting, and is now in trouble with their boss”, then this can be used here as well).
  + The facilitators demonstrate a “bad day” scenario.
  + The demonstration lasts 2–3 minutes.
  + Facilitator 1 plays the helper.
* Begin the demonstration. Tell the person to talk about their day.
* Make sure to give the person time and space to explain what has happened that day.
* Summarise what the person has shared.
  + - For example: “It sounds like you are feeling stressed because you missed the bus.”
    - Use open-ended questions.
* “How did you feel when you missed the bus?”
* “That sounds so stressful. How did you feel when all of this was going on?”
* “What do you think you will say to your boss when you meet tomorrow to discuss the problem?”
  + - Use words to describe your understanding.
* “That must have been so stressful.”
  + Facilitator 2 plays the person.
    - Attempt to explain your bad day to the helper.

***2. Group discussion***

* Discuss with the group what behaviours they saw, and which were helpful or unhelpful. Some prompts are suggested below:
  + “What sort of things did the helper say? How did these things affect the person?”
  + “What sort of questions did the helper ask?”
  + “Was the person able to explain her thoughts and feelings? Why or why not?”
  + “Did the helper summarise the person’s statements? What did the helper say to do this?”
  + “Using these behaviours, how would daily interactions change in your work?”
  + “Was this interaction different from the one before, and if so, why?”
* Facilitator 2 (the person) can also describe how they felt with Facilitator 1 (the helper).
* List (on a flipchart, sticky notes, blackboard/whiteboard, etc.) the different behaviours that the group identifies (this can continue on from the previous activity).
* Briefly summarise the behaviours shown in the demonstration, including any that were brainstormed by the trainees. Add them to the table of unhelpful and helpful behaviours for verbal communication at the end of the module.

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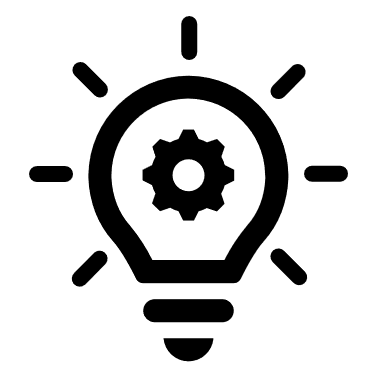
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## Group activity: Individual pairs practise verbal communication

**Materials needed:** Timer (clock, watch, other) and bell and/or other alarm for timekeeping.

**Instructions:** Have fun! This activity will allow trainees to experience “unhelpful” verbal communication. This will help them to loosen up and explore what it feels like to be on the receiving end if a helper is unhelpful.

The group then discusses behaviours that they showed as a helper, and what they felt as a person on the receiving end of unhelpful behaviours.

***Facilitator Tip***: Suggest to trainees that they mix both non-verbal and verbal communication skills they’ve learned. They can also mix both unhelpful and helpful behaviours.

***Experiencing unhelpful verbal communication***

**1. Role-play**

* Divide the group into pairs.
* Ask one member of each pair to play the helper, and one to play the person seeking help..
* The person playing the “unhelpful” helper uses the following topic: “What is your favourite food and why is it your favourite?”
  + The helper asks, “What is your favourite food and why is it your favourite?” and the person tries to respond.
* Inform the group that you will signal (e.g. with a bell, hand clap, etc.) when the activity is over *[e.g. at 2 minutes]*

1. **Discussion**

* Discuss with the group how they felt when playing the helper and how they felt as the person.
  + “As the helper, what types of behaviour did you use? How did the person respond?”
  + Did anyone use a mix of non-verbal and verbal skills, or helpful and unhelpful behaviours? What was that like?
  + “How did it feel to be the person describing what food you liked and why you liked it?”
  + “What might this be like if it happened when helping someone in distress?”
* Take notes and add behaviours to the list of “unhelpful” verbal communication

**Brief Role Play for Module 1** – Non-verbal and verbal communication skills

* Module 2 Role Play
* ENACT Scoring Template: Non-verbal communication skills
* ENACT Scoring Template: Verbal communication skills

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**Overview:** Trainees will work again in pairs, this time to show facilitators their “helpful” skills in both non-verbal and verbal communication. During the role plays, facilitators observe (e.g., walk around the room, join ‘break out’ rooms) and rate trainees on the ENACT item # 1 and # 2.

**Materials needed:** Timer (clock, watch, other) and bell and/or other alarm for timekeeping. The two facilitators will need to use the ENACT rating tool for Items #1 (non-verbal communication) and #2 (verbal communication) to rate each trainee. This can be done on the EQUIP digital platform (which can be used summarising scores and review of helpful and unhelpful behaviors at the group level) or on paper copies of ENACT. (See the scoring form for competencies #1 and #2 reproduced below.)

**Instructions**:

1. The facilitators explain to the group how this practice exercise strengthens their learning and gives facilitators feedback on their strengths.

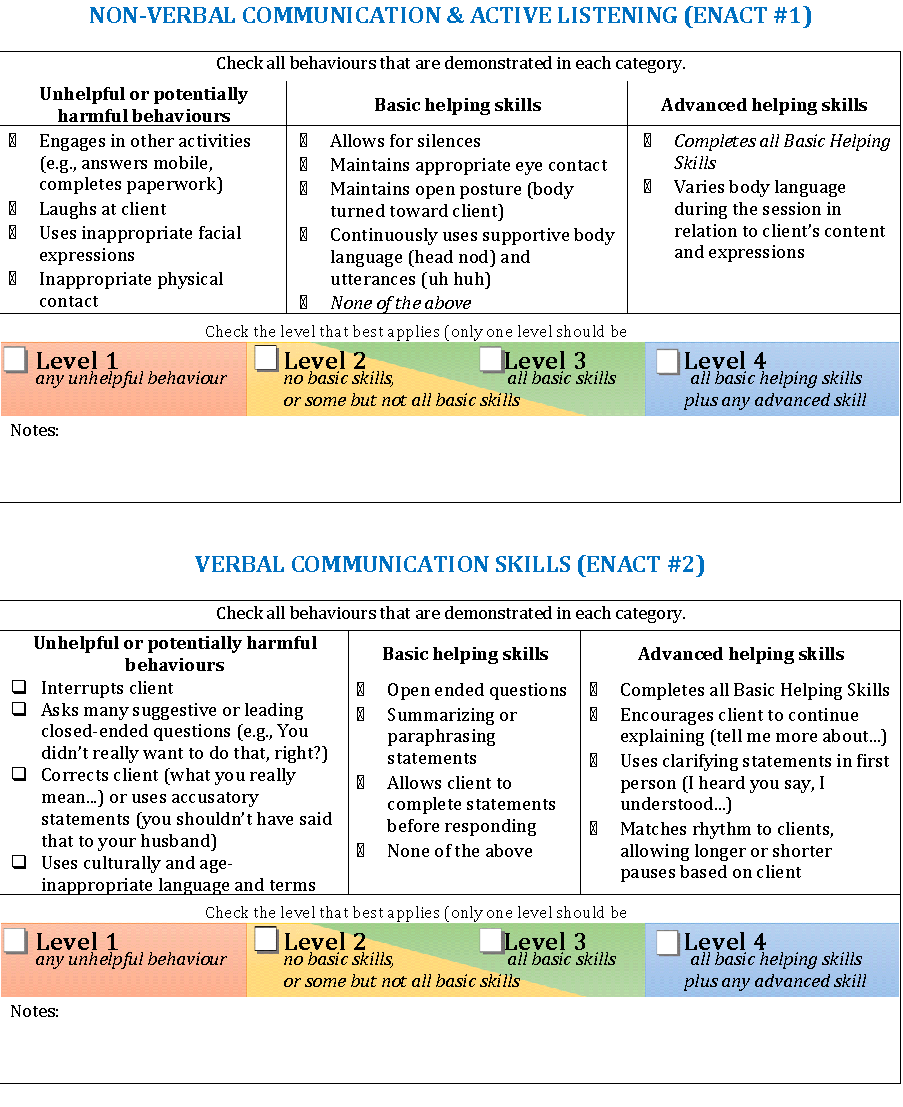
**For example**: **“**Now we will practise helpful behaviours. To bring together our learning from this session, in this practice you will combine your non-verbal and verbal helpful behaviours to practise effective communication in daily interactions. While we’re practising, we will be walking around to see your skills in action. We will take notes and see how much we’ve been able to progress during this communication skills session.”

1. Divide the group into pairs. If possible, change the pairs so trainees can work with someone new.
2. Ask each member of the pair to take turns, with one playing the helper and the other the person, and then they switch. Tell the group that each role play should be about 5 minutes.
3. Make sure that each person gets a chance to practise being a “helpful” helper.
4. Share the specific instructions with the group. These role-play instructions can be provided on a PowerPoint slide, written on a white board, or given as paper handouts to trainees:

Instructions to the **person being helped**: Think about something that was mildly stressful in the past week (e.g., a busy day, a minor stress at work, something difficult caring for children or other relatives, hearing bad news from a friend, colleague, or relative). Share this experience when asked by the helper.

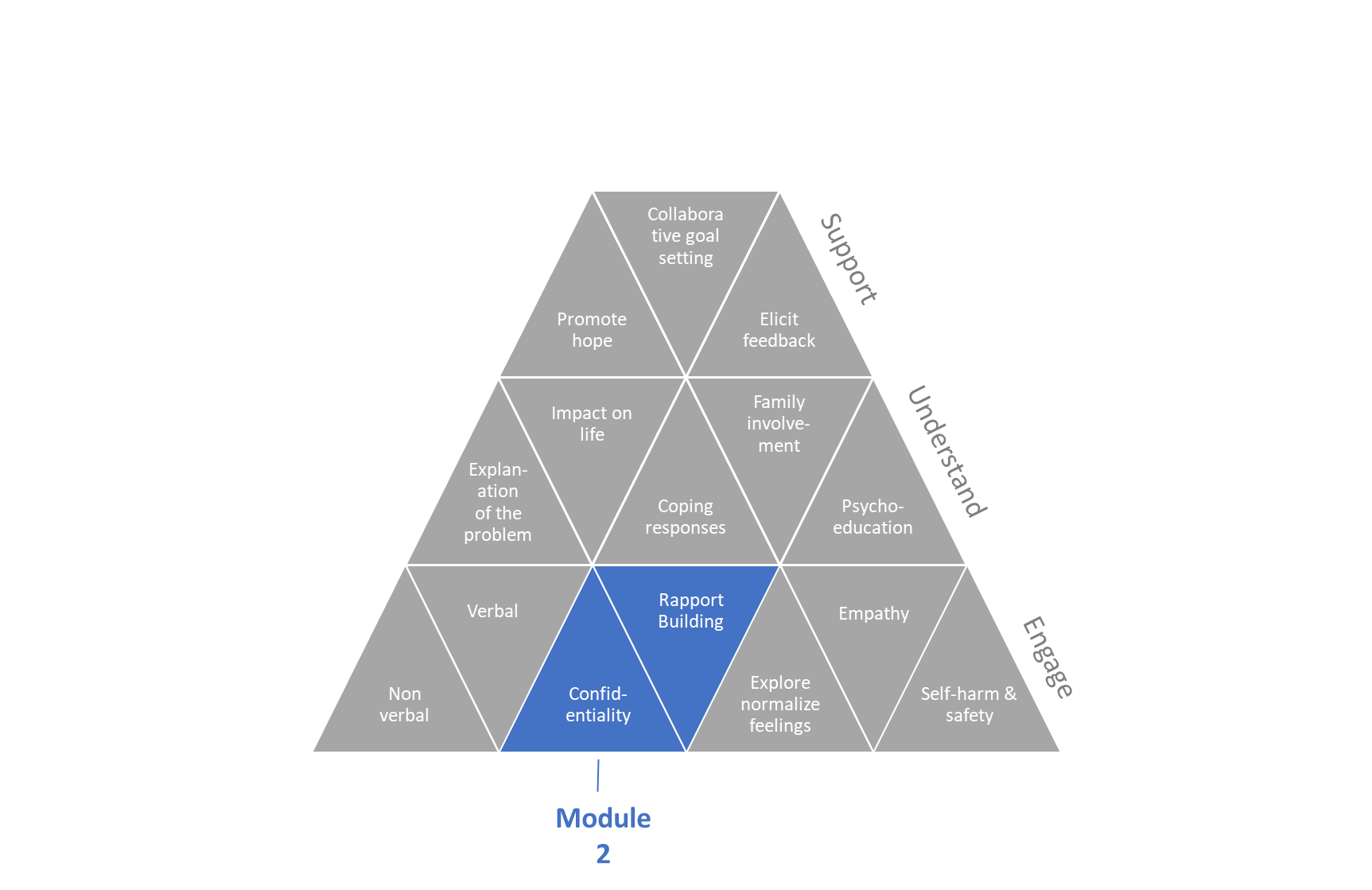
Instructions to **helper**: The person being helped has come to see you. You have previously met this person. Therefore, introductions are not needed. Start the role play with this statement to the person being helped: *“How was your past week? Were there any stressful times over the past week?”* While the person being helped responds to your question, use helpful non-verbal and verbal skills.

1. The facilitators walk around the room to observe the pairs as they practise. While observing, facilitators rate ENACT items 1# and #2 as trainees act as the helper. Observe each trainee for about 2-3 minutes to identify what helpful and unhelpful communication skills are displayed. The full role play does not need to be observed.
2. After all trainees have been observed and rated by one of the facilitators, the facilitators should thank the trainees for doing the role plays. General feedback on some of the helpful behaviours observed can be shared. Facilitators can conduct a full review of the competency ratings in the evening after the first day’s training is completed, then more specific feedback provided on the morning of day 2.



# **Module 2:** Rapport building and confidentiality (ENACT #3, #4)

1. Objective 1: Define confidentiality and rapport building and why they are important
2. Objective 2: Identify behaviours for addressing confidentiality and rapport building during your interactions
3. Objective 3: Distinguish between helpful and unhelpful behaviours for addressing confidentiality and rapport building



**This module covers the following**:

* What are rapport building and confidentiality?
* How do we incorporate rapport building and confidentiality into our interactions?
* Why are rapport building and confidentiality important for health and well-being?

**Structure of module:**

* Introducing the concept [5 minutes]
* Group activity 1: Three important things [10 minutes]
* Exercise 1: Facilitators demonstrate “helpful” rapport building and confidentiality [10 minutes]
* Group activity 2: Creating confidential settings [20 minutes]
* Group activity 2: Individual pairs practise “helpful” rapport building and confidentiality [10 minutes]
* Review of concept and learning points [10 minutes]

**Materials** (optional): Facilitators can use the table of “Unhelpful and helpful behaviours for rapport building and confidentiality” at the end of the module as a handout for trainees.

**Instructions:** One facilitator introduces the concept, and then both facilitators deliver the activities following this introduction. The facilitators take notes on the brainstorming activities done by trainees for each activity.

* The facilitator reminds trainees when activities begin: “We will list behaviours that you bring up and add them to this list of behaviours for confidentiality. We will list these along the way as we brainstorm.”

## Introducing the concept

***Note: Below is a sample text to cover the concepts and points above. Facilitators may adapt the language to the context as necessary, but must ensure that the points are adequately covered.***

###### **What is rapport building?**

* Rapport building refers to making culturally appropriate introductions. Helpers should introduce themselves and describe their role. Helpers should ask the person being helped what they would like to be called. Helpers should use culturally appropriate terms based on age and gender when referring to the person being helped.

###### **What is confidentiality?**

* Confidentiality ensures a private, safe and comfortable space for the person to share thoughts and feelings with the helper. Conversations shared between the helper and the person should remain private and should not be passed on to family, friends, employers or others without the person’s permission. Introducing confidentiality when interacting with a person can vary for different types of worker; however, it is important that workers introduce confidentiality early on – usually when they are meeting the person for the first time and describing their engagement with them.
* Confidentiality cannot be guaranteed in all situations. Its limitations must be clearly explained to the person, including when information may need to be shared with others. This can include situations such as a risk of harm or to safety, if a supervisor is monitoring sessions or if the location is not private (e.g., an outdoor space, a shared office or a shared space such as the person’s home).
  + For example, if a person is at risk of harming themselves or harming others, or at risk of harm from others, the helper will share confidential information with others and report this to the designated person (e.g. a supervisor).
  + Another instance where confidentiality is not guaranteed is if a helper needs to report to a supervisor.
* Clearly explain when information may need to be shared with others and who will be told.
  + For example: “I may share some things you tell me with my supervisor when I need to get advice on how best to support you, or to identify what support or resources might be helpful for you.” Or: “If your safety is at risk, such as harming yourself or harming others, or someone is harming you, I may need to discuss with my supervisor or others who could help you.”
* Explain why it can be important to share information with others when a person being helped explains particular issues with the helper.
  + The person should be reminded that, when you reach out to others, it is for their safety and for yours. Here are some examples of explaining why it is important to share information with others:
    - “My supervisor is very experienced and is here to make sure that you are safe at all times. That is why it is important for me to share with them my progress on our sessions.”
    - “My supervisor is very helpful and experienced. They are well trained in helping people who are at risk of harm, and that is why it is important for me to tell them when your safety might be at risk.”
* The helper should take steps to ensure confidentiality and should adjust conversation topics based on the setting. For example:
  + If holding a session or private conversation remotely, be sure that both people are using headphones or are in a quiet space away from others.
  + If the person has a family member nearby, agree on a code word to change the topic of conversation if needed.
  + If you are speaking with a person in a busy health-care setting, find a quiet place away from others.

**Optional:**Provide a mnemonic or other learning summary technique.

* Example of a mnemonic (acronym) for confidentiality: **TRUST:** **T**alk about confidentiality, **R**emind of exceptions, **U**se private spaces, **S**uggest alternatives, adjust **T**opics.

## Group activity 1: three important things

* Ask each person to take 5 minutes to write down/brainstorm responses to the following:
  + “Three important things I learned about confidentiality are [–], [–] and [–].”
* Then, ask them to share these three things with another person in the group [5 minutes].

**Note:** If training is being done remotely, ask for 2–3 volunteers to share what they have written, and then ask for feedback from the group.

## Exercise 1: Facilitators demonstrate “helpful” confidentiality

**Instructions:** This activity has two parts.

1. The facilitators demonstrate “helpful” confidentiality for the trainees to observe.
2. The group then discusses behaviours that the facilitators have demonstrated (and others suggested by the trainees), listing helpful behaviours for confidentiality. These can be added to the table of helpful behaviours at the end of the module. *Be sure to explain this process to your trainees as needed.*

***1: Demonstration, outline of concepts and sample prompts [3–5 minutes]***

Facilitators may refer to the sample recordings on EQUIP Platform and adapt them to the context and setting.

* The facilitators will demonstrate what helpers should do when describing confidentiality, including describing the limits of confidentiality and when they will need to involve others in their interactions and share information with others to promote safety and well-being.
* The demonstration lasts 3–4 minutes.
* Facilitator 2 plays the person using the service and begins the role-play, telling the helper: “No one knows about this secret talent I have, but I want to share it with you.”
* Facilitator 1 plays the helper:
  + - Respond to the person, clearly explaining that shared conversations will remain confidential and will not be passed on to family, friends or employers without their permission.
    - Explain when information will need to be shared with others (e.g. if the person raises concerns about safety or they themselves have concerns about their safety, such as harm to self, harm to others or harm from others).
    - Explain the chain of communication for this (e.g. when the helper will report to a supervisor; when the helper will report to authorities).
    - Explain why it is important to share information with others (e.g. “My supervisor is highly trained and experienced in keeping others safe, myself included. Because we want to make sure that you are safe and well taken care of, it is important that I share information with others at these times”).
    - Confirm that the person understands and agrees to the process of confidentiality, and ask if they have any questions.
  + **Note:** If demonstrating remote delivery competencies (e.g. providing support via phone or Internet), include strategies for increasing private space. For example:
    - Ask the person if they would like to use headphones for the session.
    - Ask if they are comfortable where they are located.
    - Ask if they would like to agree on a code word in case anyone nearby can hear the discussion.

***2: Group discussion [6–7 minutes]***

* Discuss with the group what behaviours they saw, and which were helpful or unhelpful. Some prompts are suggested below:
  + “What sort of things did the helper say? How did those things affect the person?”
  + “What sort of questions did the helper ask?”
  + “Did the helper address all aspects of confidentiality? What were they?”
  + “Using these behaviours, how would daily interactions change in your work?”
* The facilitator playing the person can describe how they felt with the helper.
* Take notes as needed and add to the list of “helpful” confidentiality skills in the table at the end of the module.

## Group activity 2: Impacts on confidentiality by setting

**Objective**:Settings can influence confidentiality. In a crowded clinic, people may not feel comfortable sharing personal information and a helper cannot assure confidentiality because others may overhear the conversation. During phone or video calls, a helper may not know who is listening into the conversation. These issues need to be considered when explaining confidentiality and considering what information should be discussed. This activity will help trainees think about how the setting influences confidentiality.

**Instructions**:Trainees breakout into groups to discuss issues related to confidentiality and how to promote confidentiality. After this, the groups share 1–2 sentences that summarise their responses to the scenarios.

***1 :*** Divide the trainees into groups of three. Ask each group to respond to one of the scenarios below. Each group should think of 1–2 sentences about how to respond, including a list of the barriers they identify in the scenario.

* Scenario 1: John contacts you remotely using *[insert connection, e.g. mobile phone, video calling]*. He wants to have a phone/video chat with you. John lives with his mother, wife and two children.
  + What might be some barriers to confidentiality?
  + What steps might you take to ensure that both John and you have privacy when providing remote support?
* Scenario 2: Sam comes to you for help. Sam is 20 years old and he is with his mother. She says that she needs to listen to everything that Sam talks about. They meet you at your office, but currently your office has no electricity and it is too dark to meet inside with the door closed.
  + What are some barriers to confidentiality? What could you do to make the situation more confidential?
  + How might you explain confidentiality to Sam’s mother?

***2:*** Review the groups’ answers. Each group should summarise their scenario in 1–2 sentences, including the barriers they identified and ways around them. As the groups share, list the creative ways they have brainstormed to create private settings.

* + Examples of things the facilitator might list as barriers identified: remote confidentiality (people living in shared spaces), allowing family members to listen, finding space in busy locations.
  + Examples of ways around the barriers: types of outdoor spaces that are quiet, changing topics of conversation, creating code words.
  + List (on a flipchart, sticky notes, blackboard/whiteboard, etc.) the different barriers and ways around them.

## Group activity 3: Individual pairs practise “helpful” confidentiality

**Materials needed:** Timer (clock, watch, other) and bell and/or other alarm for timekeeping.

**Instructions:** This activity has two parts:

1. Trainees practise “helpful” confidentiality.
2. The group then discusses behaviours that the trainees showed and felt, listing any additional helpful behaviours for confidentiality. *Be sure to explain this process to the trainees as needed.*
3. **Role-play**

* Divide the group into pairs.
* Ask the pairs to each take a turn playing the helper and the person. They can use the topic: “A secret talent I feel comfortable sharing”.
* Make sure that each person takes a turn playing the helper.
* Inform the group that you will signal (e.g. with a bell, hand clap, etc.) when the pairs should switch roles *[at 2 minutes]* andwhen the activity is over *[at 4 minutes]*.

1. **Discussion**

* Discuss with the group how they felt as the helper and how they felt as the person.
  + “How might you use this in your work?”
  + “In what ways is this helpful to your work?”
* Add notes as needed to the list of “helpful” confidentiality behaviours.

## Review of concept and learning points

**Materials:** Flipchart, sticky notes, blackboard/whiteboard or PowerPoint (PPT) presentation.

**Instructions:**

* Why is confidentiality important for health and well-being?
  + Ask the group to brainstorm the question, “How is confidentiality important in your work?” Allow a few trainees to respond, then share additional examples:
    - When a health worker or other service provider creates confidential spaces, the people using the service feel respected and more open to sharing their feelings.
    - When a nurse maintains confidentiality, the person is more likely to trust them and to accept medical attention.
    - When a doctor accurately explains confidentiality, a patient may feel safer to confide in the doctor that they are in an unsafe situation at home.
  + Brainstorm with the group the question, “What differences in confidentiality are there for different types of work?” Allow a few trainees to respond, then share additional examples:
    - A nurse might need to share confidential information with others if a patient tests positive for a serious communicable disease or illness, e.g. COVID-19 or a sexually transmitted infection.
    - Police officers are less able to ensure confidentiality because they are working to uphold the law and must report according to the rules and regulations set by the local or national government.
* Outline unhelpful and helpful behaviours in the table below. Be sure to add ideas brainstormed with the group during the module.

|  |  |
| --- | --- |
| **Unhelpful and helpful behaviours for confidentiality and rapport building** | |
| **Unhelpful or potentially harmful behaviours** | **Helpful behaviours** |
| * Not introducing yourself * Not asking a person what they want to be called * Referring to someone by a culturally inappropriate term or demeaning term, referring to an adult man as ‘boy’, or woman as ‘hey lady’, etc. * Forcing the person to disclose information to the helper or others * Describing confidentiality inaccurately * Promising that everything will be kept confidential, without exceptions * [Add other behaviours brainstormed by the trainees here] | * Introducing yourself and your role/profession * Asking a person what they would like to be called * Explaining confidentiality * Listing exceptions for self-harm or harm to others * Explaining why it can be important to share confidential information with others (other health workers, family members, etc.) * Explaining how sharing confidential information with others will be discussed with the person and what the chain of communication will be * [Add other behaviours brainstormed by the trainees here] |

**Brief Role Play for Module 2** – Rapport building and confidentiality

* Module 2 Role Play
* ENACT Scoring Template: Confidentiality
* ENACT Scoring Template: Rapport building

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**Overview:** Trainees will work again in pairs, this time to show facilitators their “helpful” skills in both rapport building and promoting confidentiality. During the role plays, facilitators observe (e.g., walk around the room, join ‘break out’ rooms) and rate trainees on the ENACT item #3 and #4.

**Materials needed:** Timer (clock, watch, other) and bell and/or other alarm for timekeeping. The two facilitators will need to use the ENACT rating tool for Items #3 (explanation and promotion of confidentiality) and #4 (rapport building) to rate each trainee. This can be done on the EQUIP digital platform (which can be used summarising scores and review of helpful and unhelpful behaviours at the group level) or on paper copies of ENACT. (See the scoring form for competencies #3 and #4 reproduced below.)

**Instructions**:

1. The facilitators explain to the group how this practice exercise strengthens their learning and gives facilitators feedback on their strengths.

**For example**: **“**Now we will practise helpful behaviours. To bring together our learning from this session. While you all are practising, we (the facilitators) will be walking around to see your skills in action. We will be taking some notes to give you all feedback on how to improve the skills of confidentiality and rapport building.”

1. Divide the group into pairs. If possible, change the pairs so trainees can work with someone new.
2. Ask each member of the pair to take turns, with one playing the helper and the other the person, and then they switch. Tell the group that each role play should be about 5 minutes.
3. Make sure that each person gets a chance to practise being a “helpful” helper.
4. Share the specific instructions with the group. These role-play instructions can be provided on a PowerPoint slide, written on a white board, or given as paper handouts to trainees:

Instructions to the **person being helped**: This is your first time meeting the helper. Do not introduce yourself unless asked to do so by the helper. When asked by the helper about how you are feeling or what problems you are having, ask the helper “*I am worried that you might tell my family or other people about what we are discussing*.”

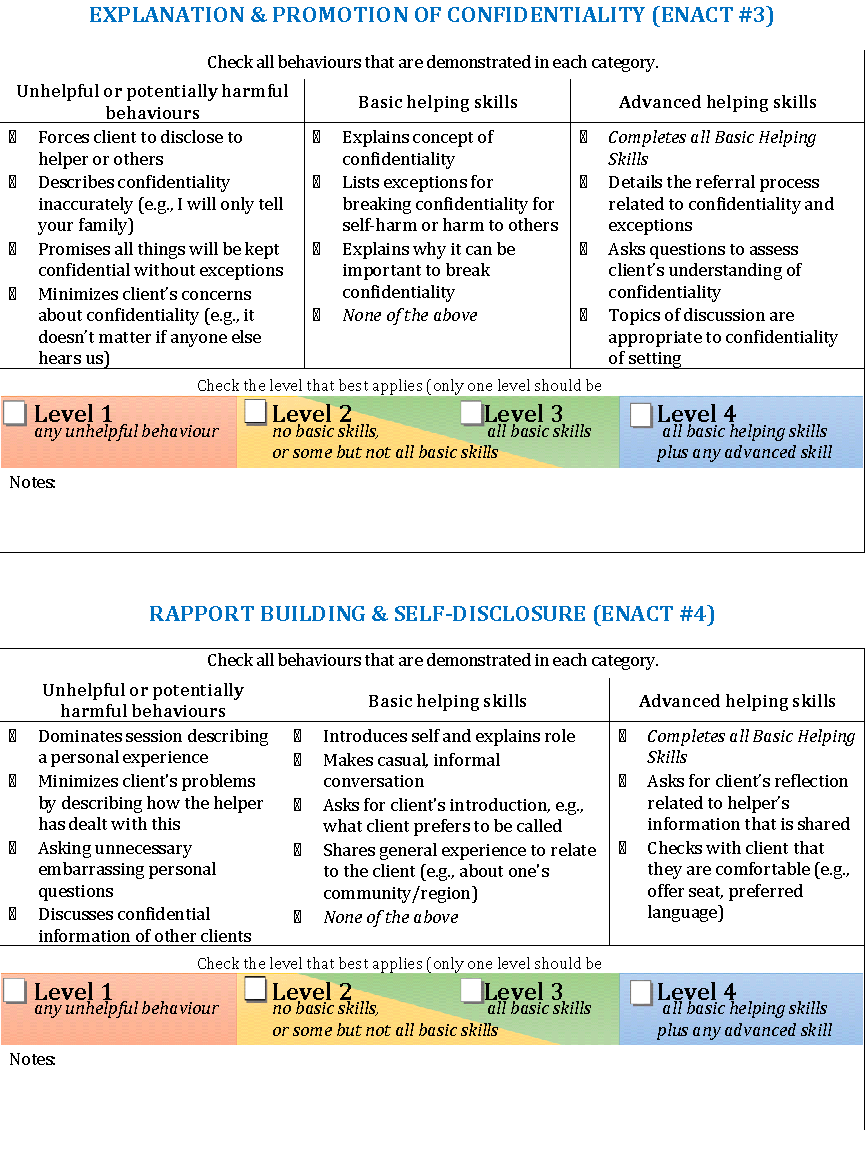
Instructions to **helper**: The person being helped has come to see you. This is your very first time meeting this person coming to you for help.

1. The facilitators walk around the room to observe the pairs as they practise. While observing, facilitators rate ENACT items #3 and #4 as trainees act as the helper. Observe each trainee for about 2-3 minutes to identify what helpful and unhelpful confidentiality and rapport building skills are displayed. The full role play does not need to be observed.

Key behaviours to record on the ENACT form are:

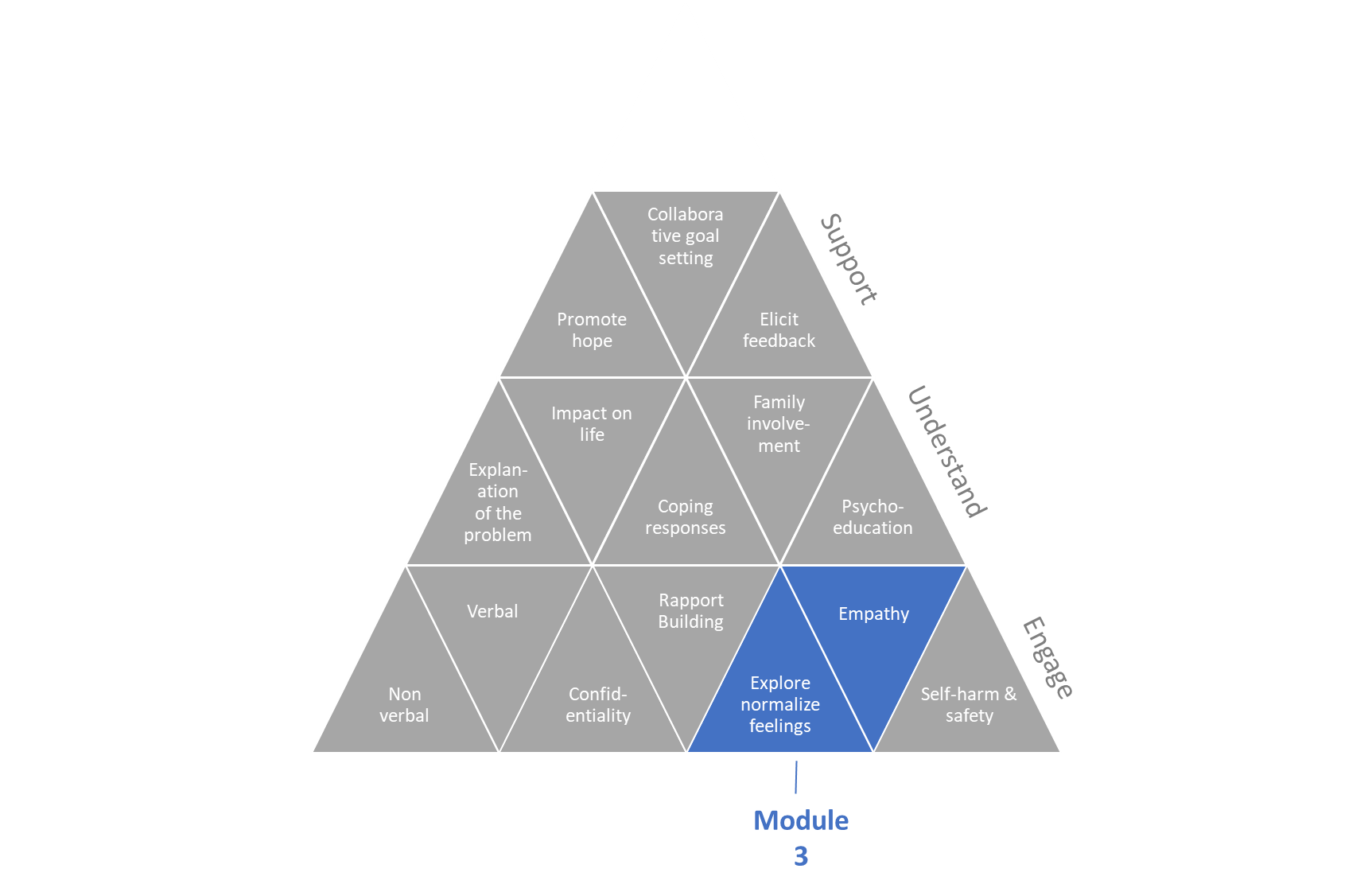
* Does the helper introduce her/him/themself?
* Does the helper ask the person seeking help what they would like to be called?
* Does the helper accurately explain confidentiality?

1. After all trainees have been observed and rated by one of the facilitators, the facilitators should thank the trainees for doing the role plays. General feedback on some of the helpful behaviours observed can be shared. Facilitators can conduct a full review of the competency ratings in the evening after the first day’s training is completed, then more specific feedback provided on the morning of day 2.



# **Module 3**: Empathy, responding to feelings, and normalisation (ENACT #5, #6)

1. Objective 1: Describe the meaning of empathy and responding to someone’s feelings and why it is important
2. Objective 2: Identify behaviours that express empathy and responding to someone’s feelings in your context
3. Objective 3: Distinguish between helpful and unhelpful behaviours when showing empathy and responding to someone’s feelings



This module is divided into two Sessions and covers two important skills – Session 1: showing empathy; and Session 2: responding to other people’s feelings.

* What does it mean to show empathy?
* What does it mean to respond to someone’s feelings?
* Why is empathy important for health and well-being?
* Why is responding to someone’s feelings important for health and well-being?

**Structure of module:**

**Session 1: Showing empathy**

* Introducing the concept of empathy
* Exercise 1: Empathy case study and discussion
* Group activity 1: Empathy exercise and discussion

**Session 2: Responding to feelings**

* Introducing the concept of normalisation
* Exercise 2: Normalisation case study and discussion
* Group activity 2: Ways to respond to emotions
* Review concept and learning points

**Materials** (optional): Facilitators can use the table of “Unhelpful and helpful behaviours for empathy and normalising feelings” at the end of the module as a handout for trainees.

**Instructions:** One facilitator introduces the concept, and then both facilitators deliver the activities following this introduction. Facilitators take notes on the brainstorming activities and add suggestions to the table of unhelpful and helpful behaviours for empathy and responding to feelings at the end of the module.

The facilitator tells trainees: “In the following activities, you will be brainstorming some different ideas. I will add the behaviours you identify to our list about empathy.”

## Session 1: Showing empathy

## Introducing the concept of empathy

***Note: Below is a sample text to cover the concepts and points above. Facilitators may adapt the language to the context as necessary, but must ensure that the points are adequately covered.***

“Emotions are contagious.” – Daniel Goleman, *Emotional Intelligence*[[1]](#footnote-1)

“Compassion is contagious. Every moment we choose compassion, we move towards a better world.” – Amit Ray, *Walking the Path of Compassion*

“Yawns are not the only infectious things out there besides germs. Giggles can spread from person to person. So can blushing. But maybe the most powerful infectious thing is the act of speaking the truth.” – Vera Nazarian

**What does it mean to show empathy?**

* Empathy involves understanding a situation from someone else's point of view, including their thoughts and feelings. It means perceiving and experiencing the world through their eyes and heart.
* As human beings, emotions relating to how we experience the world can be contagious. Laughter can be contagious even when we don’t know what someone is laughing about. Our facial expresions, such as smiles, frowns and eyes opened wide with surprise moves between us without us even thinking about it.
* One of the most important foundational helping skills is being able to see and feel an experience from another person’s perspective, so we can help to reduce their distress. To do this, we need to be able to “catch” their emotional experience.
* As helpers, we often need to identify the emotions and feelings of others, even when they don’t name them. We can help another person and share with them that we see their perspective by putting a name to their feelings.
* When we do this well, we can be a mirror and help by **reflecting feelings** back to the person. Reflecting feelingsshows that we identify the feelings that the person has shared with us and encourages the person to think more about how they are feeling. As a helper working with a person during a session, it is important to actively and continuously show care or concern with the person.

**It is important to demonstrate empathy even if we don’t always feel empathy or cannot relate to another person’s experiences.**

When working with people who are experiencing high levels of distress, it is important to acknowledge their emotions. This can be done by naming emotions that a person might be experiencing, based on what they have shared with us.

For example:

“It is so sad that you [lost your loved ones].”

“I can see you are very distressed.”

“I can see this is frustrating for you.”

“I can see that your situation is very painful.”

“This seems really hard for you.”

“[These memories] seem to be causing you a lot of stress.”

“You have so many stresses and worries. I can see it is difficult for you and that you are trying your best.”

As much as possible, we should avoid saying, “I understand how you feel/I know how you feel”. This is because it might cause a negative reaction (especially if someone is angry) such as, “How can you know how I feel?!” Instead, use phrases such as, “I can see this is…” or “This seems really hard for you…” as they show empathy but do not suggest that you know how the participant is feeling.

## Exercise 1: Empathy – case study and discussion

As helpers, we need to identify emotions. Often, this can be done even without the person using words to name emotions or feelings. In this exercise, the facilitator tells a story and asks the trainees to identify emotions at different points in it.

**Instructions:** The facilitator presents the story below about a person cooking a meal for a friend. At different points in the story, stop and ask the trainees to identify the emotion the person is feeling. Ask trainees how they identified that emotion.

*The facilitator may adapt the case study in advance to be contextually and culturally relevant to the setting and trainee group*.

**Case study (example)**

One day Anita was coming home from work to meet her friend Deepa, who she had invited over for dinner. Anita was planning to cook rice, lentils, vegetables and chicken. Unfortunately, that day she had to work late. She was now rushing to get to the market and then get home in time to cook. She got to the market and it was very crowded. She looked at her watch and it was already late. She looked around, unable to decide which ingredients to buy first. She kept looking at her watch.

**Questions the facilitator asks trainees:**

*“How do you think Anita felt at this time?”*

*“What made you think she was feeling this way?”*

In a rush, Anita eventually bought her ingredients and got home. She started cooking dinner, and began with her rice cooker. Then she got a pan to cook the chicken. But when she opened her grocery bag to get the chicken, she saw that the chicken wasn’t there and it was a goat instead. Her friend Deepa does not eat goat. She remembered how the butcher wasn’t paying attention when packing her order. She thought about the butcher and threw the goat meat into the garbage.

**Questions the facilitator asks trainees:**

*“How do you think Anita felt at this time?”*

*“What made you think she was feeling this way?”*

Anita cooked the food she did have. But in her rush and frustration some things were undercooked, and some were burned. Deepa had arrived, and she put the food on the plate to bring it out to her. She couldn’t believe that she was going to serve this to Deepa. She wanted to go and hide. She kept moving the food around on the plate to make it look better. She slowly walked into the room, where Deepa was sitting at the table.

**Questions the facilitator asks trainees:**

*“How do you think Anita felt at this time?”*

*“What made you think she was feeling this way?”*

Anita apologised to Deepa and explained what had happened with her evening. Deepa put her hand on Anita’s arm and said not to worry about it at all. She shouldn’t feel embarrassed; the same thing had happened to her a few weeks ago when she had planned a dinner party. Deepa said that a new dumpling shop had just opened nearby, which she’d be excited to try. Together they agreed to go there instead. Anita’s shoulders felt lighter at this suggestion, and she said to Deepa, “Grab your coat, we’re going out!”

**Questions the facilitator asks trainees:**

*“How do you think Anita felt at this time?”*

*“What made you think she was feeling this way?”*

**Facilitator reviews learning concepts:**

“In this story, we never hear what Anita’s emotions are, but by paying attention to her actions and by looking at things from her perspective, we can imagine the emotions she might be feeling. We often need to do this as a helper.”

**What if, as a helper, I name the wrong emotion?**

“We won’t always name the emotion correctly, because we are not mind-readers and we are still learning about the person. However, it is important to try naming the emotions anyway because this creates a meaningful interaction between the helper and the person. So, even if you are unsure, try naming the emotion anyway and keep asking questions. Often, this will encourage the person to explain more about the emotions they are experiencing.”

## GROUP ACTIVITY 1: Empathy – exercise and discussion

**Instructions:** This activity has two parts:

1. Trainees work in pairs to try to understand what another person is feeling, without having to ask them.
2. The facilitators then lead a brief group discussion, reviewing how we can identify emotions without asking exactly what the emotion is.

***1****:*

* Split the trainees into pairs. Each trainee takes a turn playing the helper and guessing what the person’s emotion is.
* Pass around envelopes with the name of an emotion written on a card inside. Only one person in the pair can look at the emotion – that will be the person using the service, and the other person will be the helper. The helper can ask any questions of the person, except “How or what are you feeling?”.
  + Example questions: “What have you been doing recently? How do you experience this in your body? What have you been talking to others about? What have you been thinking about? What does this situation remind you of?”
* The trainees playing the helper try different questions, and observe what questions are helpful in identifying or “guessing” the emotion. The person cannot use the emotion word itself in any of their responses. If the helper guesses the wrong emotion, keep going with the role-play, allowing the helper to continue asking questions.
* After the helper identifies the emotion or 4 minutes are up, the pair reverse roles. The facilitator gives the pairs a new envelope with the name of another emotion and they have a further 4 minutes in the new roles.

**Facilitator tip: list of possible emotion cards**

* Afraid/fearful
* Angry
* Sad
* Worried/anxious
* Happy/joyful
* Envious/jealous
* Embarrassed
* Frustrated/annoyed
* Confused/uncertain
* Guilty

***2: Brief discussion led by facilitators:***

After the activity, the whole group can discuss how to identify emotions without asking the person directly what the emotion was. Ask what the clues were, and what worked and what didn’t. The discussion might also reflect the fact that if people got the emotion wrong, this provided an opportunity for more open discussion and for the person to correct the helper and give more information. The first step in empathy is to build rapport with the person, which helps with identifying the emotions that the person is feeling.

## Session 2: Responding to feelings

## Introducing the concept of normalisation

***Note: Below is a sample text to cover the concepts and points above. Facilitators may adapt the language to the context as necessary, but must ensure that the points are adequately covered.***

###### **What does it mean to normalise a person’s feelings?**

* When a person shares their feelings with you, it is helpful to confirm, or validate, their symptoms, reactions and feelings, and reassure them that such experiences are understandable, and acceptable. Sometimes it can be helpful if a person learns that others might feel the same way as they do. This normalises the feeling without making their personal experience seem trivial (e.g. “Many other individuals also have fears about going out when they have seen someone being beaten”; “This is a terrifying experience – it is normal that you feel afraid and angry”).
* Exploration and normalisation of feelings confirm for an individual that the emotions they are experiencing are expected, or normal, for their situation. This can also allow the person to feel calmer and safer, and prepare them to listen and communicate.

## Exercise 1: Normalisation – case study and discussion

This exercise illustrates a case example of a community health worker responding to a person’s emotions.

**Instructions:** This activity has two parts.

1. The facilitators present the case study (act it out).
2. They then use discussion questions to prompt the trainees to reflect on what occurred in the case study and on similar interactions specific to their own work.

*Facilitators may adapt the case study in advance to be contextually and culturally relevant to the setting and trainee group.*

**1. Case study (example)**

Rohit meets with a community health worker (CHW).

* CHW: “Hi, Rohit, thanks for calling me. What did you want to chat about?”
* Rohit: “I have been having headaches, but I am afraid about going to the doctor.”
* CHW: “Okay. Can you tell me more about that?”
* Rohit: “I am worried that if I go, my doctor will say it is something very serious. I had an uncle who had a lot of headaches before he had to go to the hospital.”
* CHW: “Ah, I see, thanks for explaining, Rohit. That is a very common reaction. It sounds like you are worried you might have to go to hospital. Many people feel worried that when they are sick it could be something serious. Sometimes we would prefer not to know if it is something serious, especially if someone you know has had a serious illness.”

**2. Discussion**

* “Was the community health worker being empathic to Rohit? What specific words or skills did they use to show empathy?”
* “Was the community health worker able to reflect Rohit’s feelings?”
* “When might you use empathy and normalisation in your work? What types of situations can you think of?”
* “In what other ways might you use this approach at work or in general?”

## Group activity 2: Ways to respond to emotions

**Instructions:** This activity has three parts:

1. In this activity, the facilitators ask the group to split into small groups of 2–3 people each, and use the scenarios provided below to think about ways in which they can “respond to emotions”.
2. After this, the facilitators hold a group discussion so that groups can share the different ways in which they responded.
3. Again in small groups, the trainees share their own experiences and practise empathy and normalising feelings, and then report back to the main group.

*Facilitators may adapt the scenarios to their specific context and setting.*

***1. Scenarios [8 minutes*]**

**Example scenario:** Amir says, “I keep coming home late. I am embarrassed because I lost my job and I don’t want my family to know.”

**Example response from group *[empathy]*:** “I see, and thanks for sharing, Amir. I see why you might feel embarrassed *[reflection]*. It sounds like you’re worried about how your family will react to you losing your job *[validation]*. Many people who lose their jobs struggle with feelings of shame or embarrassment *[reflection]*. How do you feel, knowing that others might have similar responses to this situation as you do now?”

***Empathy response is marked as “[empathy]”.*** *This response is used to show Amir that we are trying to see the world through his eyes.*

***Validation response is marked as “[validation]”*.** *This response is used to normalise how Amir is feeling, and to underline that many people have similar feelings in situations like his.*

***Reflection of feelings response is marked as “[reflection]”.*** *By restating that Amir is feeling “embarrassed”, we actively reflect his feelings back to him and further deepen our empathy in “seeing the world through his eyes”. It can also be helpful to include a question to encourage Amir to reflect on his own feelings after he has shared them, such as the question at the end of the response.*

* The facilitator gives each group the scenarios below to read. Groups are asked to imagine that they are working with the person who has shared their experiences and feelings (i.e. Sally or Luke).
* The facilitatorasks each group to think of at least two helpful responses they could give to each person. Each response might consist of a few sentences.

**Scenarios for group work**

1. Sally says, “I am exhausted and I can’t get out of bed. I feel scared because I am not keeping up with work.”
2. Luke says, “I am worried and feeling stressed about getting sick. What if I get sick and lose my job?”

***2. Group discussion [6–7 minutes]***

* Groups can present one response to each person’s statement. Groups can read the response aloud, display it on a whiteboard or similar, or they can opt to role-play the response.
* List (on a flipchart, sticky notes, blackboard/whiteboard, etc.) the different behaviours that the group identifies.
* Briefly summarise the behaviours and how they relate to the concepts of empathy, reflecting feelings and normalising feelings, as described above.
* **Facilitators should consider:** Make sure that each group’s responses include the following: normalising the feeling, asking the person to reflect on their feelings, and showing empathy. See the example above with *[empathy]*, *[validation]* and *[reflection]* for how this might be done.

***3. Share and tell [10 minutes]***

* Recall the story about Anita and Deepa. One of the most helpful things for Anita was hearing Deepa say that she could identify with how she was feeling about the ruined meal. In this role-play, we explore how interaction occurs to normalise distress**i**ng or undesirable feelings.
* The facilitator asks the trainees to form groups of three. One trainee can describe a time that they made a mistake when cooking a meal, the second trainee responds with “helpful” empathy and normalisation, and the third observes and takes notes. Then, still in their groups, they discuss the behaviours that they showed one another, and list helpful behaviours for empathy and normalisation *[end the activity at 5 minutes with a bell or other signal]*.
* The facilitator asks one person from each group to share 1–2 short pointsonsomething new that they have learned about the normalisation of feelings and empathic behaviours.
* Take notes and add to the table of “helpful” normalisation of feelings and empathy skills at the end of the module.

## Review concept and learning points

**Materials:** Flipchart, sticky notes, blackboard/whiteboard or PowerPoint (PPT) presentation.

**Instructions:** Review learning points from the module activities using the prompts below.

* Why is it important for health and well-being to show empathy and to normalise and reflect feelings?
  + Ask the group to brainstorm: “How are empathy, normalisation and reflecting feelings important in your work?” Facilitators should first encourage responses from trainees, then share additional examples:
    - When a health worker or other service provider is empathic and reflects and normalises feelings, the person using the service feels more comfortable in describing and providing fuller information about their concerns.
    - When a teacher is empathic and reflects and normalises feelings, their students are likely to do better in their work and to work harder.
    - When a social worker is empathic and reflects and normalises feelings, the people they are helping are more likely to explain their circumstances and comply with case plans.
    - Even in fields such as surgery, when a surgeon is empathic and reflects and normalises feelings, their patients are more likely to spend less time in hospital and to recover fully.
    - When a person has a health-care provider who is empathic and reflects and normalises feelings, they are less likely to go to many different health workers or other providers in search of someone who “listens” to them.
* Outline unhelpful and helpful behaviours in the table below. Be sure to add ideas brainstormed with the group during the module.

|  |  |
| --- | --- |
| **Unhelpful and helpful behaviours for empathy and normalising feelings** | |
| **Unhelpful or potentially harmful behaviours** | **Helpful behaviours** |
| * Stating that the person’s response is unusual for a particular situation (e.g. “People don’t usually react this way”) * Minimising or dismissing the person’s feelings or emotions * Forcing the person to describe their emotions * Being critical of the person’s concerns * Being dismissive of the person’s concerns * Saying inappropriate things or coming across as fake or acting when responding * [Add other behaviours brainstormed by the trainees here] | * Appropriately encouraging the person to share their feelings * Explaining that other people might have similar feelings, reactions and concerns when faced with similar experiences * Being warm, friendly and genuine throughout the session * Actively and continuously showing concern or care for the person * Asking questions to help see the problem from the person’s perspective * [Add other behaviours brainstormed by the trainees here] |

**Brief Role Play for Module 3** – Empathy, responding to feelings, and normalisation

* Module 3 Role Play
* ENACT Scoring Template: Eliciting and normalising feelings
* ENACT Scoring Template: Empathy

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**Overview:** Trainees will work again in pairs, this time to show facilitators their “helpful” skills in both discussing feelings and showing empathy. During the role plays, facilitators observe (e.g., walk around the room, join ‘break out’ rooms) and rate trainees on the ENACT item #5 and #6.

**Materials needed:** Timer (clock, watch, other) and bell and/or other alarm for timekeeping. The two facilitators will need to use the ENACT rating tool for Items #5 (discussing feelings) and #6 (showing empathy) to rate each trainee. This can be done on the EQUIP digital platform (which can be used summarising scores and review of helpful and unhelpful behaviours at the group level) or on paper copies of ENACT. (See the scoring form for competencies #5 and #6 reproduced below.)

**Instructions**:

1. The facilitators explain to the group how this practice exercise strengthens their learning and gives facilitators feedback on their strengths.

**For example**: **“**Now we will practise helpful behaviours. To bring together our learning from this session, in this practice you will combine your skills in discussing feelings and showing empathy. While you all are practising, we (the facilitators) will be walking around to see your skills in action. We will be taking some notes to give you all feedback on how to improve the way you discuss feelings and show empathy.”

1. Divide the group into pairs. If possible, change the pairs so trainees can work with someone new.
2. Ask each member of the pair to take turns, with one playing the helper and the other the person, and then they switch. Tell the group that each role play should be about 5 minutes.
3. Make sure that each person gets a chance to practise being a “helpful” helper.
4. Share the specific instructions with the group. These role-play instructions can be provided on a PowerPoint slide, written on a white board, or given as paper handouts to trainees:

Instructions to the **person being helped**: After the helper asks you about the reason you came to see them, tell the helper “*My son just finished his schooling, and I am staying up at night worrying that he won’t be able to find a good job to support himself. I’m tired every morning because of staying up at night worrying about him.*”

Instructions to **helper**: Introduce yourself and ask the person what they would like to be called. Then ask them, “*Please tell me about why you came to see me today.”* Use your skills to discuss the person’s feelings and show empathy.

1. The facilitators walk around the room to observe the pairs as they practise. While observing, facilitators rate ENACT items #5 and #6 as trainees act as the helper. Observe each trainee for about 2-3 minutes to identify what helpful and unhelpful discussing feelings and empathy skills are displayed. The full role play does not need to be observed.

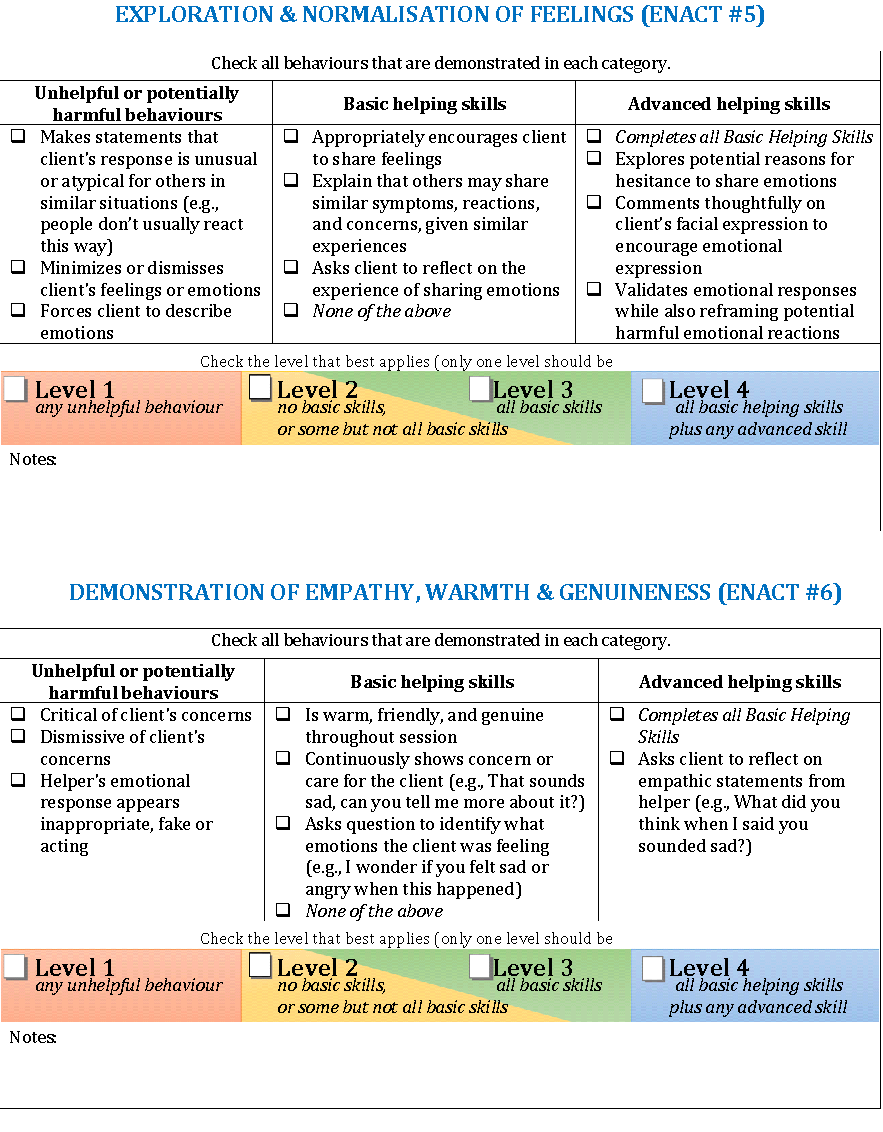
Key behaviours to record on the ENACT form are:

* Does the helper encourage the person seeking help to share their feelings?
* Does the helper acknowledge when the person brings up things that may be distressing?
* Does the helper acknowledge that other people may feel similarly in this situation?
* Does the helper ask the person what it feels like to be sharing about this topic?

Behaviours that may be harmful should also be recorded on the ENACT form:

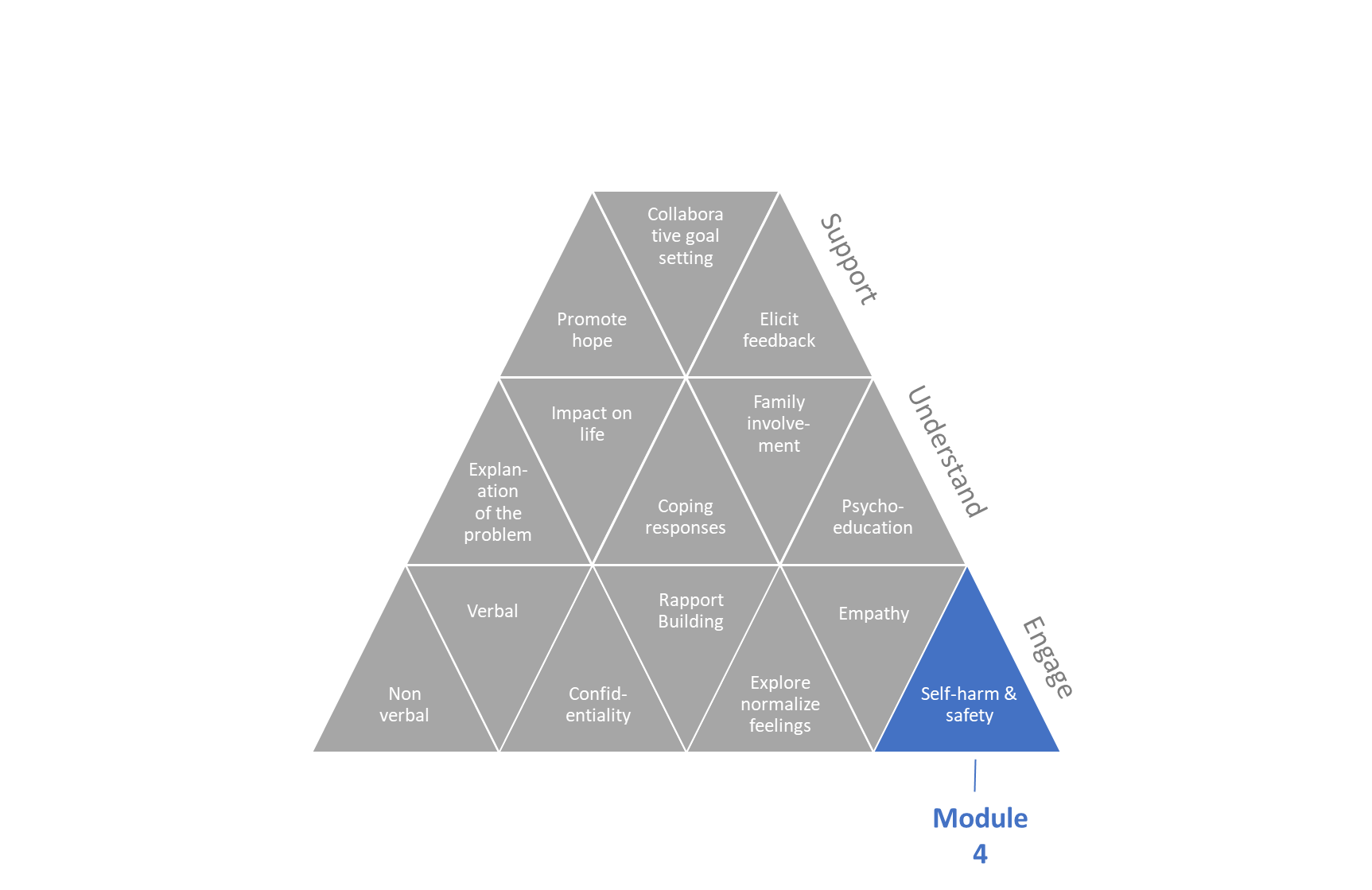
* Does the helper force the person to keep talking even if they are distressed?
* Does the helper seem fake or like they are only pretending to care about the person in distress?

1. After all trainees have been observed and rated by one of the facilitators, the facilitators should thank the trainees for doing the role plays. General feedback on some of the helpful behaviours observed can be shared. Facilitators can conduct a full review of the competency ratings in the evening after the first day’s training is completed, then more specific feedback provided on the morning of day 2.



# **Module 4**: Assess suicidal behavior and promoting safety (ENACT #7)

* 1. Objective 1: Describe what suicidal behavior is and why it is important to assess for suicidal behavior when helping others in your context
  2. Objective 2: Identify behaviors for assessing suicidal behavior when helping someone in your context
  3. Objective 3: Distinguish between helpful and unhelpful behaviors for assessing for suicidal behavior



**This module covers the following:**

* What is suicidal behaviour?
* What does a “helpful” assessment of suicidal behaviour look like?
* Why is assessing suicidal behaviour important for health and well-being?

**Structure of module:**

* Introducing the concept [15 minutes]
* Exercise 1: First “helpful” demonstration by facilitators [10 minutes]
* Exercise 2: Second “helpful” demonstration by facilitators [10 minutes]
* Group activity 1: “What I find most puzzling” [15 minutes]
* Group activity 2: Individual pairs practise “helpful” assessment of suicidal behaviour [10 minutes]
* Review concept and learning points [10 minutes]

**Note to facilitators:** This module does not cover developing a safety plan, but you may refer to further resources if you want the trainees to learn more. One resource is the World Health Organization’s online course for Assessing and Supporting People with Suicidal Behaviour: <https://whoequipremote.org/en-gb/node/903>

**Materials** (optional): Facilitators may use the “Unhelpful and helpful” table at the end of the module as a handout for trainees.

**Instructions:** One facilitator introduces the concept, and then both facilitators deliver the activities following this introduction. The facilitators take notes on the brainstorming sessions and add suggestions to the table of “Unhelpful and helpful ways of assessing suicidal behaviour” at the end of the module.

## Introducing the concept [15 minutes]

***Note: Below is a sample text to cover the concepts and points above. Facilitators may adapt the language as necessary to the context, but must ensure that the points are adequately covered.***

###### **What is suicidal behaviour?**

**Suicidal behaviour** refers to a range of behaviours that include suicidal thoughts (or ideation), planning for suicide, attempting suicide and dying by suicide.

**What is assessing suicidal behaviour?**

**Assessing suicidal behaviour** means trying to determine whether a person is at imminent risk of harming themselves. **Imminent** means that something is about to happen or is likely to occur soon. **Imminent risk of self-harm/suicide** means when someone is about to attempt suicide or to harm themselves.

It is important to assess suicidal behaviour before the person acts. If we do not ask a person directly about suicide, we may miss the chance to support them when they are in need. By learning how to ask about suicidal behaviour, we can promote safety and find ways to help.

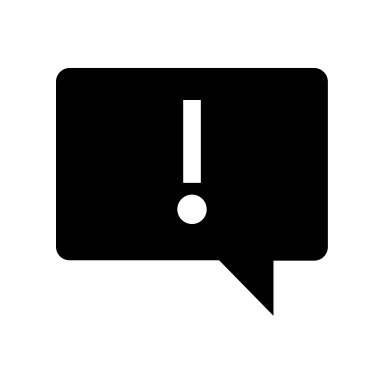
**Protective factors** guard against the risk of suicide. These include access to social support and strong personal relationships, connectedness, resilience, subjective personal well-being and effective positive coping strategies.

**Risk factors** for suicide describe things that might increase a person’s vulnerability to suicidal behaviour. Risk factors could include:

* **Individual-level factors** (relating to the person and their personal history), such as previous suicide attempt(s), chronic pain, mental disorders, harmful use of alcohol or substances, loss of job or financial loss, hopelessness or family history of suicide.
* **Relationship factors**, such as lack of social support, feelings of isolation, relationship problems or loss of a loved one.
* **Community risk factors**, such as disaster, war and conflict, adjusting to a new culture or being displaced from one’s home or country, discrimination, trauma or abuse.
* **Society-level or health risk factors**, including having access to means of suicide, inappropriate media reporting about suicide, stigma associated with seeking help and barriers to accessing health care.
* **For youth,** risk factors also include school stress, bullying and family conflicts at home.

**Suicide warning signs** can signal that a person might be at risk of suicidal behaviour. Some suicide warning signs might be very clear and obvious, while others might be difficult to see. Also, some people who attempt suicide might not show any warning signs at all. Warning signs can include a person:

* Talking about wanting to die or killing themselves or being in unbearable pain, talking about feeling hopeless or having no purpose, talking about feeling alone or being a burden to others, saying things like “No one will miss me when I’m gone”;
* Looking for ways to kill themselves (such as seeking access to pesticides, firearms or medication, or searching the Internet for ways of taking one’s own life);
* Arranging personal end-of-life business (e.g. writing a will);
* Showing signs of being very upset, angry or struggling to communicate;
* Telling you about a major change in sleep or eating habits;
* Not having any supportive family members or friends.

**Note:** Warning signs, risk factors and protective factors do not predict who will die by suicide and who will not. Therefore, it is necessary to assess suicidal behaviour individually for each person, especially when they are seeking psychological support.

**Common myths about suicide.**[[2]](#footnote-2),[[3]](#footnote-3),[[4]](#footnote-4) Facilitators can review the following myths with the group, or they can opt to use them in an activity, such as “True or False”. If doing this as a “True or False” activity, ask the group to stand in a line and, when they hear the statement, move to the left if it is true and to the right if it is false. If the course is being held online, you can ask the trainees to respond “true” or “false” using the chat function.

* + **People who talk about suicide do not mean it.** 
    - Many people who attempt or die by suicide have, at some stage, told another person about their intentions, or given some clue or warning sign. Any signs, comments or talk of suicide should be taken seriously.
    - People who talk about suicide may be reaching out for help or support. Many who speak about suicide experience depression, anxiety or hopelessness and feel that there is no other option.
  + **Talking openly about suicide might cause the person to attempt suicide, or give them ideas about suicide that they might not have thought about before.**
    - There is no evidence that speaking about suicide leads to suicidal behaviour. In fact, the opposite is true.
    - Talking openly and honestly about suicide can save a person’s life. They are more likely to speak about their concerns if those offering support are open and non-judgemental about these thoughts and provide empathic understanding.
  + **If someone is determined to kill themselves, nothing will stop them.**
    - The majority of people who think about suicide have mixed feelings about wanting to live and wanting to die. Most people are looking for a way to stop the pain (or other strong emotions) they are feeling. By being open about suicide, we can find ways to support people with that pain and find other ways in which they might manage their difficulties.
  + **People who die by suicide are people who don’t want help.**
    - Many people who struggle with suicidal behaviour seek help, but the ways they do this might not be obvious. For example, they do not always seek help for mental health problems but perhaps seek support for physical or other problems. They might also seek help from family or friends, even though they may not say that they want to die.
  + **Only people with mental health conditions or mental illness are suicidal.**
    - People of any age, gender, race, culture, religion or nationality or of any other group affiliation, as well as people living with or not living with mental health conditions or psychosocial disabilities, can be vulnerable to suicidal behaviour. Likewise, many people with mental health conditions do not exhibit suicidal behaviour.
  + **Never ask about suicide.**
    1. People accessing services can feel a sense of relief when they are asked and given permission to talk about suicide. Talking about suicide can be a very positive experience for the person using a service.
  1. **Most suicides happen suddenly and without any warning.**
     1. Although some suicides seem to occur without any warning, many people who attempt suicide do show verbal or behavioural warning signs, even if these are not direct or obvious.

**Asking about suicidal thoughts, feelings, and behaviors:** This module covers the basics of asking about suicidal behaviour and how to be prepared to make a referral.

When assessing for suicide, remember to use non-verbal and verbal communication skills. For example:

* Listen empathically and without judgement.
* Allow for silences and use gestures to show understanding (e.g. “Mmhm, uhuh”, nodding your head), even if you are speaking on the phone and the person cannot see you (as this helps you to remain engaged).
* Use clarifying and reflective statements (e.g. “I heard you say…”).
* Support and validate the person’s experiences and feelings.
* Ask open-ended questions about the person’s needs and concerns.
* Avoid interrupting or rushing the person.

Do NOT:

* Give direct advice: e.g. “You should stop thinking that way. Keep yourself busy.”
* Use judgemental statements that might cause a person to feel guilty about having such thoughts: e.g.“How could you ever think that – what would happen to your children?”
* Lecture the person: e.g. “You have so much to live for” or “Why would you ever think that way?”
* Suggest to the person that you are afraid of their response: e.g. “You haven’t thought of killing yourself – have you?”
* Use terms that suggest that suicide is a “bad” thing, such as the term “to commit suicide”.
* Project your own beliefs about suicide onto others: e.g. “Suicide is a sin.”
* Minimize a person’s feelings or thoughts about suicide: e.g. “Don’t be silly, life is not that bad.”
* Suggest a person is not serious in their thoughts about suicide: e.g. “If you really wanted to kill yourself, you would have already found a way. You’re just looking for attention.”

***Being prepared for referrals***

It is essential to know how to make referrals and to have resources ready. In particular:

* Familiarize yourself with your organization’s policies and procedures for assessing and managing suicidal behaviours.
  + *Note to facilitators: It is okay if your organisation does not have a policy: this course material should be adjusted as needed for the trainees.*
* Know the local guidelines or processes for communicating with emergency services if a suicide attempt is in progress or a person is at imminent risk of self-harm/suicide.
* Have a list of suicide helplines and/or services so that if the person has suicidal ideation, s/he can immediately call these numbers.

## Exercise 1: First “Helpful” Demonstration by Facilitators

**Instructions:** This activity has two parts.

1. The facilitators demonstrate “helpful” skills for the assessment of suicidal behaviour for the trainees to observe.
2. The facilitators then lead a discussion about the behaviours that they have demonstrated (and other ideas suggested by the trainees), listing skills that are helpful for assessing suicidal behaviours. *Be sure to explain this process to your trainees as needed.*

***Part 1: Demonstration, outline of concepts and sample prompts [3–5 minutes]***

Facilitators may refer to the sample recordings provided with these materials and adapt the demonstration to the context and setting.

* Introduce the concept of the demonstration, e.g. “Talking openly, directly and honestly about suicide can save a person’s life. Make sure to create a safe, non-judgemental and open environment when asking about suicide. If you are a psychosocial support helper, remind the person that this is something you ask of everyone you are working with.”
* The demonstration should take 3–5 minutes.
* The facilitators use the description and prompts below.
  + Facilitator 1 plays the helper (begins the role-play).
  + Facilitator 2 plays the person.
* Helper: “I ask these questions to everyone I see because sometimes, when people face challenges and feelings as you have described to me, they think about hurting themselves or taking their own life. I’d like to ask if you have experienced any thoughts like this and if you’ve ever wanted to end your life?”
* Person: “No, I have never had these thoughts.”
* Helper: “So, you’ve just told me that you have not been having thoughts about harming yourself or attempting suicide?”
* Person: “Yes. I’ve never really thought that was an option.”
* Helper: “Okay. I want you to know that I might ask you about this again in future because I need to ensure that you are keeping safe. And, of course, you can talk to me about this if your experience changes in any way.”

***Part 2: Group discussion [3–4 minutes]***

* Discuss with the group what they saw.
  + “What behaviours did the helper use?”
  + “How was the helper being direct?”
  + “How did the helper show a non-judgemental attitude? What kind of questions did the helper use?”
  + “What unhelpful behaviours did the helper successfully avoid?”
    - E.g. giving direct advice, interrupting, lecturing the person.
* Facilitator 2 (the person) can also describe how they felt with Facilitator 1 (the helper).
* List (on a flipchart, sticky notes, blackboard/whiteboard, etc.) the different behaviours that the group identifies.
* Briefly summarise the behaviours, including any additional behaviours that the trainees observed.

## Exercise 2: Second “helpful” demonstration by facilitators [10 minutes]

Of note: the roles for suicide risk assessment included in this foundational helping skills manual are limited to low-risk scenarios with the intention that this is promoting basic risk assessment skills that are important to all helpers regardless of their provider or community role. The expectation is that any individual can ask about suicide risk and make referrals when needed. This manual does not include counselling skills for high risk situations. For more on managing high risk situations see materials in WHO mhGAP-IG or broader recommendations in WHO Live Life.

**Instructions:** This activity has two parts.In the role-play, the facilitators demonstrate “helpful” skills for the assessment of suicidal behaviour for the trainees to observe. They then discuss the behaviours that they have demonstrated (and others suggested by the trainees), listing helpful skills for assessing suicidal behaviours. *Be sure to explain this process to your trainees as needed.*

***Part 1: Demonstration, outline of concepts and sample prompts [3–5 min]***

Facilitators may refer to the sample role-play recordings provided with these materials and adapt the role-play to the context and setting.

* The demonstration should last 3–5 minutes.
* The facilitators use the description and prompts below.
  + Facilitator 1 plays the helper (begins the role-play) and Facilitator 2 plays the person.
    - Person: “Sometimes I go to bed and wish I wouldn’t wake up in the morning.”
    - Helper: “I heard you say that you wish you wouldn’t wake up in the morning. It’s normal to have these feelings when you are dealing with so much stress, and you are very brave for sharing this with me. When someone talks about these feelings, it’s important that I ask some additional questions to make sure that you are safe. I’d like to know if you have ever had thoughts or made any plans to take your life.”
    - Person: “No, I have never thought of that as an option.”
    - Helper: “Okay, so you’ve just told me that you have been having thoughts about not waking up in the morning, but you have no current plans to end your life.”
    - Person: “Yes, I only think like that sometimes, I guess. It is how I feel sometimes.”
    - Helper: “I understand, given all you’ve been going through. Have you ever attempted to take your own life?”
    - Person: “No, I would not do that. It is a sin of God.”
    - Helper: “Okay. So, you sometimes have thoughts about not waking up in the morning, but you do not plan to take your life and have never tried to take your life before?”
    - Person: “Yes, that’s right.”
    - Helper: “Thank you so much for sharing this with me. I want you to know that I might ask you about this again in future, because I really need to know that you are keeping safe. And, of course, you can talk to me about this if your experience changes in any way. In the meantime, I’d like to talk about what we might do if you ever felt that you were at risk of harming yourself or if I was concerned that you might be at risk.”

***Part 2: Group discussion***

* Discuss with the group what they saw.
  + “What was different in this role-play from the last role-play?”
  + “How was the helper being direct?”
  + “How did the helper show a non-judgemental attitude? What kind of questions did the helper use?”
  + “What unhelpful behaviours did the helper successfully avoid?”
    - E.g. giving direct advice, interrupting, lecturing the person.
* Facilitator 2 (the person) can also describe how they felt with Facilitator 1 (the helper).
* List (on a flipchart, sticky notes, blackboard/whiteboard, etc.) the different behaviours that the group identifies.
* Briefly summarise the behaviours, including any additional behaviours that the trainees observed.

## Group activity 1: “What I find most puzzling”

**Instructions:** The facilitators gather information on the trainees’ learning from the previous activities about assessing suicidal behaviour to help answer anything that might be puzzling or difficult to understand or things that need to be clarified.

**Steps:**

* List the key learning points on assessing suicidal behaviour as headers in separate columns, including:
  + Asking about suicidal thoughts and behaviours;
  + Normalizing asking about suicidal thoughts and behaviours;
  + Asking about any plans or attempts at suicide;
  + Asking about previous plans, means and attempts at suicide;
  + Contacting a supervisor or other referral services.
* Ask the group to rank which of these are the most puzzling to them to the least puzzling, particularly HOW to use these skills.
* Go through each item and address what is puzzling or confusing, and demonstrate the skills as needed.

## Group activity 2: Individual pairs practise “helpful” assessment of suicidal behaviour

**Materials needed:** Timer (clock, watch, other) and bell or other alarm for timekeeping.

**Instructions:** This activity has two parts.In pairs, the trainees practise “helpful” skills for the assessment of suicidal behaviour. Then, as a group, they discuss the skills that they have practised, listing helpful and unhelpful skills for assessing suicidal behaviour. *Be sure to explain this process to the trainees as needed.*

**1. Role-play**

* Divide the group into pairs.
* Ask each pair to take a turn playing the helper and the person. Ask the trainees to use the demonstrations performed by the facilitators as an example.
* Each person in the pair should get a chance to practise being a helpful helper.
* Inform the group that you will signal (e.g. with a bell, hand clap, etc.) when the pairs should switch roles *[at 2 minutes]* andwhen the activity is over *[at 4 minutes]*.

**2. Discussion**

* Discuss with the group how they felt as the helper and how they felt as the person.
* Take notes and add relevant suggestions to the table of “helpful” skills for assessing suicidal behaviour at the end of the module.

## Review concept and learning points

**Materials:** Flipchart, sticky notes, blackboard/whiteboard or PowerPoint (PPT) presentation.

**Instructions:**

1. Review why assessing suicidal behaviour is important for health and well-being.
   1. Brainstorm with the group: “What other foundational helping skills should be used when assessing for suicidal behaviour? For example, would we normalise feelings? Would we use empathy and verbal and non-verbal communication? How?”
2. Review helpful and unhelpful ways of assessing suicidal behaviour in the table below. Be sure to add suggestions brainstormed with the group during the module.

|  |  |
| --- | --- |
| **Unhelpful and helpful ways of assessing suicidal behaviour** | |
| **Unhelpful or potentially harmful behaviours** | **Helpful behaviours** |
| * Not asking about self-harm * Lecturing a person and citing religious or legal arguments against self-harm (e.g. “You know this is a sin, or this is against the law”) * Expressing disbelief (e.g. accusing the person of talking about self-harm in order to get attention; stating that others would not actually harm the person or their children) * Encouraging the person not to tell anyone else about self-harm or potential harm to others * [Add other behaviours brainstormed by the trainees here] | * Asking about self-harm or harm to others, or exploring harm if this is raised by the person * Asking about current intent, means or prior attempts * Asking about risk and/or protective factors * [Add other behaviours brainstormed by the trainees here] |

1. Refer to additional resources, including the WHO online course, “Assessing and Supporting People with Suicidal Behaviours” <https://whoequipremote.org/en-gb/node/903?category=1672>

**Brief Role Play for Module 4** – Assessing suicidal behavior and promoting safety

* Module 4 Role Play
* ENACT Scoring Template: Assessing risk of harm

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**Overview:** Trainees will work again in pairs, this time to show facilitators their “helpful” skills assessing risk of harm and promoting safety. During the role plays, facilitators observe (e.g., walk around the room, join ‘break out’ rooms) and rate trainees on the ENACT item #7.

**Materials needed:** Timer (clock, watch, other) and bell and/or other alarm for timekeeping. The two facilitators will need to use the ENACT rating tool for Items #6 (assessing harm and promoting safety) to rate each trainee. This can be done on the EQUIP digital platform (which can be used to view score summaries and review of helpful and unhelpful behaviours at the group level) or on paper copies of ENACT. (See the scoring form for competencies #7 reproduced below.)

**Instructions**:

1. The facilitators explain to the group how this practice exercise strengthens their learning and gives facilitators feedback on their strengths.

**For example**: **“**Now we will practise helpful behaviours. To bring together our learning from this session, in this role play, you will practise your skills to assess risk of harm and promote safety. While you all are practising, we (the facilitators) will be walking around to see your skills in action. We will be taking some notes to give you all feedback on how to improve how you assess risk of harm and promote safety.”

1. Divide the group into pairs. If possible, change the pairs so trainees can work with someone new.
2. Ask each member of the pair to take turns, with one playing the helper and the other the person, and then they switch. Tell the group that each role play should be about 5 minutes.
3. Make sure that each person gets a chance to practise being a “helpful” helper.
4. Share the specific instructions with the group. These role-play instructions can be provided on a PowerPoint slide, written on a white board, or given as paper handouts to trainees:

This role play takes place after the helper and person being helped have already met, done introductions, and explained confidentiality. The helper and person being helped already know each other’s names and what they preferred to be called.

Instructions to the **person being helped**: When the helper asks how you have been feeling lately, you should reply “*There are some nights when I go to bed and I wish I wouldn’t wake up in the morning*,” or “*Sometimes I think my family would be better off if I weren’t alive.”*

Instructions to **helper**: Introduce yourself and ask the person what they would like to be called. Then ask them, “*Tell me more about how you are feeling these days.”* Use your skills to assess risk of self-harm and promote the person’s safety.

1. The facilitators walk around the room to observe the pairs as they practise. While observing, facilitators rate ENACT item #7 as trainees act as the helper. Observe each trainee for about 3-4 minutes to identify what helpful and unhelpful assessing risk and promoting safety skills are displayed. The full role play does not need to be observed.

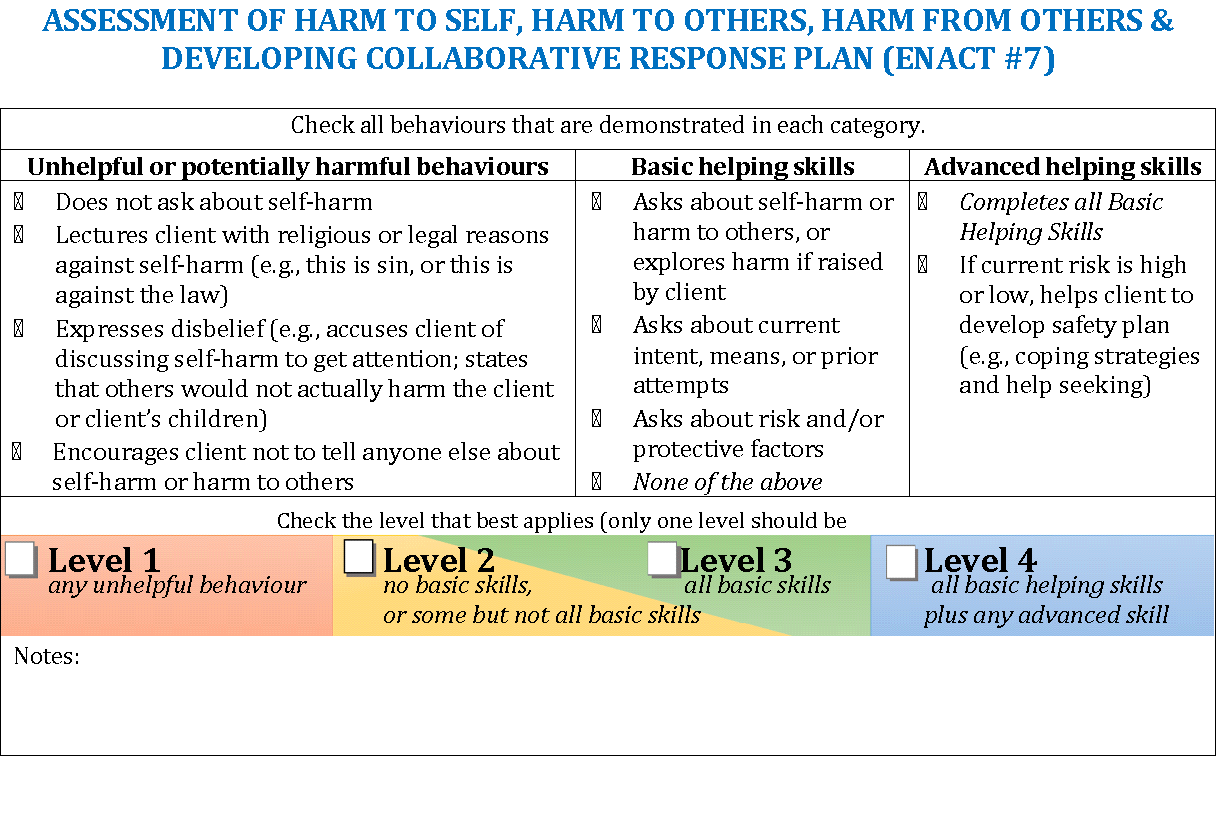
Key behaviours to record on the ENACT form are:

* Does the helper ask about thoughts or plans of suicide or other self-harm?
* Does the helper ask about any prior thoughts or acts of self-harm?
* Does the helper ask about access to means of self-harm (pesticide, guns, etc.)?
* Does the helper develop a safety plan about who can be contacted if these feelings worsen?

Behaviours that may be harmful should also be recorded on the ENACT form:

* Does the helper minimise the thoughts about self-harm (e.g., you shouldn’t feel that way, you have a lot to live for)?
* Does the helper lecture the person in distress (e.g., you know it is a sin, or it is illegal, to try to kill yourself)?

1. After all trainees have been observed and rated by one of the facilitators, the facilitators should thank the trainees for doing the role plays. General feedback on some of the helpful behaviours observed can be shared. Facilitators can conduct a full review of the competency ratings in the evening after the first day’s training is completed, then more specific feedback provided on the morning of day 2.



# **Mid-Training Module**: “Could help, should help and ready to help” - A reflection on attitudes and preparedness to help others

**Mid-Training Reflection on Attitudes and Preparedness to Help Others**

*Note: This module is beneficial at the mid-point of the training to reflect on skills learned and discuss willingness and readiness to help others. Attitudes and readiness towards helping others influences all foundational helping skills and supports trainees in reaching their competency goals.*

*This module does not include a competency assessment. It is intended to support helpers in thinking through their motivation, readiness to empathise, and how their well-being affects their competency to help others.*

**Attitudes Module**: Attitudes toward helping others: “Could help, should help, ready to help”

1. Objective 1: Describe what it means to have ‘attitudes’ towards helping and why it is important to notice these attitudes
2. Objective 2: Identify three common attitudes towards helping and how they can affect your foundational helping skills
3. Objective 3: List three questions that should be answered before using your foundational helping skills to help others

# Attitudes toward helping others: “could help, should help and ready to help”

This module covers the following:

* How do our attitudes towards helping affect how we help others?
* How does connecting our attitudes and behaviours strengthen our foundational helping skills and help us to help others?

**Structure of the module:**

**Module overview** (15 minutes)

**Session 1: “Could help”**

* + Introducing the concept of “could help”
  + Exercise 1: Case study on brainstorming barriers to and enablers of “could help” behaviours

**Session 2: “Should help”**

* + Introducing the concept of “should help”
  + Exercise 2: Brainstorming a positive “should help” attitude for facilitators

**Session 3: “Ready to help”**

* + Introducing the concept of “ready to help”
  + Group activity 1: Facilitators practise “ready to help” skills using relaxation exercise
  + Exercise 3: Practice activity for “could help, should help and ready to help”
  + Review concept

## Module overview

**Timing:** 15 minutes

***Note: Below is a sample text to cover the concepts and points above. Facilitators may adapt the language to the context as necessary, but must ensure that the points are adequately covered.***

###### How do our attitudes towards helping affect how we help others?

So far, the modules in this foundational helping skills training course have focused mostly on how we can best communicate with others in a helping way. A very important aspect of communicating with others is how **we feel about helping** others.

* How we feel affects the way we react to others. Empathy is a natural human process, but there are times when our bodies and brains are more likely to feel and respond with empathy.
* In certain circumstances, the natural processes of empathy can be blocked. For example, when we feel threatened, anxious, worried, afraid or angry, we are less likely to feel empathy. This lack of empathy, or “blocked empathy”, can be apparent when working with people.
* “Blocked empathy” or “lack of empathy” can be seen by others in our verbal and non-verbal communication. It can block our ability to understand the other person’s feelings, and it changes the way that we ask certain types of questions, as well as how we react and respond to the people we are helping and to others around us.

**How does connecting our attitudes and behaviours strengthen our foundational helping skills and help us to help others?**

In this module, we will explore three ideas that help to loosen any blockage and facilitate the flow of empathy: these are “**could help, should help and ready to help**”.

* **Could help** is when you feel that you are able to support someone with their problem or difficulty. The opposite of “could help” is the feeling that you cannot do anything for the person.
* **Should help** is the mindset that the person you are working with is someone who deserves your energy and attention as a helper, and that your professional and/or personal goals include supporting this person.
* **Ready to help** refers to when you feel that you can and should help this person *now*, during your interaction with them.
  + Sometimes we might feel that we can and should help, but at that moment we are not able to, either for professional or personal reasons.
  + Therefore, it is important to foster a feeling of “ready to help”, so that we have the best results when we interact with people.

If we think of empathy as water flowing through a network of irrigation channels to water a dry field, then these three areas are possible blockages in the system which mean that the field will stay dry. We need to remove each of the barriers at least partly for the water to flow in.

## Session 1: Could help

## Introducing the concept of “could help’

**Timing:** 15 minutes

**What does “could help” mean?**

As people in helping roles (as social workers, health workers, teachers, NGO workers, etc.), our empathy can be affected by whether we feel that we CAN HELP someone, as opposed to feeling that we cannot help them. If someone comes to us with an overwhelming problem and we don’t know how we can be helpful, this will have an impact, or block, on our empathy. There are numerous situations or reasons that might make us feel that we cannot help a person:

*[Note to facilitator: write summary versions of the points below on a flipchart, sticky notes, blackboard/whiteboard, etc. for the trainees to see.]*

* We feel that the problem is not something we can do anything about (e.g. giving someone a job, getting them out of a violent situation, curing their child’s illness).
  + This is especially important for certain types of health problems that we might view as untreatable, such as a severe mental illness, cancer or other serious condition.
* We don’t have enough time to provide all the help that the person might need (e.g. because of the other people we are working with, we might not feel that we can spend the time needed to listen to everything the person needs to share).
* We don’t have the tools or materials needed to help in our professional role (e.g. a health worker lacks the appropriate medications; a social worker lacks vouchers or insurance supports; a teacher lacks materials for a student).

## Exercise : When we are able vs. unable to help someone

**Timing:** 15 minutes

**Group free-listing** : Ask the trainees to come up with a list of other circumstances or instances in which they might feel that they are unable to help.

**How to turn “can’t help” in “could help”**

At times when you might feel that you can’t help someone, there are usually a few things you can do to modify the situation.

* *Think of what you can accomplish:*
  + One of the most important things is setting a goal for yourself of something that is achievable. If your expectation for the person you are working with is that you are going to cure their cancer or take away their grief about the death of a loved one, you are setting yourself up for failure. It is important to think about what goal you might realistically be able to accomplish and to have this goal in mind for yourself. You are more likely to engage if you can come up with something that can be done, even if your only goal is to give the person some time to discuss their experience.
* *Collaborate with the person on what can be accomplished:* 
  + Coming up with something in your own mind about what can realistically be done is very helpful. It is even better to mutually come up with a realistic goal with the person.
    - For example, the person’s goal might be “I want to find a job”.
      * As a helper, you won’t be able to do that for them, but what might be something that you and the person could accomplish in that session?
      * This is about finding a goal that is a step on the path to the person’s larger goal.
      * It is also about finding an answer to the question, “What can we accomplish, now, today, together?”
    - Note: We will look further at creating realistic goals in a later module.
* *Remember to provide a space for listening:* 
  + Listening and giving a person time to share is helpful for their mind and body when they are distressed. One of the most important lessons from the foundational helping skills curriculum is that empathic listening is in and of itself a form of healing.
    - When we feel that we are being listened to, connected with and understood by others, this not only feels good psychologically but it has important effects on the body.
    - When we feel heard, pain feels less acute; even inflammation in the body goes down and our immune system gets stronger. Therefore, even if the only thing we do is provide a space to listen, it still means that we “can do” something.
* *Have the resources in place to support people:* 
  + Another important part of feeling that you can help someone is to have the resources in place to provide help.
    - Do you have the information to refer them to a physical or mental health specialist if that is what they need?
    - Do you have a physical space for a confidential conversation?
    - If you are a health worker and you identify a health problem, do you have the materials available for a medical test or do you have the medications needed?
    - For example, consider when you are asking about suicidal behaviour . If you feel that you can’t help someone, you probably won’t ask about what is troubling them. But if you know that there are people and resources you could connect the person with, then you will feel more confident about helping, and more likely to ask them.

## Exercise: Case study – brainstorming barriers to and enablers of “could help” behaviours

**Timing:** 15 minutes

*Facilitators: Review the case study with the group. Ask them to brainstorm 1–2 answers for each of the questions following the scenario below.*

**Scenario:** Arturo has come to see health worker Juan because he needs medication for his diabetes. When Juan asks Arturo how he is doing, Arturo says that he is unhappy that he does not earn enough money in his current job to send his children to a boarding school. He feels that he has failed his children and his family. He tells Juan that all he wants in life right now is to find another job. He asks if Juan can help him get a job in the clinic because he has heard that they pay a lot of money.

How do you think Juan is feeling about Arturo right now?

What are some things that Juan could think about that he could realistically do to help Juan at this moment?

How could Juan talk to Arturo about coming up with a collaborative goal for something realistic that they could accomplish together?

## Session 2: Should help

## Introducing the concept of “should help”

**Timing:** 15 minutes

**What does “should help” mean?**

The next thing that is important to consider about empathy is the feeling that we should help someone else. There are times when maybe we feel that we *could* help someone but that we should not help them.

* In the scenario above involving Juan and Arturo, Juan might feel that he shouldn’t help Arturo because he thinks Arturo will just drink away any job he gets, or that his own reputation will suffer if he recommends Arturo for a job with someone else.
* In the helping professions, there are many different reasons why we might feel that we should not help someone. For example, we might blame the problem on the individual, we might think that they won’t appreciate or make use of the help we give them, or we might think that helping them will take something away from other people who deserve help more. All of these thoughts have an impact on the flow of empathy in our minds and bodies.

**Common reasons why we might feel that we shouldn’t help a person or patient**

* *We blame the person for the problem:* 
  + Sometimes we might blame a person for their own problem, and this can reduce our empathy towards them. For example, if someone has a health problem due to smoking, drinking alcohol or using drugs, we might not feel that we should help them because they caused the problem themselves.
* *We don’t think the person will listen to our advice:* 
  + Sometimes we might feel that a person will not listen to our advice or follow our instructions, so we think that we shouldn’t bother helping them.
* *We think that others will disapprove of us for helping the person:* 
  + Sometimes our work colleagues, family members or members of our community might disapprove of us for helping certain types of people, so we think that we shouldn’t help them.
  + This might be because they have a disease that is considered contagious, or maybe colleagues would disapprove if you helped a person with a mental illness, or a person with a particular sexual orientation, religious background, etc.
* *We see this person as disrupting our regular work:*
  + Sometimes we feel that we shouldn’t help a person because this might take time away from the other duties we need to perform.
  + This can happen with people who have mental health problems, because others might stereotype them as taking up a lot of time. Or, when working with an immigrant or person who doesn’t speak the same language, it might feel like this is going to disrupt other activities that need to be done.
* *We think that this person is someone else’s responsibility:*
  + Sometimes we might feel that the person in need of help isn’t our responsibility. We might think that they can only be helped by a specialist, or that a social worker should handle the problem, or it is the family’s responsibility. In these instances, we might feel that we shouldn’t help.
* *Suicidal thoughts:*
  + Suicidal thoughts and behaviours can be an area where we think that we shouldn’t help someone. For example, we might think that talking about the person’s situation will make it worse. Or we might think that suicide is a crime, and that the police should handle the situation, or that it is the duty of a religious leader to counsel the person. If we have heard these things before, we might feel that we should not help. However, everyone can make a helpful difference by asking someone if they are having suicidal thoughts or feelings and referring them to get help. See Module 4 for more information on asking about suicidal thoughts and feelings.

## Exercise 2: Turning “shouldn’t help” into “should help” behaviours

**Timing:** 15 minutes

**Instructions:** This activity has two parts:

1. The facilitator first leads a brainstorming activity with the group.
2. They then summarise the key points listed below.

**Part 1: Group brainstorming**

How do we counter the feeling that we shouldn’t help someone?

As a group, brainstorm some ideas about how we can counter feelings that we shouldn’t help. What are some ways in which we can turn “shouldn’t help” into “should help”?

**Part 2: How to turn “shouldn’t help” into “should help”**

Following on from the ideas discussed during the brainstorming session, there are some key things to keep in mind in order to counter the idea that we shouldn’t help. These suggestions are like shovels that help us to clean out the blockages in the irrigation channels.

**Key point 1: We must try to remember that we never know all the details of a person’s life.**

* We might blame a person for their health problem, but we can never know everything about the circumstances that contributed to their situation and what is in their control or what is beyond it.
* We should realise that if they have come to ask for help, then that is the first sign of wanting to change. We can play a major role in helping someone with that change.

**Key point 2: We can think of ways to change the circumstances so we can create the best possibility of helping someone.**

* When we feel that we shouldn’t help because we have more important things to do or that helping them will be disruptive, we can think about ways to change the circumstances to create the best possibility of helping someone.
  + For example, if a person needs more time, you can try to schedule them at times that will be less disruptive to other activities, or you can schedule more time in advance so that this doesn’t interfere with your other duties.

**Key point 3: We can create opportunities to have a conversation about what it means as an organisation to help everyone.**

* Finally, if you feel that colleagues, supervisors or others might disapprove of you helping someone, it creates an important opportunity to have a conversation about what it means as an organisation to help everyone.
* Sometimes such conversations are difficult to have with supervisors, and it can be important to identify resources and allies. Increasingly, there are advocacy organisations for different groups of people, and these can be good places to start talking about how to address these issues in your organisation.
  + For example, there are advocacy organizations for people with mental illness, people living with HIV and survivors of gender-based violence (GBV) and of political torture and sex trafficking, to name just a few groups who are commonly discriminated against.

## Session 3: Ready to help

## Introducing the concept of “ready to help”

**Timing:** 15 minutes

**What does “ready to help” mean?**

The final blockage in our irrigation channels is whether or not we are ready to help.

* When we don’t feel emotionally ready to help, this also blocks the flow of empathy.
* The most common reason that we don’t feel ready to help is because of our own emotions.
* When we feel anxious, worried, afraid or angry, it is often hard to recognize and feel the emotions of the people we are working with. Therefore, it is important to recognize our emotional state and use skills to address our emotions before we engage with a person.

**There are a number of ways to manage our own emotions to help us feel ready to engage.**

* *Identifying our own emotions:*
  + Before working with people, we should take a moment to recognize what we are feeling and to be aware of that. This can be a brief check-in with yourself, or something more advanced such as practising mindfulness.
  + There are various types of courses to teach health workers and other helpers to use mindfulness to improve their helping skills.
* *Using relaxation exercises:*
  + When we are feeling strong emotions, we can do some exercises such as deep breathing, progressive muscle relaxation or positive visual imagery to calm and focus ourselves.
* *Sharing with colleagues:*
  + When we have difficult experiences with the people we are working with or in our professional lives, it can be quite helpful to share regularly with colleagues. This includes activities such as debriefing, supportive supervision, peer supervision and other staff support. Setting up a regular time to share difficulties with colleagues can help us to feel ready to help again and prevent burnout.
* *Prioritising self-care:*
  + If we don’t take care of ourselves, it is very difficult to help others. Therefore, engaging in regular self-care is very important. This can include things such as making sure you get adequate sleep, have a good diet, take exercise and do things that are meaningful to you, such as time with family, religious or spiritual activities, sport clubs, etc.

## Group activity 3: Relaxation exercise

**Timing:** 20 minutes

***Relaxation exercise***

At this point the facilitator should lead the group in a brief relaxation exercise of their choosing.

This could be the **deep breathing exercise from Problem Management Plus** or another breathing exercise. It could be a progressive muscle relaxation exercise or visualisation. It can be any activity that the facilitator has experience doing, and it should be something that the trainees can then do on their own in the future.

**Note:** Be sure that trainees are not required to close their eyes in any activity because this can feel unsafe for some people. You can always give the option of “close your eyes if you would like to”, but don’t require that participants do so.

## Session 4: Practice activity “could help, should help and ready to help”

**Timing:** 15 minutes

The final part of this module involves doing a practice exercise to demonstrate the importance of “could help, should help and ready to help” for our empathy and ability to help others.

**Instructions:** This activity has two parts:

1. In the first part, trainees pair up and demonstrate “could help, should help and ready to help” in role-play activities. The purpose is to have the trainees experience the feelings and behaviours of a helper who is not ready to help and feels that they could not and should not help. In this way, trainees will most effectively understand the process of using the steps to “could help, should help and ready to help” in the second role-play.
2. In the second part, the facilitator guides a group discussion and summarises learnings.

**1: Practising “could help, should help and ready to help” using role-plays**

**Note:** Facilitators have the optionto **first demonstrate the role-play**. It might be helpful for the trainees to see the facilitators demonstrate “couldn’t help or shouldn’t help”, while possibly exaggerating some of the aspects, so that they can loosen up while also understanding the importance of addressing occasions when we feel that we cannot or should not help others.

* First, have the group pair up.

**First role-play:**

* We will go back to the story of Arturo and Juan *[feel free to change the names and gender of the characters as needed for your activity]*.
* One person in the pair plays Arturo, who is coming in to get his diabetes medicine, and Juan is a health worker.

🡪 If you are playing Arturo, you should tell Juan about your problem of not making enough money and needing another job, and then ask Juan for a job in the clinic.

🡪 For those of you playing Juan, here are some things to consider:

* You just had a difficult time with another person whose father was blaming you for his son not getting better **(not ready to help)**.
* You are in a public consultation space **(could not help)**.
* You have only 5 minutes before you need to be at a meeting with your supervisor **(could not help)**.
* You also think that Arturo is lazy and won’t work hard even if he gets a new job **(should not help)**.
* You remember you heard a story that Arturo once gave a lot of his money to his brother to buy a shop, even though everyone said it was a bad investment **(should not and could not help)**.

**Second role-play:**

* The same person plays Arturo and the same person plays Juan again, but this time things will be a little different.

🡪 For those playing Juan, consider these new points:

* You just had a difficult time with another person. But right after that, you took a moment to take five deep breaths (do the five deep breaths now) **(Juan is preparing to be ready to help)**.
* You are in a public consultation space, but you have the option of going to a private room across the hall **(could help)**.
* You have only 5 minutes, but your supervisor has told you that if you need extra time with a person you can have it, and he can meet you later if necessary **(could help)**.
* When Arturo asks you about the job, you know that you can’t give him a job but you could still be helpful by hearing more about how he is doing **(should help)**.
* You want to find something that you and Arturo could focus on together in your discussion – you know it won’t get him a job immediately, but maybe it will help him on the path to that goal **(could help)**.

**2: Group discussion and summary of learning**

***Group discussion:*** *Discuss these experiences with the group. Use the following discussion points:*

* For the people playing Arturo, what did you notice was different about how Juan interacted with you in the two scenarios?
* For the people playing Juan, in what ways did your body feel different between the two scenarios? How were your emotions different between the two scenarios? How was your response to Arturo different?

***Summary of learning***

Facilitators review what has been learned:

“Our attitudes are just as important as our skills when we are helping people. We can know all of the skills needed, but sometimes we might not show those skills because of how we are feeling and the circumstances of the situation. Paying attention to our attitudes can help to make our skills shine through – just like clearing rocks out of an irrigation channel and letting the water flow into a dry field.”

**We should always ask ourselves three questions:**

* **Do I feel that I could help this person?**
  + If not, what can I change about my expectations and/or the circumstances so that I feel that I could help?
* **Do I feel that I should help this person?** 
  + If not, what is stopping me? What could I do to change my feelings or the circumstances so I feel that I should help them?
* **Do I feel ready to help them?**
  + If not, what could I do to prepare myself so that I am ready to help them?

**Reminder to trainees:** Throughout this training, during your role-plays with the facilitator and evaluators, take a few moments to prepare yourself so that you feel that you could help the person, that you should help them, and that you are ready to help them.

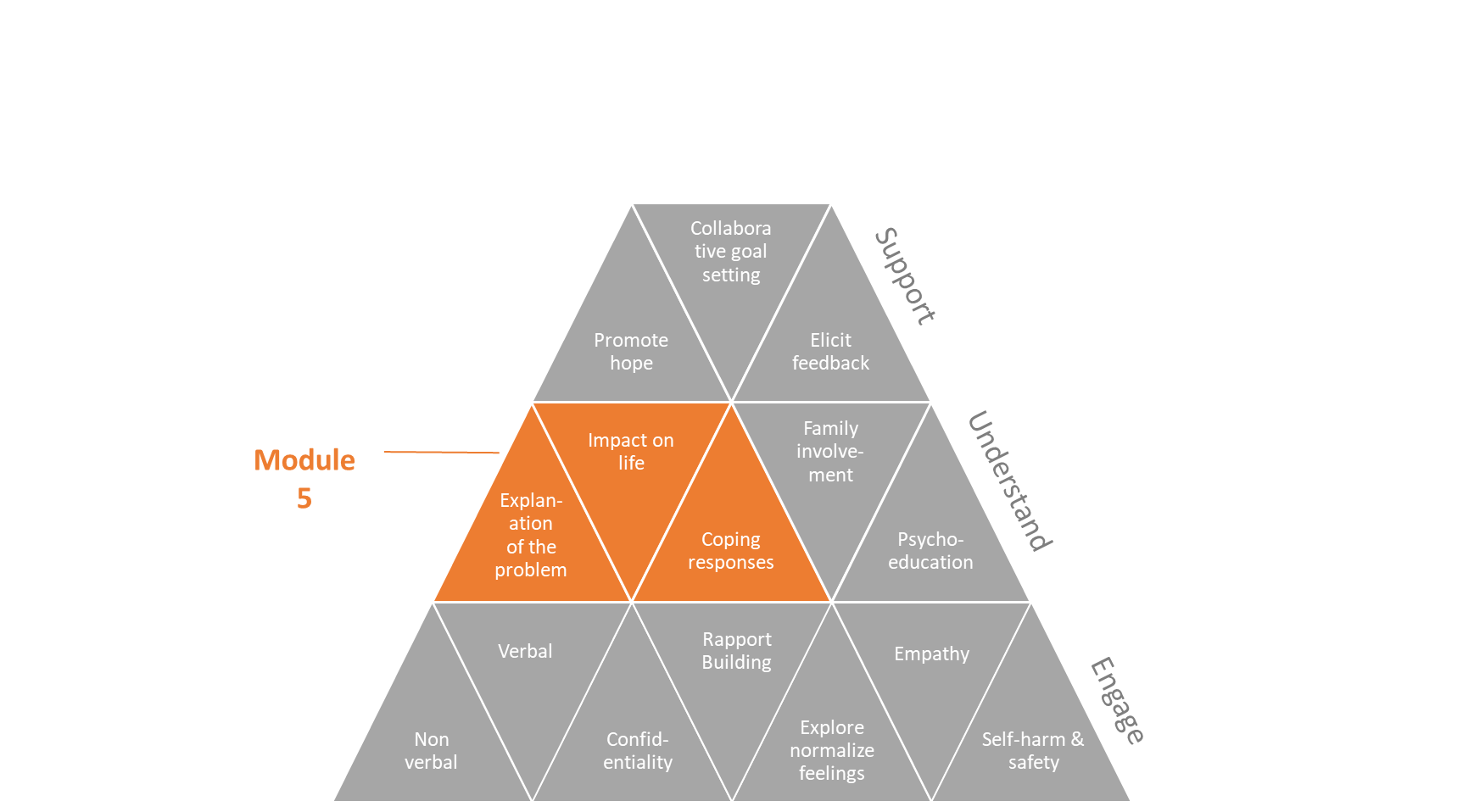
**[Session ends]**

There is no role play for this *Attitudes Toward Helping* module. The purpose of this module was to reflect on when and why we may feel ready to help others and when we may not feel in a situation to help. When we reflect on ‘could, should, and ready’, it will help us to identify when we can best empathise with others and support them. The ‘could, should, and ready’ is a good quick check-in with yourself when preparing to help others.

# Foundational helping skills: Tier 2 - UNDERSTANDING

# **Module 5**: Explanation of the problem (perceived cause of the problem), impact on life (social functioning), and prior coping (ENACT #8, 13)

* 1. Objective 1: Describe the importance of understanding a person’s explanation of the problem (e.g., what they believe caused the problem), impact on life (connection to social functioning), and importance of promoting prior helpful coping skills.
  2. Objective 2: Identify how to ask a person about their explanation of what caused the problem; how to connect psychosocial distress impacts daily life; and identifying and supporting positive prior or current coping skills
  3. Objective 3: Distinguish between helpful and unhelpful behaviours for assessing for understanding a person’s explanation of the problem, connecting to functioning, and supporting positive prior coping



**This module covers the following**:

* What is an explanatory model?
* What is the impact on life of psychosocial problems?
* How do positive and negative coping responses impact psychosocial distress?

**Structure of module:**

* Introducing the concept [5 minutes]
* Group Activity 1: “What is it, why is it helpful and what could go wrong?” [20 minutes]
* Exercise 1: Facilitators demonstrate “unhelpful” explanatory models, impact on life, and coping strategies [20 minutes]
* Exercise 2: Distinguishing helpful and unhelpful skills to discuss the person’s explanation of what caused the problem, impact on daily life, and coping skills [10 min]
* Review concept and learning points [10 minutes]

**Materials (**Optional) Facilitators may use the “Unhelpful and helpful” table of behaviours at the end of each module as a handout for trainees.

**Instructions:** One facilitator introduces the concept, and then both facilitators deliver activities following this introduction. Facilitators take notes on the brainstorming activities and add suggestions to the table of helpful and unhelpful explanatory models at the end of this module.

* The facilitator tells trainees: “In the following activities, you will be brainstorming some different ideas. I will add the behaviours you identify to our list of explanatory models, impact on daily life, and coping strategies.”

## Introducing the concept [5 min]

***Note: Below is a sample text to cover the concepts and points above. Facilitators may adapt the language to the context as necessary, but must ensure that the points are adequately covered.***

###### **What are explanatory models, and why are they helpful?**

Explanatory models help us to understand a person’s perspective on their problems. To get to know the person and their needs, it is important to see their problems from their point of view.

Ask the person to explain what they think is causing their problems or symptoms (e.g. “What do you believe caused these problems? What do you think is causing your headaches and sleeplessness?”).

It is also helpful to understand perspectives of the person’s family members or of other people close to them. For example, ask the person if a family member agrees with their explanation or whether they have a different point of view.

###### **What is the connection between psychosocial distress and impact on daily life?**

Psychosocial, psychological, and mental health problems can lead to negative impacts on daily life. For example psychosocial distress such as withdrawal, irritability, and anxiety can negatively impact social relationships. When a person is feeling hopeless and has low motivation, this can lead to poor performance in work and school. If a person becomes very tired and has no energy for daily activities, they may stop engaging in personal grooming and other self-care.

###### **What are coping strategies?**

When people experience psychosocial distress, psychological difficulties, or mental health problems, they respond in a number of ways. Sometimes, we engage in positive coping, such as doing activities that will improve our physical and mental health (exercise), or we talk to supportive people in our lives, or we come up with small steps to tackle a problem. We may also engage in harmful or negative coping. This can include using drugs or alcohol to deal with stress, taking risks that put our physical well being or financial security in jeopardy, or engaging in social media that makes us feel worse about ourselves (Instagram, Facebook, TikTok, etc.).

## Group Activity 1: “What is it, why is it helpful and what could go wrong?”

**Timing:** 20 minutes

**Instructions:** This activity helps trainees to understand the concepts above by summarising what they have learned about explanatory models, impact on life, and coping strategies. The activity has three parts: 1. divide the trainees into three groups; 2. have groups present; 3. The facilitator reviews the concept of explanatory models.

***1: Divide the trainees into three groups***

Facilitators divide the trainees into three groups, labelling them Group 1, Group 2 and Group 3. Then they assign the following tasks:

1. Group 1 should prepare a list of key points from the overview of explanatory models above. Then create a list of ways in which they might use explanatory models when working with a person in their respective work or experiences. Finally, create a list of “what might go wrong” if they do not use explanatory models when working with a person. Group 1 can think of how things could go wrong for both the person and the helper.
2. Group 2 should prepare a list of key points from the overview of impact on daily life above. Then create a list of ways in which they might discuss impact on daily life when working with a person in their respective work or experiences. Finally, create a list of “what might go wrong” if they do not explore impact on daily life with a person. Group 2 can think of how things could go wrong for both the person and the helper.
3. Group 3 should prepare a list of key points from the overview of coping strategies. Then create a list of ways in which they might discuss coping strategies when working with a person in their respective work or experiences. Finally, create a list of “what might go wrong” if they do not appropriately address coping strategies when working with a person. Group 3 can think of how things could go wrong for both the person and the helper.

***2: Group presentations***

Bring the three groups back together to present their lists. Remind trainees that there are no right or wrong answers; this is a brainstorming session. After Group 1 presents, check with the other groups to see if they want to add anything to the list. Repeat this process for Groups 2 and 3.

As groups are presenting, the facilitators should be listing (on a flipchart, sticky notes, blackboard/whiteboard, etc.) the different behaviours the trainees point out. Facilitators may also refer to the table of unhelpful and helpful behaviours at the end of this module.

***3:* *Facilitators summarise the concept of explanatory models, impact on daily life, and coping strategies***

The facilitators may summarise the initial didactic in this module and can include additional information that the groups brought up during the activity.

## Exercise 1: Facilitators demonstrate “unhelpful” explanatory models, impact on life, and coping strategies

**Timing:** 20 minutes

**Instructions:** This demonstration of unhelpful behaviours will support learning while also offering an ice-breaker activity to help the trainees loosen up. Enjoy!

This activity has two parts. The facilitators demonstrate what might go wrong when a helper uses “unhelpful” explanatory models, impact on life, and coping strategies. The group then discusses the behaviours the facilitators have demonstrated (and others suggested by the trainees), with discussion prompts and a short quiz. Suggestions can be added to the table of unhelpful or potentially harmful behaviours for explanatory models, impact on life, and coping strategies at the end of the module. *Be sure to explain this process to the trainees.*

**1: Demonstration, outline of concepts and sample prompts**

Facilitators may refer to the sample recordings provided with these materials and adapt them to the context and setting.

1. The demonstration takes 2–3 minutes. The facilitators use the description and prompts below.
   * Facilitator 1 plays the helper.
   * Facilitator 2 plays the person (and begins the demonstration).
     + Facilitator 2 (person): “ I’m tired and my shoulders and neck are feeling so painful. I often have to stay in bed in the morning. Everynight, I stay up all night worrying.”
     + Facilitator 1 (helper): “I know this is all caused by the diseases anxiety and depression. You will need treatment for these conditions if you ever want to get a job again. Tell me, what does your mother think caused these pains and problems sleeping?”
     + Person: “My mother is angry with me. She says I drink too much coffee and I do not pray enough to get a job.”
     + Helper: “Your mother is a smart woman and knows what is best for you. I will treat your anxiety and depression, and you must also listen to your mother.”
     + Person: “Okay.”
     + Helper: “Don’t you know that if you don’t get help, this will have all kinds of awful impacts on you and your family. These types of conditions make it so that you can’t ever care for yourself, you can’t care for others, you are basically a worthless human being. So you must start treatment immediately.”
     + Person: “You make it sound awful and scary.”
     + Helper: “Well is there anything that you are doing now to stop it?”
     + Person: “Well, I go for long walks when I feel stressed and that clears my head and calms me down.”
     + Helper: “Well, a long walk never cured depression. You know what I recommend – you should have a few drinks at night to help you sleep. Until you get started on medicine, a few glasses of wine will do the trick to get your sleeping fixed up.”
     + Person: “Ah okay.”

**2: Group discussion and short quiz**

* Discuss with the group what they saw:
  + “Thinking about what we’ve learned so far, did the helper identify the person’s explanation for the problem? Did the helper do it in a helpful or unhelpful way? Why?”
  + “Did the helper use explanatory models with the person?”
  + “Did the helper discuss with the person in a helpful way to see the impact on their daily life?”
  + “Did the helper encourage positive coping and discourage negative coping?”
* Short quiz with the group:[[5]](#footnote-5)

1. “Which of the following was the helper missing when doing explanatory models?”
   1. The helper didn’t give the person her/his opinion on what has caused the problems.
   2. The helper didn’t ask what the person’s explanation for the problems was.
   3. The helper didn’t ask if the person agreed with their mother.
   4. Both ‘b’ and ‘c’
2. “Which of the following was the helper missing when doing connection to daily functioning?”
   1. The helper forgot to ask what impacts the person observed.
   2. The helper did not ask about what impacts others in the person’s life observed.
   3. The helper forgot to tell the person depression and anxiety only impact daily life if the person is weak and doesn’t try hard.
   4. Both ‘a’ and ‘b’
3. “Which of the following did the helper do when discussing coping strategies?”
   1. The helper asked about what coping strategies were used.
   2. The helper forgot to ask about any potential negative coping strategies that the person wants to reduce doing.
   3. The helper forgot to ask about other coping strategies that person used in similar situations in the past.
   4. All of the above

* List (on a flipchart, sticky notes, blackboard/whiteboard, etc.) the discussion points agreed upon and answers to the short quiz.
* Briefly summarise the behaviours demonstrated by the facilitators, along with any that were brainstormed by the trainees.
  + For example: technical language, stigmatising language, ignoring the person’s explanation of the problem, not clearly explaining mental health problems or treatment/programme, going along with a family member’s potentially harmful explanation of the problem, etc.

## Exercise 2: Distinguishing helpful and unhelpful skills to discuss the person’s explanation of what caused the problem, impact on daily life, and coping skills [10 min]

**Instructions:** This activity follows on from the previous demonstration, but this time using helpful behaviours. It has two parts: 1. the facilitators demonstrate “helpful” discussion of explanatory models, and 2. The group discusses the behaviours the facilitators have demonstrated (and others suggested by trainees), using the discussion prompts. The facilitators add suggestions to the list of helpful behaviours for explanatory models, impact on daily life, and coping skills at the end of the module. *Be sure to explain this process to the trainees.*

***1: Demonstration, outline of concepts and sample prompts [3–5 min]***

Facilitators may refer to the sample recordings provided with these materials and adapt them to the context and setting.

1. The demonstration takes 3–5 minutes. The facilitators use the description and prompts below.
   1. Facilitator 1 plays the helper.
   2. Facilitator 2 plays the person (and begins the demonstration).

* Facilitator 2 (person): “It has been two months and I cannot find a full-time job. I’m tired and my shoulders and neck are feeling so painful. I often have to stay in bed in the morning. By the time I have any energy, it is night-time and no jobs are open for me to apply to. Then I stay up all night worrying.”
* Facilitator 1 (helper): “I see. What do you think is causing your shoulders and neck to hurt?”
* Person: “I don't know, I think I am getting old and my body doesn’t work well anymore.”
* Helper: “Mhm, I see. And you said you are close with your mother, what does she think is causing the problems?”
* Person: “My mother thinks I drink too much coffee and I do not pray enough.”
* Helper: “Hmm, I see. It sounds like you are feeling worried about not finding a job, and your tiredness and painful back are keeping you from getting out of bed in the morning, and that this started or got worse after not being able to find a job.”
* Person: “Yes, yeah that is how it has been going.”
* Helper: “But your mom sees it differently and it sounds like she thinks if you drank less coffee or prayed more, the sleep problems and pain would go away. So maybe you two see this differently? Or is there anything similar about how you and your mom see the problem?”
* Person: “Hmm. Well, yeah, I think she knows not having a job has been hard on me. So I guess she thinks about it similarly to me in that way. And, maybe she’s right that I am drinking too much coffee while I'm home all day worrying.”
* Helper: “That sounds like there are some ways that you and your mom share an understanding of this difficult time.”
* Person: “Yeah, but praying isn’t going to get me another job. That’s not my thing.”
* Helper: “Is there a way that you could talk to your mom about this?”
* Person: “I guess I could tell her that it bothers me that she just tells me to stop drinking coffee and pray more, and tell her that I am really worried about getting a job, and I would like her to acknowledge that. I could ask her to stop telling me to pray all the time because it won’t get me a job. Also, I could tell her she’s right that I am drinking too much coffee, and I will try to cut down.”
* Helper: “Let’s see how she reacts when you share that, when you feel comfortable doing that.”
* Person: “Ok”
* Helper: “I was wondering what impacts you have seen on your daily life when you are worrying a lot?”
* Person: “Well the biggest thing is that I don’t sleep, then I am all irritable during the day and get upset easily with my family members?”
* Helper: “Any impacts on your professional life, such as your current job search.”
* Person: “Yeah, when I am tired, I give up so quickly searching for jobs on the internet. I end up just scrolling through Instagram and TikTok and seeing all my successful and happy friends. I feel the worst about my life whenever I spend time on Instagram and TikTok.”
* Helper: “Yes, lots of time spent on Instragram, TikTok, and social media can leave us feeling bad about ourselves. I wonder if there are things that you do that you find helpful and make you feel better?”
* Person: “Well, even if I just go for a walk for half an hour, I find that I feel a little better about things. It clears my head and then I can come back and do job searches again.”
* Helper: “Is there anything you could do to replace Instagram and TikTok with more walking because you find that helpful, and it is good for your physical health too.”
* Person: “Maybe I can fix a time with one of my friends to go for a walk together. That will then be some peer pressure to get me out of the house and off social media. My friend yells at me whenever I pull out my mobile when we are together, so I think she is a good influence.”
* Helper: “She sounds like a good influence. Why don’t you try that next week?”

***2: Group discussion [5 min]***

* Discuss with the group:
  + “How did the helper respond to the person’s problems?”
  + “What did the helper do differently in this demonstration compared with the previous one?”
  + “Did the helper use explanatory models? How?”
  + “Did the helper explore the impact on daily functioning?”
  + “Did the helper identify some positive and negative coping skills?”
  + “Did the helper assist the person to find a way to substitute an unhealthy coping mechanism with a healthy coping mechanism?”
  + “What other things did the helper do that were helpful?”
* Facilitator 2 (the person) can also describe how they felt with Facilitator 1 (the helper).
* List (on a flipchart, sticky notes, blackboard/whiteboard, etc.) the discussion points agreed upon and answers to the short quiz.
* Briefly summarise the behaviours demonstrated by the facilitators, along with any that were brainstormed by the trainees.

## Review concept and learning points

**Materials:** Flipchart, sticky notes, blackboard/whiteboard or PowerPoint (PPT) presentation.

**Instructions:**

1. Review why using explanatory models, connection to daily functioning, and exploring coping strategies are important for health and well-being.
   1. Brainstorm, using the examples suggested below.
      * Explanatory models give helpers a better perspective on how the person views their problems.
      * Using explanatory models ensures that the person is at the centre of the treatment, programme or strategy.
      * Helping persons in distress understand the connection with daily functioning can support engagement with care, treatment, and positive behaviour change
      * Exploring coping strategies can uncover positive strategies that can be reinforced
      * Negative coping strategies can be identified and ideally reduced and replaced with positive coping strategies.
2. Outline helpful and unhelpful behaviours in the table below. Be sure to add suggestions brainstormed with the group during the module.
3. **Suggested:**Provide a mnemonic (acronym) OR other learning summary technique.

|  |  |
| --- | --- |
| **Unhelpful and helpful behaviours to understand the person's explanation for the problem, impact on life, and coping strategies** | |
| **Unhelpful or potentially harmful behaviours** | **Helpful behaviours** |
| * Criticising the person’s view of their problems as being ignorant, superstitious, etc. * Endorsing harmful beliefs held by the person or by people in their social network * Criticises client for letting symptoms impact functioning (e.g., you are weak, you have no willpower) * Makes client feel guilty for impact on children, family, and others * Makes negative statements about client's coping strategies (that would never work...) * Encourages or shows acceptance of harmful coping strategies * [Add other ideas brainstormed by the trainees here] | * Asking about the person’s view of the cause of the problem * Asking family members or other people in the person’s social support network about their views of the cause of the problem * Asks about daily functioning * Discusses the connection (the relationship) between daily functioning and mental health * Asks clients about current or past coping strategies (how they keep going after the problem started…) * Praises client for positive or safe current or prior solutions * Reflection on prior unhealthy strategies and brainstorm positive alternatives * [Add other ideas brainstormed by the trainees here] |

**Brief Role Play for Module 5** – Connection to social functioning and support prior coping

* Module 5 Role Play
* ENACT Scoring Template: Person’s explanation of the problem
* ENACT Scoring Template: Impact on life (connection to social functioning)
* ENACT Scoring Template: Supporting prior coping

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**Overview:** Trainees will work again in pairs, this time to show facilitators their “helpful” skills, understanding the person’s perspective on the cause of the problem, impact on daily life, and coping skills. During the role plays, facilitators observe (e.g., walk around the room, join ‘break out’ rooms) and rate trainees on the ENACT item #8, 9, and 13. The goal is to see how trainees: (a) understand the problem from the perspective of the person in distress, (b) understand how the problem is impacting the person’s life, and (c) understand how the person is coping with that problem.

**Materials needed:** Timer (clock, watch, other) and bell and/or other alarm for timekeeping. The two facilitators will need to use the ENACT rating tool for Items #8, #9, and #13 to rate each trainee. This can be done on the EQUIP digital platform (which can be used to view score summaries and review of helpful and unhelpful behaviours at the group level) or on paper copies of ENACT. (See the scoring form for competencies #8, 9, and 13 reproduced below.)

**Instructions**:

1. The facilitators explain to the group how this practice exercise strengthens their learning and gives facilitators feedback on their strengths.

**For example**: **“**Now we will practise helpful behaviours. To bring together our learning from this session, in this role play, you will practise your skills to understand the problem from the perspective of the person in distress, understand the impact on their life, and understand how they are coping with the problem. While you all are practising, we (the facilitators) will be walking around to see your skills in action. We will be taking some notes to give you all feedback on how to improve how you set collaborative goals, promote realistic hope, and elicit feedback.”

1. Divide into **groups of 2**. The two roles are:
   * One person will play the helper
   * One person will play the person in distress

1. Ask each member of the group to take turns, with one playing the helper, and the other the person in distress; then they switch. Make sure that each person gets a chance to practise being a helper.
2. Tell the group that each role play should be about 5 minutes.
3. Share the specific instructions with the group. These role-play instructions can be provided on a PowerPoint slide, written on a white board, or given as paper handouts to trainees:

This role play takes place after the helper and person being helped have already met, done introductions, and explained confidentiality. The helper and person being helped already know each other’s names and what they preferred to be called. The group members can use their own names for the purposes of the role play. The problem being discussed in this role play is that the person in distress is having problems sleeping and worrying a lot. The person recently lost her job.

Instructions to **helper**: The goal of the role play is to understand what the person thinks may have caused or contributed to the problem, how the problem is impacting the person’s life, and how they are coping with it. Start the role play by posing a question such as “*There can be different causes of difficulties in our lives. What may have caused or contributed to the problem we are discussing today?”*

Instructions to the **person being helped**:

* When asked about possible causes, you can provide a statement such as, *“I don’t know if I have these problems because I lost my job and worry all the time now. Or maybe, I am just cursed.”* If asked about family’s perception, provide a different perceived cause, e.g., *“My family thinks I have these problems because I am weak and lazy.”*
* If asked about the impact on your life, give a response such as, “*When I’m worried and haven’t slept well, I am forgetful…”* followed by examples such as “*I don’t pay attention when I cook and sometimes put in too much salt and my family complains.”* Or, “*I ask the same question a few times in a conversation, and people laugh at me – ‘you just asked that’”* Or, “*I go out of the house, then forget where I was supposed to be going.”*
* If asked about how you cope with the worry about not having a job, share some **positive examples**, for example, “*Sometimes when I am worried, I go do work in the garden and that gives me something to focus on”*, or “*I try to give myself one task a day, like looking online for any job postings.”* And, also share some **negative examples**, for example, “*But, when I get totally overwhelmed, sometimes I just start eating junk food and snacks while watching TikTok. I can spend hours doing that.”*

1. The facilitators walk around the room to observe the pairs as they practise. While observing, facilitators rate ENACT item #8, #9, and #13 as trainees act as the helper. Observe each trainee for about 3-4 minutes to identify what helpful and unhelpful behaviours are displayed for involvement of family members. The full role play does not need to be observed.

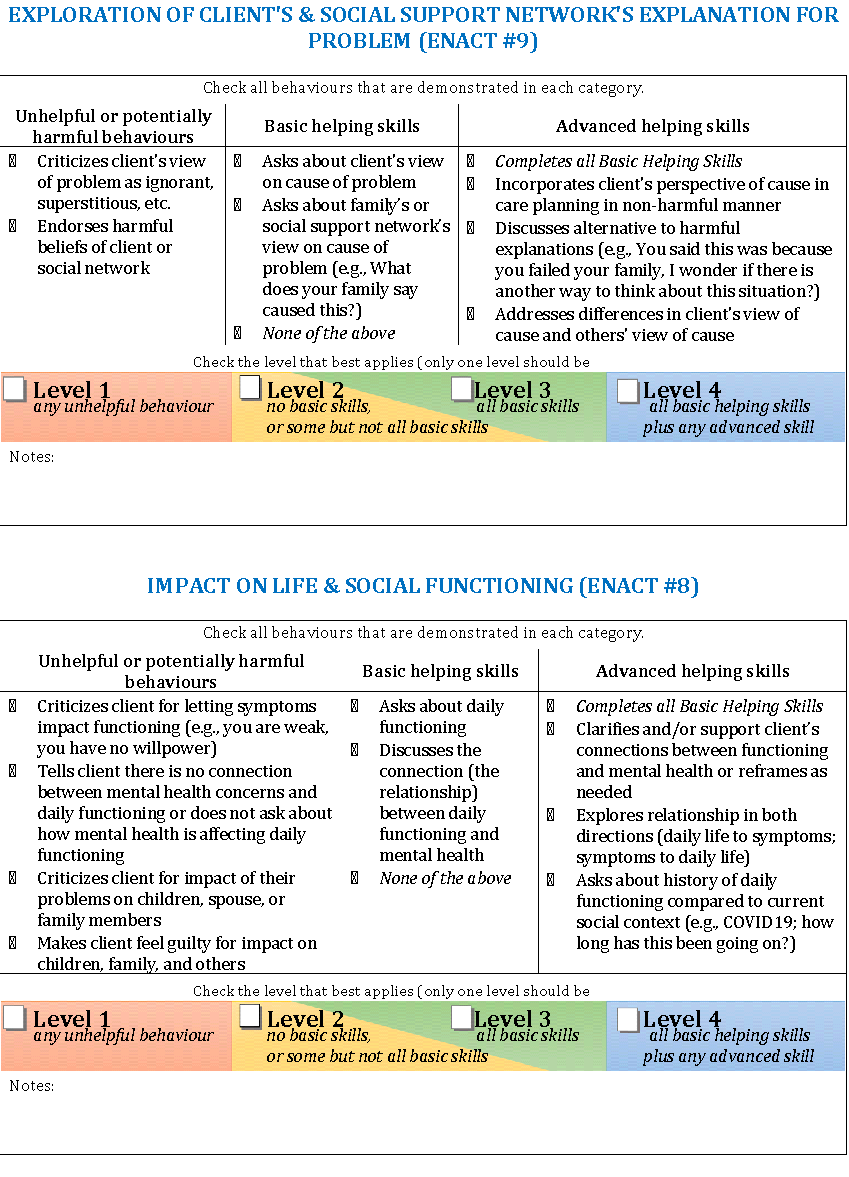
Key behaviours to record on the ENACT form are:

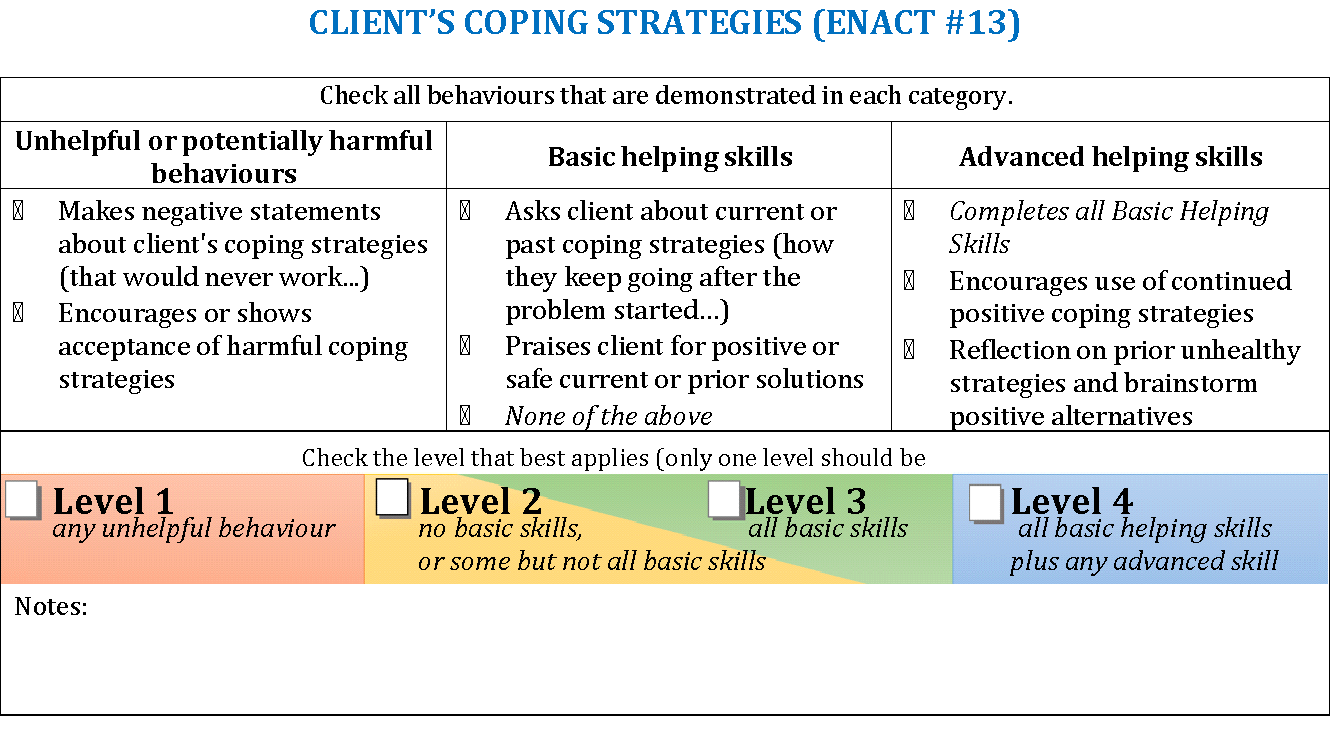
* Does the helper ask what the person thinks the cause of the problem is?
* Does the helper ask what others think the cause is, e.g., what do friends or family members think cause this?
* Does the helper ask about the impact on daily life?
* Does the helper ask about how the person copes with the problem?
* Does the helper praise positive coping strategies?
* Does the helper explore alternatives to harmful coping strategies?
* Does the helper gently challenge perceptions of causes that are harmful or negative (e.g., if the person says the cause of the problem is that they are lazy, point out things that the person is doing that are not lazy such as seeking help or other positive actions)?

Behaviours that may be harmful should also be recorded on the ENACT form:

* Does the helper criticise or dismiss the person’s belief about the cause (e.g., that’s silly – you’re not cursed; or, your family may be correct that you aren’t trying hard enough)?
* Does the helper minimise the impact of the problem on daily life (e.g., everyone has these problems, they are no big deal; or, if you just tried harder, you wouldn’t have these problems)?
* Does the helper support or suggest harmful coping strategies, (e.g., well, we all need a drink sometimes, when you feel stressed you should just have some wine)?

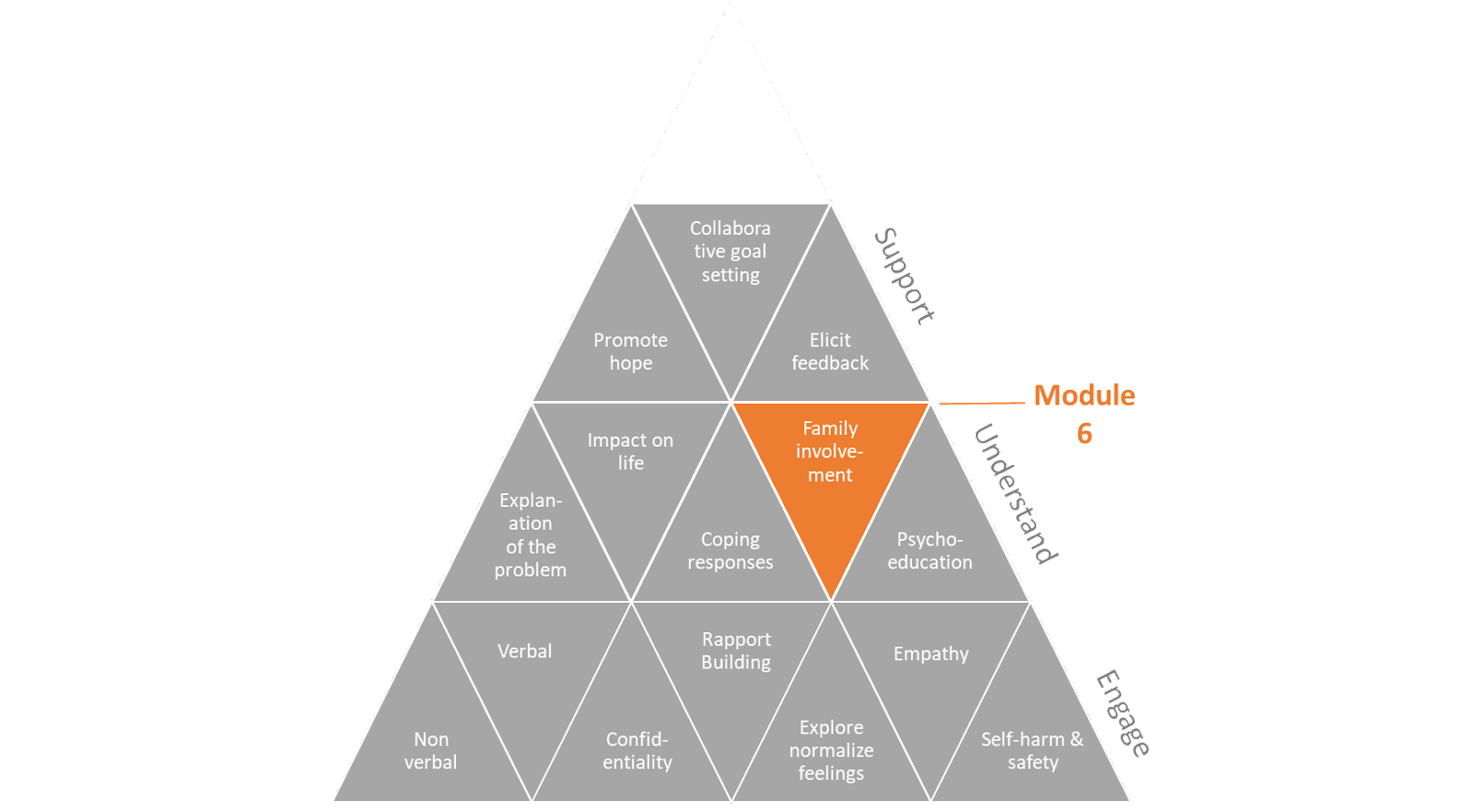
1. After all trainees have been observed and rated by one of the facilitators, the facilitators should thank the trainees for doing the role plays. General feedback on some of the helpful behaviours observed can be shared. Facilitators can conduct a full review of the competency ratings in the evening after the second day’s training is completed, then more specific feedback provided on the morning of day 3.





# **Module 6**: Involving family or other people we trust (ENACT #10)

* 1. Objective 1: Describe what it means to involve family members or other people we trust when helping, and why it is important
  2. Objective 2: Identify behaviours for involving family members or other people we trust when helping someone in your context
  3. Objective 3: Distinguish between helpful and unhelpful behaviours when involving family members or other people we trust



**Learning objectives:**

* What does it mean to involve family members or other people we trust?
* How do we involve family members or other trusted people during support or treatment?
* Why is the involvement of family members or other trusted people important to health and well-being?

**Structure of module:**

* Introducing the concept (5 minutes)
* Exercise 1: Identifying different social supports (15 minutes)
* Exercise 2: Review Concept with Group Discussion (15 minutes)
* Exercise 3: Facilitators demonstrate Helpful Involvement of Family (15 minutes)
* Group activity 2: Individual pairs practise “helpful” assessment of suicidal behaviour (10 minutes)
* Review concept and learning points (10 minutes)

**Materials** (Optional): Facilitators may use the “Unhelpful and helpful involvement” table at the end of the module as a handout for trainees.

**Instructions:** The facilitators introduce the concept, and then deliver the activities following this introduction. The facilitators take notes on the brainstorming activities and add suggestions to the table of helpful and unhelpful involvement at the end of the module.

* The facilitator tells trainees: “In the following activities, you will be brainstorming some different ideas. I will add the behaviours you identify to our list of skills for involving family members and other people close to a person.”

## Introducing the concept

**Timing:** 5 minutes

***Note: Below is a sample text to cover the concepts and points above. Facilitators may adapt the language to the context as necessary, but must ensure that the points are adequately covered.***

###### **Which people count as a family member or other trusted person?**

A family member or other trusted person can be anyone in a person’s life who could support their health and well-being. This could be a family member, a friend, a caring neighbour or anyone who they feel comfortable with and can trust. The person does not need to live with the family member or other close person, but it can help if this person is physically nearby or easily contacted by telephone.

**What does it mean to involve family members or trusted person(s)?**

Family members or other people close to us can offer significant support when we need it. Family members and people close to us are some of our best encouragers or “cheerleaders” and are often trustworthy enough to share our feelings and problems with. They typically know our strengths and weaknesses, and because they often live with us or close by, they can help to remind us to stay on track with our goals.

When we are connected with people who support and encourage us, such as family members and other trusted persons, during times of crisis or need, we can often cope better and manage problems more successfully.

As helpers, we should ask the person to identify a trustworthy family member, friend or other close person, and then ask them if they would like to involve that family member or close person in order to strengthen support.

Sometimes the person might not want to involve any family member or close person, and that is okay. It is important to first check with the person and to get their permission before involving anyone close to them. Similarly, if a family member asks to be involved, it is important to ask the person if they are comfortable with this. Never force a person to have a family member or other companion involved: always ask them for permission.

## Exercise 1: Identifying different social supports

**Timing:** 15 minutes

**Instructions:** In this exercise, the trainees explore how the involvement of family members or other trusted people varies for different people and situations. The activity has two parts.

***1: “People and situations” in groups [10 min]***

* Divide the trainees into small groups. There should be no fewer than three people and no more than six people in each group.
* Then assign each group one of the following “People and situations” scenarios and ask them to brainstorm at least two different ways to involve social support, using the questions included in the scenarios.
* Each group has 10 minutes to learn about the scenario and respond to the questions.

**People and situations**

1. Karla is a 15-year-old girl. She went to the market to pick up groceries and tried a new shortcut on the way home. She got lost along the way and became very frightened. Soon she came across a police officer and asked her for help.
   * Who might be some trusted people the police officer could ask Karla about?
   * What if a trusted person who Karla lives with is not home or cannot be reached by telephone: who else could the police officer suggest?
2. George is a 74-year-old man. He was walking down the street, fell over and lost consciousness. A passerby helped him to get to the nearest primary care facility to get checked out. When George became fully conscious, a nurse was there to help him and ask him some questions.
   * Who might be a trusted person the nurse would ask George about to help him feel safe and to pick him up?
   * Could the nurse consider whether there are any people close to him who might not be helpful? How could the nurse ask George about this?
3. Rebecca is a 34-year-old woman. She is pregnant and is visiting the local antenatal care centre in her town. Her mother and mother-in-law have both come with her. When the midwife meets Rebecca, she can tell that Rebecca is a bit stressed, and she is very quiet. Rebecca’s mother immediately tells her Rebecca’s story and symptoms, quickly echoed by Rebecca’s mother-in-law.
   * Could the midwife ask Rebecca if she would like her mother and mother-in-law to be involved in her care? How might the midwife do this?
   * Why is it important for the midwife to ask Rebecca who she would like to involve in her care, even if the mother and mother-in-law are very close to Rebecca and care about her health and that of the baby?
4. John is a 28-year-old man. He has been experiencing very low energy and cannot stop worrying about making enough money to look after his wife and baby son. He went to a local care clinic where he met briefly with a community health worker (CHW). He tells the CHW his problems and how he has not been able to sleep or spend time with his friends. He has very low energy and doesn’t think that his friends want to spend time with him.
   * How could the CHW ask about John’s family or people close to him?
   * How might the CHW decide to involve John’s family or close friends?
   * Why is it important for the CHW to first ask John about who to involve, rather than immediately calling John’s wife or one of his close friends to tell them that John is at the clinic?

***2: Group summaries***

Ask each group to briefly summarise their scenarios and to share their answers to the questions. Ask the other groups if they agree or disagree with the group’s answers, and why, and if they want to add any other suggestions.

## Exercise 2: Review Concept with Group Discussion

**Timing:** 15 minutes

**Instructions:** The facilitators lead a discussion with the whole group to summarise learning points about involving family members or other trusted persons.

**Use the following prompts to brainstorm with the trainees:**

* What are ways that family members or other trusted people could support a person?
  + (Suggested answers: reminding them of homework, medicine or appointments, providing emotional support, supporting them in other activities, etc.)
* What are key things you should do with a person before suggesting the involvement of a family member or other trusted person?
  + (Suggested answers: check to see if the person feels supported by a family member or other close person; if yes, make sure that the person has given the helper permission to speak with a family member or other close person before the helper makes any contact. If a family member or close person is already with the person, the helper should try to ask the person separately to confirm they are comfortable to have the family member there.)
* Should you ask the person what type of personal details they would like to share with, or keep private from, the family member or other trusted person before involving them? How might you ask this?
  + (Suggested answers: yes, make sure that the person has given permission for the helper to speak with a family member or other trusted person and that the helper has agreed with the person the kind of information that they are happy to share. You can ask, for example, “Is there anything you would like me to share with your family member specifically? Would you like me to tell your friend everything you have just told me?”)

## Exercise 3: Facilitators demonstrate Helpful Involvement of Family

**Timing:** 15 minutes

**Instructions:** This activity has two parts. The facilitators demonstrate “helpful” involvement of family members or other trusted people, and the group then discusses what the facilitators have demonstrated (and ideas suggested by the trainees), adding helpful behaviours for involving family members or other close people to the table at the end of the module. *Be sure to explain this process to the trainees.*

***1: Demonstration, outline of concepts and sample prompts***

Facilitators may refer to the sample recordings provided with these materials and adapt them to the context and setting.

1. The role-play takes 2–3 minutes.
2. The facilitators use the description and prompts below.
   1. Facilitator 1 plays the helper (and begins the role-play).
   2. Facilitator 2 plays the person.
      1. Facilitator 1 (helper): “Abed, when we are dealing with difficult problems, it can be helpful to ask a family member or a person close to us to encourage us and remind us of our goals. Is there a person that you feel comfortable with to help you through this? Perhaps a brother or a good friend?”
      2. Facilitator 2 (person): “I have my brother, yes, he is usually there when I need him. This time feels different, though.”
      3. Helper: “It is good to hear you have a dependable brother. What do you think about asking your brother for help with this problem? Would you like me to contact him directly, or would you like to contact him together?”
      4. Person: “Maybe. I would like his help, yes, but I am not sure I want him to know what I did to get into this situation.”
      5. Helper: “Of course. It is very strong of you to ask your brother for help at this time. Would you like to think of how you might ask him for help? We can also practise before you call him so that you feel more confident in what you will say.”

***2: Group discussion***

* Discuss with the group what behaviours they saw. Some prompts are suggested below.
  + “What sort of questions did the helper ask?”
  + “Was the person able to identify a family member or trusted person? Why or why not?”
  + “Was there anything more the helper might have done to explore how Abed feels about involving his brother?”
  + “Using these helpful behaviours, would you change your daily interactions at your work when working with a person?”
* Facilitator 2 (the person) can also describe how they felt with Facilitator 1 (the helper).
* List (on a flipchart, sticky notes, blackboard/whiteboard, etc.) different behaviours that the group points out (this can be continued from the previous activity).
* Briefly summarise the behaviours portrayed in the demonstration, including any that were brainstormed by the trainees. Add them to the table of helpful and unhelpful behaviours at the end of the module.

## Review concept and learning points

**Timing:** 10 minutes

**Materials:** Flipchart, sticky notes, blackboard/whiteboard or PowerPoint (PPT) presentation.

**Instructions:**

1. Review why involving family members or other trusted people is important for health and well-being.
2. Outline helpful and unhelpful behaviours in the table below. Be sure to add any ideas brainstormed with the group during the module.
3. **Suggested:**Provide a mnemonic (acronym) or other learning summary technique.

|  |  |
| --- | --- |
| **Unhelpful and helpful involvement of family or other trusted persons** | |
| **Unhelpful or potentially harmful behaviours** | **Helpful behaviours** |
| * Telling the person not to involve family members or trusted people in any way during treatment or recovery * Forcing the person to involve family or trusted people in the treatment process * Demanding to speak with family members or trusted people without getting permission from the person * Allowing an accompanying trusted person to disempower the person * [Add other ideas brainstormed by the trainees here] | ● Asking about trusted person(s) in the person’s life   * Asking the person how they would like to involve the trusted person(s) in the care process   ● [Add other ideas brainstormed by the trainees here] |

**Brief Role for Module 6** – Involving family or other close relationships

* Module 6 Role Play
* ENACT Scoring Template: Involvement of family or other close relationships

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**Overview:** Trainees will work again in **groups of 2**, this time to show facilitators their “helpful” skills for involvement of family members or other close relationships. During the role plays, facilitators observe (e.g., walk around the room, join ‘break out’ rooms) and rate trainees on the ENACT item #10.

**Materials needed:** Timer (clock, watch, other) and bell and/or other alarm for timekeeping. The two facilitators will need to use the ENACT rating tool for Items #10 (involvement of family members or other close relationships) to rate each trainee. This can be done on the EQUIP platform (which can be used to view score summaries and review of helpful and unhelpful behaviours at the group level) or on paper copies of ENACT. (See the scoring form for competencies #10 reproduced below.)

**Instructions**:

1. The facilitators explain to the group how this practice exercise strengthens their learning and gives facilitators feedback on their strengths.

**For example**: **“**Now we will practise helpful behaviours. To bring together our learning from this session, in this role play, you will practise your skills to discuss involvement of family members or other close relationships. While you all are practising, we (the facilitators) will be walking around to see your skills in action. We will be taking some notes to give you all feedback on how to improve how you assess risk of harm and promote safety.”

1. Divide into **groups of 2**. The two roles are:
   * One person will play the helper
   * One person will play the person in distress
2. Ask each member of the group to take turns, with one playing the helper, and the other the person in distress; then they switch. Make sure that each person gets a chance to practise being a helper.
3. Tell the group that each role play should be about 5 minutes.
4. Share the specific instructions with the group. These role-play instructions can be provided on a PowerPoint slide, written on a white board, or given as paper handouts to trainees:

This role play takes place after the helper and person being helped have already met, done introductions, and explained confidentiality. The helper and person being helped already know each other’s names and what they preferred to be called. The group members can use their own names for the purposes of the role play.

Instructions to the **person being helped**: Start the role play by saying “*My family member (*select wife, husband, mother, sister, etc.) *wants to know what they need to help*.*”* Additional, optional responses can be comments such as “*My sister is always asking me how to help, but I don’t think she understands me the most*,” or “*My sister always asks me what I talk about when I meet with you?”*

Instructions to **helper**: Respond to the person being helped in regards to involvement of family members or other close persons.

1. The facilitators walk around the room to observe the pairs as they practise. While observing, facilitators rate ENACT item #10 trainees act as the helpers. Observe each trainee for about 3-4 minutes to identify what helpful and unhelpful behaviours are displayed for involvement of family members. The full role play does not need to be observed.

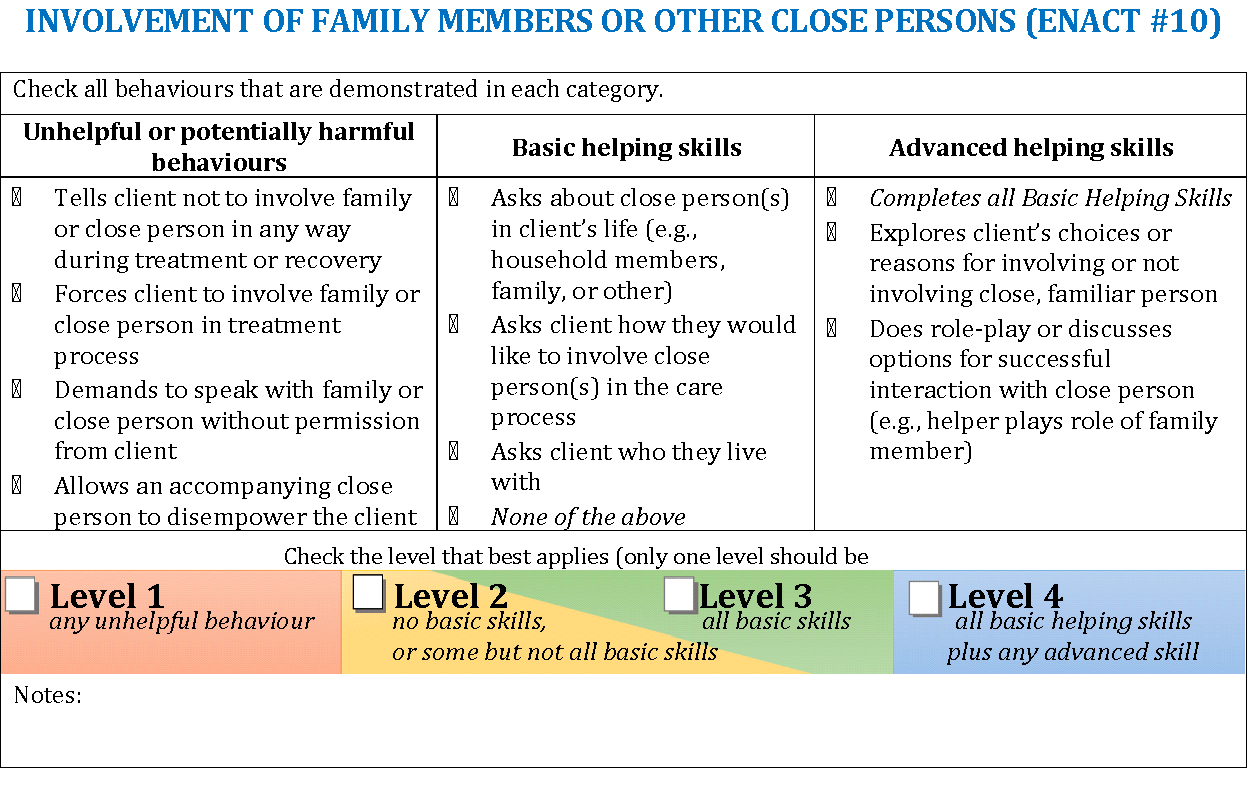
Key behaviours to record on the ENACT form are:

* Does the helper ask the person if they would like this relative to be involved in her care or support?
* Does the helper ask if there is someone else that the person feels close to whom she would like involved in the care?
* Does the helper ask about with whom the person lives?
* Does the helper ask questions about why certain family members or other close persons would be her preferred person to involve in the care process?

Behaviours that may be harmful should also be recorded on the ENACT form:

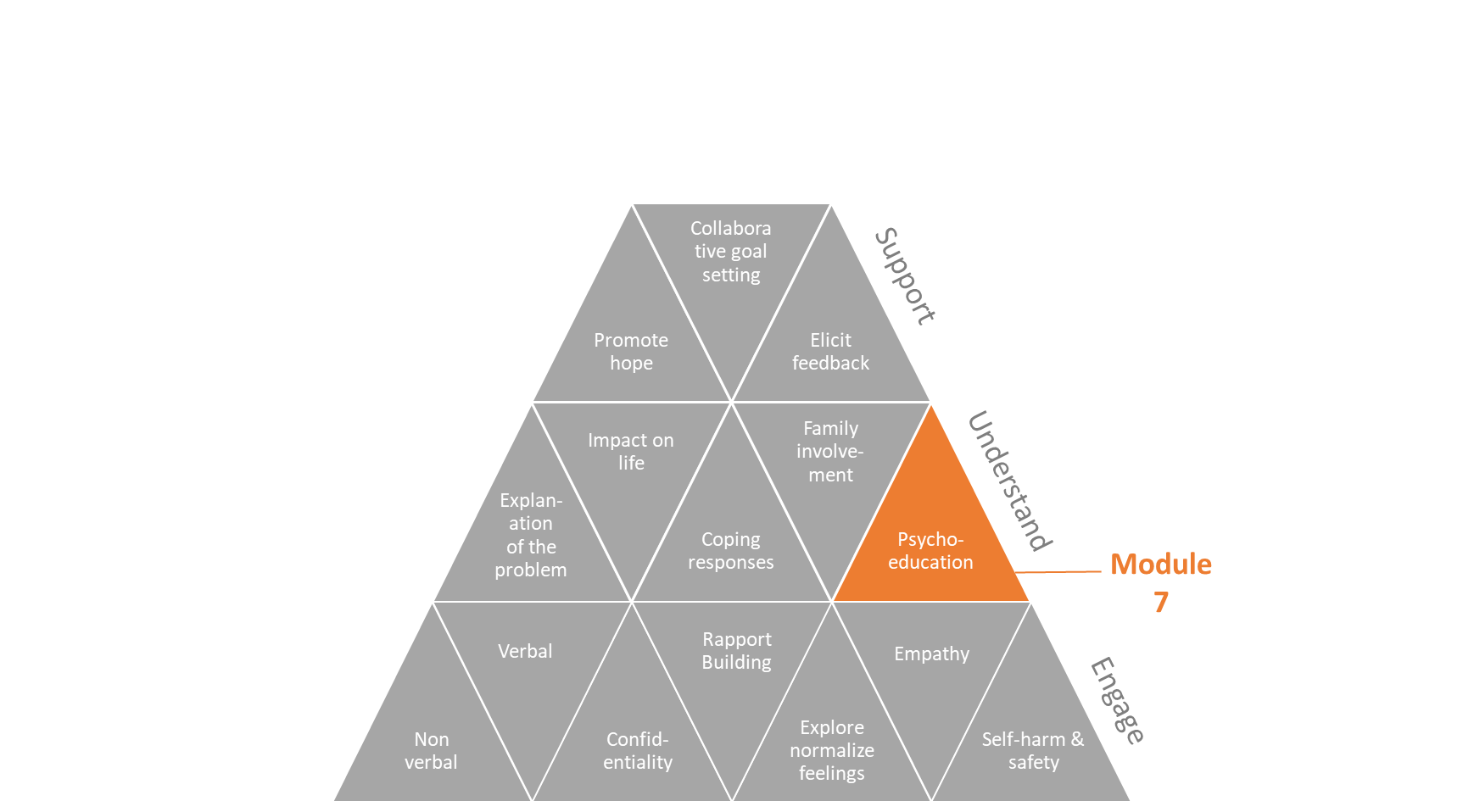
* Does the helper tell the person not to involve family members, e.g., that this is just a 1-on-1 process?
* Does the helper force the person to involve a family member even if the helper doesn’t want to involve the family?
* Does the helper request to speak with the family without asking the person’s permission?

After all trainees have been observed and rated by one of the facilitators, the facilitators should thank the trainees for doing the role plays. General feedback on some of the helpful behaviours observed can be shared. Facilitators can conduct a full review of the competency ratings in the evening after the second day’s training is completed, then more specific feedback provided on the morning of day 3.



# **Module 7**: Psychoeducation (ENACT #14)

* 1. Objective 1: Define psychoeducation and why it is important
  2. Objective 2: Identify how helpers can engage in psychoeducation
  3. Objective 3: Distinguish between helpful and unhelpful behaviours when conducting psychoeducation



**This module covers the following**:

* What does it mean to offer psychoeducation?
* How do we use psychoeducation when providing support?
* Why is psychoeducation important to support health and well-being?

**Structure of module:**

* Introducing the concept (5 mins)
* Group Activity 1: “What is it, why is it helpful and what could go wrong?” (15 minutes)
* Exercise 1: Facilitators demonstrate “unhelpful” psychoeducation (10 minutes)
* Exercise 2: Distinguishing helpful and unhelpful psychoeducation (10 minutes)
* Review concept and learning points (10 minutes)

**Materials (**Optional) Facilitators may use the “Unhelpful and helpful” table of behaviours at the end of each module as a handout for trainees.

**Instructions:** One facilitator introduces the concept, and then both facilitators deliver activities following this introduction. Facilitators take notes on the brainstorming activities and add suggestions to the table of helpful and unhelpful psychoeducation at the end of this module.

* The facilitator tells trainees: “In the following activities, you will be brainstorming some different ideas. I will add the behaviours you identify to our list of psychoeducation skills.”

## Introducing the concept

**Timing:** 5 minutes

Note: Below is a sample text to cover the concepts and points above. Facilitators may adapt the language to the context as necessary, but must ensure that the points are adequately covered.

**What does it mean to offer** **psychoeducation?**

Psychoeducation refers to giving the person you are working with information on mental health problems, stressors or symptoms and different resources, stress management techniques or programmes that might help them.

Psychoeducation should teach a person how different mental health problems might affect them and their daily lives, and different strategies that might support them to deal with their problems.

Psychoeducation should include the person’s own explanatory model. The helper should first understand what the person thinks is causing their problems, so that they can educate using the person’s own words.

**Facilitators can read or show the following example to trainees**:

* Helper: “What do you think is causing you to lose sleep?”
* Person: “Well, I think I am not sleeping because I am so stressed and worried. Then I am so tired I cannot get out of bed and keep up with my tasks.”
* Helper: “I see. It sounds like your worries are keeping you from sleeping well and interfering with your daily tasks. Sometimes, when we are distressed and thinking too much, it can make it harder for us to sleep and keep up with our usual schedules. When we meet, we can work together on strategies that will help you manage your stress and a plan to help you keep up with your tasks and do things that you like, so that you feel less worried.”

## Group Activity 1: “What is it, why is it helpful and what could go wrong?”

**Timing:** 15 minutes

**Instructions:** This activity helps trainees to understand the concepts above by summarising what they have learned about psychoeducation. The activity has three parts: 1. divide the trainees into three groups; 2. have groups present; 3. The facilitator reviews the concept of psychoeducation.

***1: Divide the trainees into three groups***

Facilitators divide the trainees into three groups, labelling them Group 1, Group 2 and Group 3. Then they assign the following tasks:

1. Group 1 should prepare a list of key points from the overview of psychoeducation.
2. Group 2 should create a list of ways in which they might use psychoeducation when working with a person.
3. Group 3 should create a list of “what might go wrong” if they do not use psychoeducation, when working with a person. Group 3 can think of how things could go wrong for both the person and the helper.

***2: Group presentations***

Bring the three groups back together to present their lists. Remind trainees that there are no right or wrong answers; this is a brainstorming session. After Group 1 presents, check with the other groups to see if they want to add anything to the list. Repeat this process for Groups 2 and 3.

As groups are presenting, the facilitators should be listing (on a flipchart, sticky notes, blackboard/whiteboard, etc.) the different behaviours the trainees point out. Facilitators may also refer to the table of unhelpful and helpful behaviours at the end of this module.

***3:* *Facilitators summarise the concept of psychoeducation***

The facilitators may summarise the initial didactic in this module and can include additional information that the groups brought up during the activity.

## Exercise 1: Facilitators demonstrate “unhelpful” psychoeducation

**Timing:** 10 minutes

**Instructions:** This demonstration of unhelpful behaviours will support learning while also offering an ice-breaker activity to help the trainees loosen up. Enjoy!

This activity has two parts. The facilitators demonstrate what might go wrong when a helper uses “unhelpful” psychoeducation. The group then discusses the behaviours the facilitators have demonstrated (and others suggested by the trainees), with discussion prompts and a short quiz. Suggestions can be added to the table of unhelpful or potentially harmful behaviours for psychoeducation at the end of the module. *Be sure to explain this process to the trainees.*

**1: Demonstration, outline of concepts and sample prompts**

Facilitators may refer to the sample recordings provided with these materials and adapt them to the context and setting.

1. The demonstration takes 2–3 minutes. The facilitators use the description and prompts below.
   * Facilitator 1 plays the helper.
   * Facilitator 2 plays the person (and begins the demonstration).
     + Facilitator 2 (person): “It has been two months and I cannot find a full-time job. I’m tired and my shoulders and neck are feeling so painful. I often have to stay in bed in the morning. By the time I have any energy, it is night-time and no jobs are open for me to apply to. Then I stay up all night worrying.”
     + Facilitator 1 (helper): “How do others in your life describe this?”
     + Person: “My best friend says my ‘batteries are backwards’. She says that I use up all my batteries at night worrying, then I have no energy during the day to do anything. So I use my batteries when I should be recharging them, and then I’ve got nothing left for day to day life. I’ve started saying that too, ‘my batteries are backwards’”
     + Helper: “This is clearly a case of mixed anxiety and depression. You have a chemical imbalance in your brain. I can refer you to someone who treats people with imbalances like you.”
     + Person (looking afraid and unsure): “Okay.”

**2: Group discussion and short quiz**

* Discuss with the group what they saw:
  + “Thinking about what we’ve learned so far, did the helper use psychoeducation? Was the psychoeducation helpful or unhelpful? Why?”
  + “What could the helper have said to the person instead of saying, ‘You are experiencing anxiety and depression’?”
* Short quiz with the group:[[6]](#footnote-6)

1. “Which of the following was the helper doing ***wrong*** when doing psychoeducation?”
   1. The helper did *not* check to see if the person had heard of the concepts of anxiety or depression.
   2. The helper did *not* incorporate the terms used by the person in distress.
   3. The helper should have explained the specific neurotransmitters involved.
   4. Both ‘A’ and ‘B’

* List (on a flipchart, sticky notes, blackboard/whiteboard, etc.) the discussion points agreed upon and answers to the short quiz.
* Briefly summarise the behaviours demonstrated by the facilitators, along with any that were brainstormed by the trainees.
  + For example: technical language, stigmatising language, ignoring the person’s explanation of the problem, not clearly explaining mental health problems or treatment/programme, going along with a family member’s potentially harmful explanation of the problem, etc.

## Exercise 2: Distinguishing helpful and unhelpful psychoeducation

**Timing:** 10 minutes

**Instructions:** This activity follows on from the previous demonstration, but this time using helpful behaviours. It has two parts: 1. the facilitators demonstrate “helpful” psychoeducation, and 2. The group discusses the behaviours the facilitators have demonstrated (and others suggested by trainees), using the discussion prompts. The facilitators add suggestions to the list of helpful behaviours for psychoeducation at the end of the module. *Be sure to explain this process to the trainees.*

***1: Demonstration, outline of concepts and sample prompts [3–5 min]***

Facilitators may refer to the sample recordings provided with these materials and adapt them to the context and setting.

1. The demonstration takes 3–5 minutes. The facilitators use the description and prompts below.
   1. Facilitator 1 plays the helper.
   2. Facilitator 2 plays the person (and begins the demonstration).
      * Facilitator 2 (person): “It has been two months and I cannot find a full-time job. I’m tired and my shoulders and neck are feeling so painful. I often have to stay in bed in the morning. By the time I have any energy, it is night-time and no jobs are open for me to apply to. Then I stay up all night worrying.”
      * Facilitator 1 (helper): “How do others in your life describe this?”
      * Person: “My best friend says my ‘batteries are backwards’. She says that I use up all my batteries at night worrying, then I have no energy during the day to do anything. So I use my batteries when I should be recharging them, and then I’ve got nothing left for day to day life. I’ve started saying that too, ‘my batteries are backwards’”
      * Helper: “That is a very helpful way to describe it. When we have lots of stress in our lives, ‘our batteries can start functioning backwards’. It sounds like you want to find a way to get your batteries flipped around so you can have a restful night sleep that is recharging so you have more energy during the day?”
      * Person: “Yeah, that’s what I want, but I just don’t know how to do it.”
      * Helper: “Hmm, I see. It sounds like you are feeling worried about not finding a job, and your tiredness and painful back are keeping you from getting out of bed in the morning. Our mind and body work together to keep us healthy. Sometimes, when we are feeling stressed and thinking too much, our batteries aren’t working the way they are supposed to. There are a number of ways that people like me can help with getting batteries working the right way around. Would you like to discuss that?”
      * Person: “Yes, sure.”
      * Helper: “Well there are some techniques that can be used to help with relaxing. These can be things like deep breathing, relaxing your muscles. That is something we can practise together then you can do on your own. There are also other skills to help with problem solving so you can move forward step by step and get things done during the day, so you feel a little more hopeful and less worried at night. And in some cases, some people may benefit from other programs, medications, and other techniques. The purpose of all of these is to reduce stress so that you don’t burn through your batteries all night worrying. Would you be interested in learning one of these techniques with me?”
      * Person: “I can try, they sound hard, and I am not sure they will work right away, but I would like to try.”
      * Helper: “Great, let’s start trying then.”

***2: Group discussion [5 min]***

* Discuss with the group:
  + “How did the helper respond to the person’s problems?”
  + “What did the helper do differently in this demonstration compared with the previous one?”
  + “Did the helper use psychoeducation? How?”
  + “What aspects of psychoeducation did the helper do that were helpful?”
* Facilitator 2 (the person) can also describe how they felt with Facilitator 1 (the helper).
* List (on a flipchart, sticky notes, blackboard/whiteboard, etc.) the discussion points agreed upon and answers to the short quiz.
* Briefly summarise the behaviours demonstrated by the facilitators, along with any that were brainstormed by the trainees.

## Review concept and learning points

**Timing:** 10 minutes

**Materials:** Flipchart, sticky notes, blackboard/whiteboard or PowerPoint (PPT) presentation.

**Instructions:**

1. Review why offering psychoeducation is important for health and well-being.
   1. Brainstorm, using the examples suggested below.
      * Psychoeducation facilitates understanding about the origins of distress and empowers people to make informed decisions about treatment.
      * Using psychoeducation improves communication between the person and helper and encourages joint problem-solving and can engage the person in care and improve their recovery.
2. Outline helpful and unhelpful behaviours in the table below. Be sure to add suggestions brainstormed with the group during the module.
3. **Suggested:**Provide a mnemonic (acronym) OR other learning summary technique.

|  |  |
| --- | --- |
| **Unhelpful and helpful psychoeducation** | |
| **Unhelpful or potentially harmful behaviours** | **Helpful behaviours** |
| * Using technical terms without checking the person’s understanding of them * Using stigmatising mental health terms * Criticising the person’s view of their problems as being ignorant, superstitious, etc. * [Add other ideas brainstormed by the trainees here] | * Conducting accurate psychoeducation using simple terms * Including local concepts and terminology in psychoeducation * [Add other ideas brainstormed by the trainees here] |

**Brief Role Play for Module 7** – Psychoeducation

* Module 7
* ENACT Scoring Template: Psychoeducation

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**Overview:** Trainees will work again in pairs, this time to show facilitators their “helpful” skills for conducting psychoeducation. During the role plays, facilitators observe (e.g., walk around the room, join ‘break out’ rooms) and rate trainees on the ENACT item #14. The goal is to see how trainees use the person’s own language and understanding to provide an explanation about psychosocial issues and explain how support and interventions could be helpful.

**Materials needed:** Timer (clock, watch, other) and bell and/or other alarm for timekeeping. The two facilitators will need to use the ENACT rating tool for Items #14 to rate each trainee. This can be done on the EQUIP digital platform (which can be used to view score summaries and review of helpful and unhelpful behaviours at the group level) or on paper copies of ENACT. (See the scoring form for competencies #14 reproduced below.)

**Instructions**:

1. The facilitators explain to the group how this practice exercise strengthens their learning and gives facilitators feedback on their strengths.

**For example**: **“**Now we will practise helpful behaviours. To bring together our learning from this session, in this role play, you will practise your skills conducting psychoeducation. While you all are practising, we (the facilitators) will be walking around to see your skills in action. We will be taking some notes to give you all feedback on how to improve your psychoeducation.”

1. Divide into **groups of 2**. The two roles are:
   * One person will play the helper
   * One person will play the person in distress

1. Ask each member of the group to take turns, with one playing the helper, and the other the person in distress; then they switch. Make sure that each person gets a chance to practise being a helper.
2. Tell the group that each role play should be about 5 minutes.
3. Share the specific instructions with the group. These role-play instructions can be provided on a PowerPoint slide, written on a white board, or given as paper handouts to trainees:

This role play takes place after the helper and person being helped have already met, done introductions, and explained confidentiality. The helper and person being helped already know each other’s names and what they preferred to be called. The group members can use their own names for the purposes of the role play. The problem being discussed in this role play is that the person's distress is having problems sleeping and worrying a lot. The person recently lost her job. The goal of the role play is to see how the helper uses the person’s description of distress to educate about psychosocial stress and benefits of support and intervention.

Instructions to **helper**: The goal of the role play is to understand how the person explains the problem and use this explanation to explain psychosocial stress and connect this with benefits of support and interventions. Start the role play by posing a question such as “*Sometimes people call what they are feeling by different names, or they explain it in a particular way to their family and others. Some people call what you are describing ‘the blues’, ‘feeling low’, ‘thinking too much’, or even ‘the black dog’. What do you call it?”*

Instructions to the **person being helped**:When asked about possible causes, you can provide a statement such as, *“Hmm. That’s interesting. You know my family and I call it ‘my personal cloud’, it is like a cloud that follows me everywhere. Everything feels darker and less hopeful where I am. Like I am stuck in a permanently dark cloudy day. Even when other people say it’s a sunny day, I feel like I have had this constant personal cloud since I lost my job.”*

The facilitators will observe how the helper responds to this.

1. The facilitators walk around the room to observe the pairs as they practise. While observing, facilitators rate ENACT item #14 as trainees act as the helper. Observe each trainee for about 3-4 minutes to identify what helpful and unhelpful behaviours are displayed for involvement of family members. The full role play does not need to be observed.

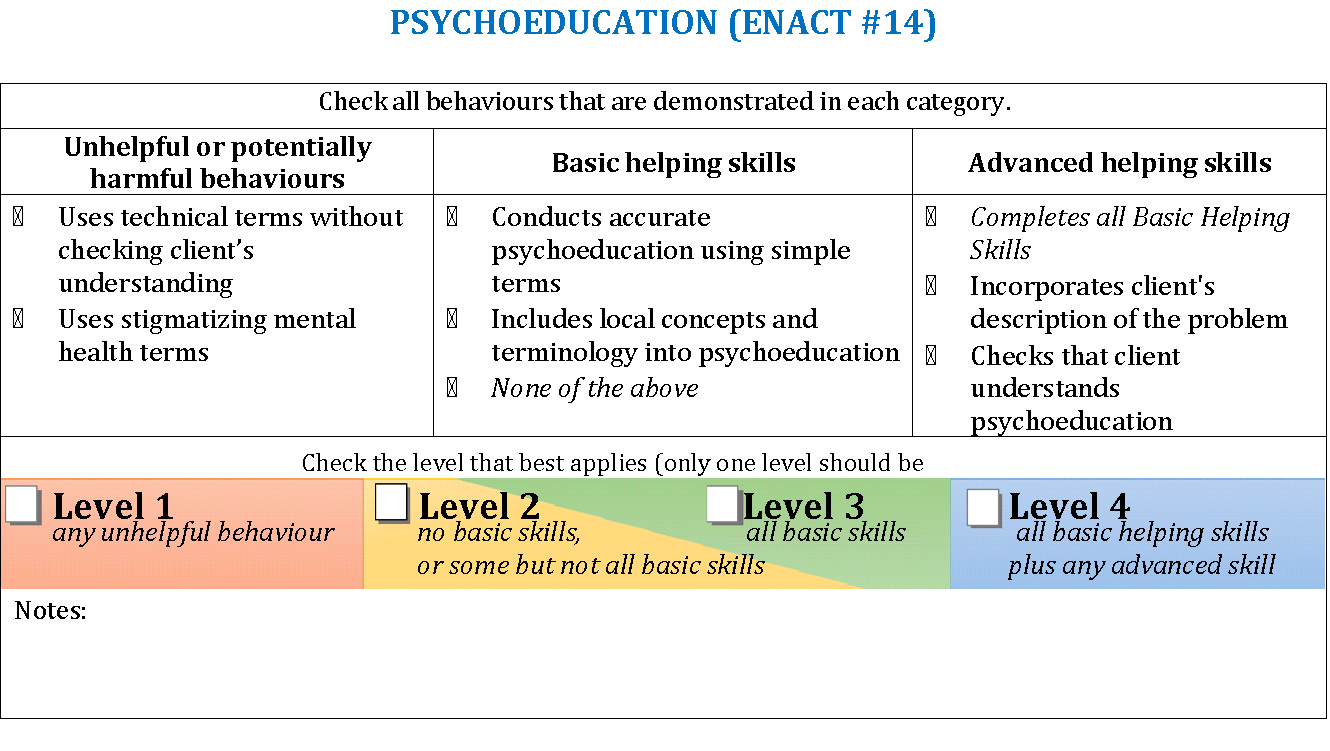
Key behaviours to record on the ENACT form are:

* Does the helper use the ‘personal cloud’ language when explaining psychosocial stress, depression, or anxiety?
* Does the helper explain how support and interventions can help to break-up the ‘personal cloud’?
* Does the helper suggest ways to track improvement over time, such as ‘we can see how big or small your personal cloud is each week as we do the intervention’.

Behaviours that may be harmful should also be recorded on the ENACT form:

* Does the helper ignore the ‘personal cloud’ description?
* Does the helper dismiss or make fun of the persons description: “there is not really a personal cloud, this is just depression and anxiety”
* Does the helper recommend support, treatment, referrals, etc. but not connect it to the ‘personal cloud’ description.

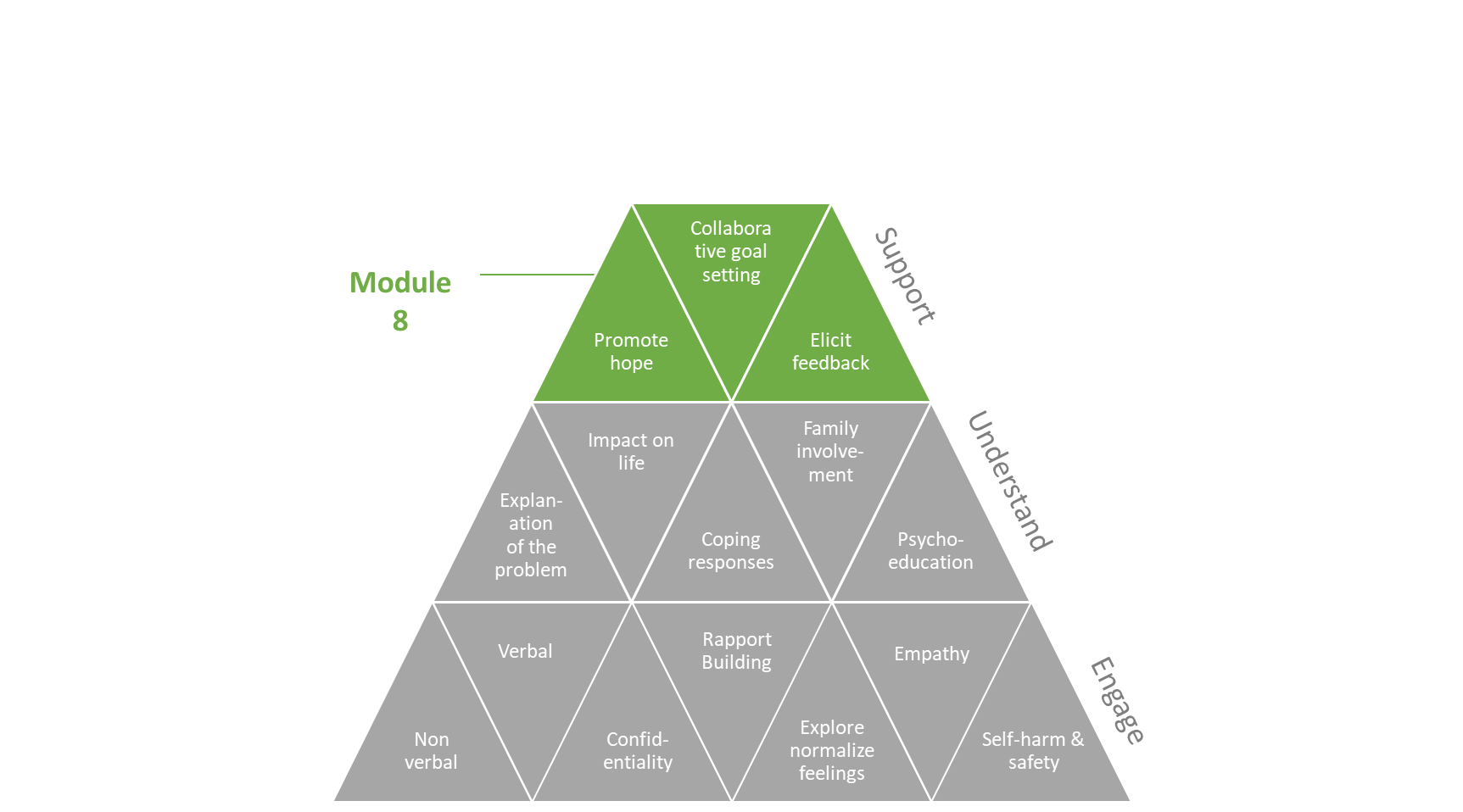
1. After all trainees have been observed and rated by one of the facilitators, the facilitators should thank the trainees for doing the role plays. General feedback on some of the helpful behaviours observed can be shared. Facilitators can conduct a full review of the competency ratings in the evening after the second day’s training is completed, then more specific feedback provided on the morning of day 3.



# Foundational helping skills: Tier 3 - SUPPORTING

# **Module 8**: Collaborative goal setting, promoting hope for change, and eliciting feedback (ENACT #11, #12, #14)

* 1. Objective 1: Describe what it means to set goals collaboratively, promoting hope, and eliciting feedback
  2. Objective 2: Identify behaviours for setting goals, promoting hope, and eliciting feedback with someone you are helping in your context
  3. Objective 3: Distinguish between helpful and unhelpful behaviours when setting goals collaboratively, promoting hope, and elicit feedback with someone you are helping



This module is divided into three sessions and covers two important skills – Session 1: collaborative goal setting; Session 2: building hope for change; and Session 3: eliciting feedback.

## Session 1: Collaborative goal setting

**This module covers the following:**

* What does it mean to set goals collaboratively?
* How do we set goals collaboratively during support and treatment?
* Why is goal setting important for health and well-being?

**Structure of module:**

* Introducing the concept (5 minutes)
* Exercise 1: Quick quiz and sharing questions and answers (5 minutes)
* Exercise 2: Facilitators demonstrate “helpful” goal setting (15 minutes)
* Review concept and learning points (5 minutes)

**Materials** (optional): Facilitators can use the table of “Unhelpful and helpful behaviours for goal setting” at the end of the module as a handout for trainees.

**Instructions:** One facilitator introduces the concept, and then both facilitators deliver the activities following this introduction. The facilitators take notes on the brainstorming activities and add them to the table of unhelpful and helpful behaviours on goal setting at the end of the module.

**The facilitator tells trainees:** “For the following activities, we will be brainstorming some different ideas. I will add the behaviours you identify to our list of skills for setting goals.”

## Introducing the concept

**Timing:** 5 minutes

***Note: Below is a sample text to cover the concepts and points above. Facilitators may adapt the language to the context as necessary, but must ensure that the points are adequately covered.***

###### What is goal setting?

* Setting goals helps us to stay motivated. When we set goals, we have an action plan with manageable steps to help us reach the specific aim or outcome we are hoping for. Setting goals helps us to feel in control and to manage our expectations as to what we can achieve.
* Although goal setting may be a long-term process and may require continual check-ins, we can also learn to set goals that are more short-term in nature and can be used to help someone immediately.

Some examples of immediate short-term goals might be:

* “My goal is to see a counsellor next week so that I can discuss my problems.”
* “I would like to ask a friend to study with me this weekend so I can do well in my test.”
* “My goal is to visit my primary care doctor tomorrow to learn how to help with my knee pain.”

**Timing:** 5 minutes

**What does it mean to set goals collaboratively?**

* People might or might not have a desired goal or outcome clearly figured out, but typically they have a reason for asking for support or help.
* It is important for helpers to ask about the person’s goals or needs in order to understand what motivates them and to discuss expectations. The helper and the person should discuss what is and what is not achievable in terms of short- or long-term goals. For example, the helper should be specific about how sharing a problem might help to relieve symptoms or manage immediate problems (*achievable*). They should also tell the person that they cannot directly make things better, such as by giving them money or a job in exchange for joining a programme (*not achievable*).
* The helper and person should establish short- and long-term goals that are realistic, achievable and meaningful to the person.
* If the person is perhaps going to spend more time with you (e.g. by participating in a psychological intervention, counselling or regular visits to a health clinic), you should work together to create a care plan with goals that align with what can be accomplished in the long term.

## Exercise 1: Quick quiz and sharing questions and answers

**Timing:** 5 minutes

**Quick quiz instructions:** This quick quiz is intended to get trainees thinking about what they have just learned. Spend 3 minutes on a brief review, then move on to the next activity.

The facilitator presents the quiz question to the trainees, and the trainees respond together by e.g. raising their hands, voting or another method.

**Quiz question:** [[7]](#footnote-7)

1. Imagine that you are a helper, and somebody asks you: “I need advice on this problem. How do I fix it?” Which of the following is a helpful way to respond?
   1. Say: “You made many mistakes trying to solve this problem, so now you must do exactly what I’m going to tell you.”
   2. Say: “No, I cannot give you advice. You must be completely independent and solve this on your own.”
   3. Say: “Please tell me more about your problem so that we can work together to find a solution. Does that sound good?”
   4. Say: “Your problem cannot be solved. Let’s focus on something else.”

Discuss the answers and share the correct answer with the group.

## Exercise 2: Facilitators demonstrate “helpful” goal setting

**Timing:** 15 minutes

**Instructions:** This activity has two parts:

1. In the demonstration, the facilitators demonstrate “helpful” goal setting.
2. The group then discusses what the facilitators demonstrated (and ideas suggested by the trainees), adding helpful behaviours for goal setting to the table at the end of the module. *Be sure to explain this process to your trainees.*

***1: Demonstration, outline of concepts and sample prompts [3–5 minutes]***

*Facilitators may refer to the sample recordings provided with these materials and adapt them to the context and setting.*

* Demonstrating the role-play should take 2–5 minutes. Facilitators use the description and prompts below.
  + Facilitator 1 plays the helper (begins role-play).
  + Facilitator 2 plays the person.
    - Facilitator 1 (helper): “Carl, now that you know you are at risk of diabetes and know some of the prevention strategies, which of them would you like to try?”
    - Facilitator 2 (person): “Yes, I want to lose weight to help prevent diabetes.”
    - Helper: “That is a great option. I’m glad you are willing to try this. How much weight would you like to lose?”
    - Person: “Well, I’ve tried losing weight before, and it can be very difficult. But I would love to lose at least 7 kilos by next month!”
    - Helper: “I see, and I like your timeline of one month. Losing 7 kilos sounds exciting, but what do you think of aiming for 3 kilos? If we make it to 3 kilos this month, then we can work our way up. What do you think of that idea?”
    - Person: “Hmm. Okay, that does sound a bit more manageable. Will I need to run every day?”
    - Helper: “Well, there are a few ways we can reach your goal. For example, you could try exercising more, eating less or eating differently. We could combine one or two of these options. What do you prefer?”
    - Person: “Well, I love to eat! I would like to try to exercise more – I want to go out for more walks. And maybe I could try to eat a little differently – but I don’t want to be eating only vegetables!”
    - Helper: “I understand – I enjoy eating too! Okay, so we will plan for you to try walking more each week, and we can discuss options for your diet. We will aim to have you lose 3 kilos by 30 days from now. Let’s meet again in two weeks to track your progress. Does that plan work for you?”

***2: Group discussion***

* Discuss with the group what behaviours they saw. Some prompts are suggested below:
  + “What sort of questions did the helper ask?”
  + “Did the helper and the person work together to set goals? How?”
* Facilitator 2 (the person) can also describe how they felt with Facilitator 1 (the helper).
* List (on a flipchart, sticky notes, blackboard/whiteboard, etc.) the different behaviours that the group identifies (this can continue on from the previous activity).
* Briefly summarise the behaviours shown in the demonstration, including any that were brainstormed by the trainees. Add them to the table of helpful and unhelpful behaviours for goal setting at the end of the module.

## Review concept and learning points

**Timing:** 5 minutes

**Materials:** Flipchart,sticky notes, blackboard/whiteboard or PowerPoint (PPT) presentation.

**Instructions:**

1. Why is goal setting important for health and well-being?
2. Review helpful and unhelpful behaviours.

|  |  |
| --- | --- |
| **Unhelpful and helpful behaviours for goal setting** | |
| **Unhelpful or potentially harmful behaviours** | **Helpful behaviours** |
| * Telling the person that goals (expectations) cannot be met but not giving a reason * Giving incorrect, misleading or unrealistic information about treatment goals * [Add other ideas brainstormed by the trainees here] | * Asking the person about goals (expectations) * Clearly explaining how the person’s goals and expectations fit with the treatment plan * [Add other ideas brainstormed by the trainees here] |

## Session 2: Building hope for change

This module covers the following:

* What does it mean to build hope for change?
* How do we promote hope when working or interacting with others?
* Why is promoting hope important for health and well-being?

Module structure:

* Introducing the concept (5 minutes)
* Exercise 1: Facilitators demonstrate promotion of hope (10 minutes)
* Group exercise 2: Addressing feelings of hopelessness (15 minutes)
* When hopelessness can be a warning sign (5 minutes)
* Exercise 2: Sentence starters (5 minutes)
* Review of concept and learning points (5 minutes)

**Materials** (optional): Facilitators can use the table “Unhelpful and helpful promotion of hope” at the end of the module as a handout for trainees.

**Instructions:** One facilitator introduces the concept (please adapt the text as needed), and then both facilitators deliver the activities following this introduction. Facilitators take notes on the brainstorming activities and add ideas to the table of unhelpful and helpful behaviours at the end of the module.

* The facilitator tells trainees, “In the following activities, you will be brainstorming some different ideas. I will add the behaviours you identify to our list of skills in promoting hope.”

## Introducing the concept

## **Timing:** 5 minutes

***Note: Below is a sample text to cover the concepts and points above. Facilitators may adapt the language to the context as necessary, but must ensure that the points are adequately covered.***

“Walk on, with hope in your heart, and you’ll never walk alone.” – Gerry and the Pacemakers[[8]](#footnote-8)

###### What does it mean to build hope?

When a helper builds hope, they are working with the person to create realistic expectations of change and to feel positive about their future. A helper can encourage the person to make positive statements about their hopes for change and praise them for asking for help and seeking care. When a person is receiving care or is being offered support, helpers should link their hopes for change to important aspects of their life. For example: “If you continue to eat well and walk every day, your health and strength will improve, and you can continue to play with your grandchildren.”

**What is a realistic hope for change?**

As a helper, you have the important role of promoting hope for a change that will help to alleviate the person’s distress. This may be hope that they can change their perspective or more instrumental change such as changing their circumstances or resources. It is important that hope is specific to something that can be achieved in the context of the helping relationship and related resources. “Blind hope” or “unrealistic hope” can be more destructive than helpful. If we make general comments like, “I know that everything is going to get better”, we can lose the trust of the people we are helping. Therefore, we want to promote hope that is focused and specific to what can realistically be accomplished, and we want to praise behaviours that are working to put that hope into action.

**How is being hopeful different from being optimistic?**

Optimism and hopefulness both look towards a positive future. However, being optimistic is being confident that things will work out as expected. Being hopeful means considering that life doesn’t always work out how we might expect it to, but that we can be hopeful for some change if we actively work towards it. When we promote hope, we need to remind the person that it is good to expect some positive changes, but that this might not make life’s problems disappear. It is important to discuss goals with the person and explain how each goal might or might not be reached, discussing and managing expectations for positive change.

**Hope is strengthened when we work together**

It is not always easy to have hope, especially when we feel alone with our problems or struggles. This is why it is critical for helpers to actively promote hope and work with the person to build hope together. Whenever possible, helpers should recognize when a person is feeling hopeless and try to encourage them to keep going. Helpers can encourage the person to reflect on a new skill or piece of knowledge that they have acquired without making them feel guilty or in the wrong for any mistakes they might have made (e.g. “Yes, these issues you’re dealing with can be very hard and change doesn’t always come right away. What if we reviewed the positive things you have done so far to see what you have learned?”).

**Suggested:**Provide a mnemonic or other learning summary technique.

* 1. Example of a mnemonic (acronym) for building hope: **HOPE:** **H**elper uses p**O**sitive statements, **P**raises and **E**ncourages change.

## Exercise 1: Facilitators demonstrate promotion of hope

**Timing:** 10 minutes

**Instructions:** This activity has three parts:

1. The facilitators demonstrate how to explain the purpose of promoting hope and linking it to an established goal.
2. The facilitators then demonstrate an example of helping a person to identify things they can use to build their own hope for change.
3. Finally, the facilitators lead a discussion on what they have demonstrated (and other ideas suggested by the trainees), listing helpful behaviours for promoting hope. *Be sure to explain this process to your trainees.*

***1: Demonstration, outline of concepts and sample prompts***

Thinking back to what we learned about goal setting,in this role-play the facilitator playing the helper explains the meaning of building hope for change. Then they connect the goal that was established (walking more each week to lose 3 kilos in 30 days) to hope that change is possible.

1. Demonstrating the role-play should take 3–5 minutes. The facilitators use the description and prompts below.
   * Facilitator 1 plays the helper (begins role-play).
   * Facilitator 2 plays the person.
     + Facilitator 1 (helper): “We have just discussed that one of your goals – the goal we will focus on together – is to walk more each week to lose 2 kilos in 30 days. For every goal we set, there are things that give us hope that the goal can be achieved, and there are things that might reduce that hope. So now I would like to work with you on an exercise to build hope for your goal. How does that sound?”
     + Facilitator 2 (person): “Okay, that sounds good.”
     + Helper: “Great! So, let me first give an example of this building and reduction of hope. Think of when we build a fire for cooking. We want to make sure that we have enough things that will contribute to the success of a good fire, such as enough wood, enough kindling and enough air flow. But we also have other things that might reduce the success of our fire, such as rain or wind. So, we need to be sure that we have enough wood and kindling to keep adding to the fire, especially when the rain tries to put it out. Does that make sense?”
     + Person: “Yes. Oh, I have had trouble with rain putting out fires plenty of times.”
     + Helper: “Heh yes, haven’t we all. So, preparing for this fire is true for any other problem – we need to think about the things that give us hope and the things that diminish our hope. We want to build reasons for hope that you will meet your goal of losing 2 kilos in 30 days, and also think of things that might reduce that hope for change.”

**The facilitators pause and summarise briefly what happened in this role-play.**

For example: “In this role-play, the helper explained the importance of building hope. The helper made sure to recognize that there are some things that help us to build hope for change, and other things that can bring our hopes down. The helper also related this back to the established goal that we learned about in the previous module on goal setting. Now, we will do another role-play as an example of helping a person to find things that can build hope for change.”

***2: Demonstration, outline of concepts and sample prompts [10 minutes]***

The facilitators introduce the story:

“Let’s take the example of Juan. Juan was very upset because his father had fallen ill. Juan needed to take care of his family’s finances, check in on his father and still manage long hours at his job. Juan met with a helper because he was so worried – he couldn’t meet these expectations, and he was having difficulty sleeping. Juan’s goal is to get a better night’s sleep. Now, we will demonstrate how Juan and his helper work on ways to build hope towards his goal of getting a good night’s sleep so that he can feel more confident about tackling all of these challenges.”

* Demonstrating the role-play should take 3–5 minutes. The facilitators use the description and prompts below.
  + Facilitator 1 plays the helper (begins role-play).
  + Facilitator 2 plays the person.
    - Facilitator 1 (helper): “Juan, we decided together that your achievable goal was to get a better night’s sleep. We also talked a bit about how building hope for this change could help you to meet this goal. What are some things that give you hope that you can get a better night’s sleep?”
    - Juan: “Yes, I remember the hope. Well, sometimes I think back to before my father was sick, and I was sleeping pretty well almost every night. What gives me hope is knowing that when I can manage my time well and am thinking about how grateful I am for my family, then I feel calm and can sleep better at night.”
    - Helper: “Those are all really great reasons. Thank you for sharing. What type of things do you think might take away your hope? There are no right or wrong answers.”
    - Juan: “Hmm. Yes. Well, the nights that are the most difficult for me to sleep are when I am worrying about the health of my father. I also start to worry about my time through the day. Sometimes after caring for my father, I feel too exhausted to eat or spend time with my family for an evening meal. Then I didn't sleep well that night.”
    - Helper: “I wonder, when you were thinking of things that take away hope, did anything new come up that could also give you hope? Sometimes, when I think about negative things, some positive ideas come up that I hadn’t thought of before.”
    - Juan: “Hmm. Yes, well, actually when I spoke about being too exhausted and not being able to share dinner with my family, I realised that when I eat well and share dinner with my family, I feel hopeful for change.”
    - Helper: “That was a thorough list that you came up with; it will help us to work together. I can think of something that gives me hope – it is that you came to meet me today, seeking help for this problem. That shows that you are reaching out for support. Asking for help from others is a good sign of a desire to improve the situation. What do you think about that?”
    - Juan: “Yeah, I didn’t realise that. I guess you’re right. It wasn’t easy for me to come, but I would like to change.”
    - Helper: “Now that we know some things that give you hope, we can find ways to promote those. We know what represents the wood, the kindling and the air flow for you. Now let’s brainstorm how we can make sure that we have enough of these things for strong hope. What would help you to work on those things that build hope for you? For example, would it be more confidence in your abilities to manage all of these challenges, or scheduling time for your family dinner?”
    - Juan: “I think scheduling time for my family dinner would bring warmth and strength.”
    - Helper: “And what can we do about times when your hope might get pushed down, times when you’re feeling less hopeful? What can we do to keep the rain and the wind away from our fire?”
    - Juan: “I think that coming to talk with you will be helpful, even if not all of the time. And I think that maybe if I write down the reasons for my hope, I can look at these before I go to bed at night.”

***3: Group discussion***

* Discuss with the group what they saw.
  + “What words and statements from the helper stood out to you?”
  + “How do you think these types of words and statements promote hope for change?”
  + “What other foundational helping skills did the helper use? For example, did they use verbal communication, empathy, non-verbal communication? How?”
  + “How did the helper explain building hope?”
  + “How did the helper support Juan in building his own hope? Do you think that you could help someone to build hope after seeing this role-play?”
  + “Was it useful for the helper to also talk with Juan about things that might reduce hope? Why or why not?”
* Facilitator 2 (the person or Juan) can also describe how they felt with Facilitator 1 (the helper).
* List (on a flipchart, sticky notes, blackboard/whiteboard, etc.) the different behaviours that the group identifies (this can continue on from the previous activity).
* Briefly summarise the behaviours shown in the demonstration, including behaviours brainstormed by the trainees.

## Group exercise 2: Addressing feelings of hopelessness

**Timing:** 15 minutes

**Instructions:** Even when we work really hard, we can sometimes find ourselves feeling hopeless. Feelings of hopelessness can make it more difficult to find hope for change. In this exercise, the facilitators will:

1. Brainstorm with the group what hopelessness can feel and sound like (e.g. what words and phrases might be used);
2. Then review some ways to help someone find hope when they are feeling hopeless.

**1: What does hopelessness feel and sound like?**

* Brainstorm comments about hopelessness. For example, a person might say:
  + “Nothing works.”
  + “I’ve tried everything, and nothing has changed.”
  + “This is pointless, I don’t know why I try.”
  + “There is no reason for trying, no one cares anyway.”
  + “What is the point?”
  + “I am tired and I can’t keep doing this.”

**2: How to work with hopelessness?**

The facilitator explains: “We should never make someone feel guilty or bad for feeling hopeless. Feeling hopeless is something that can happen to anyone. But when someone is feeling hopeless, finding reasons for hope, even the smallest ones, can help us to keep trying to meet our goals. The following are some examples of how you might help someone to find some hope.”

* Recognize the words and phrases that tell us when the person is withdrawing or wants to give up. Then encourage them to keep trying, without making them feel guilty or wrong for wanting to give up.
  + For example, you could say: “Change doesn’t come easily or quickly, even when you’re trying hard.”
* When someone shows that they are feeling discouraged, reflect with them on the work they have done so far.
  + For example, you might ask if they have learned anything helpful so far or liked one thing that they have tried. This can even mean finding something positive from the negative: for example, maybe the person has learned that they can get through really tough times with two feet on the ground.

**3: When hopelessness can be a warning sign**

The facilitator explains: “Sometimes, hopelessness can be so strong that it might be harmful to the person or it might create a risk to their safety. For example, sometimes a person can feel so hopeless that they have thoughts of not living anymore. If this happens, we want to make sure that we don’t make them feel bad or guilty for having these feelings, and to make sure that they are safe. We review ways of understanding when hopelessness can be dangerous in the module on Assessing Suicidal Behaviours.”

## Exercise 2: Sentence starters

**Timing:** 5 minutes

**Instructions:** This exercise has three stages.In this exercise, the trainees summarise what they have learned using “sentence starters”, where they fill in the blanks in the sentences below and share learnings.

**1:** Ask the trainees to fill in the blanks in the two sentences below. Give them 2 minutes to complete the sentences on their own.

* “One thing I learned today about promoting hope is [*fill in blank*].”
  + For example: “One thing I learned today about promoting hope is that a helper can promote hope by encouraging a person to make positive statements about their hopes for change.”
  + “One thing I learned today about promoting hope is that hope for change is stronger when we work together to build hope, rather than by ourselves.”
* “I will use promoting hope in my work when [*fill in the blank*].”
  + For example: “I will use promoting hope in my work when the person I am working with feels discouraged.”
  + “I will use promoting hope in my work *[as a bus driver]* when a passenger feels discouraged about the long commute due to the traffic and rain.”

**2:** After 2 minutes, split the trainees into groups (3–5 people per group) and ask them to share their responses to the sentence starters [5 minutes].

**3:** Ask one person from each group to briefly present the responses, including the most common ones, and one or two ways to promote hope at work [5 minutes].

1. For example: “Most people said that they learned [*blank*] about promoting hope. Some of us said that we would use promoting hope in our work when [*blank*].”

## Review of concept and learning points

**Timing:** 5 minutes

**Materials:** Flipchart, sticky notes, blackboard/whiteboard or PowerPoint (PPT) presentation.

**Instructions:**

* Review why promoting hope is important for health and well-being. Brainstorm using the examples suggested below:
  + - When helpers work with a person to build hope, they can encourage them to take care of themselves and others.
    - When teachers work to build hope, they can increase students’ self-esteem and improve their academic performance.
    - When nurses work to build hope, patients will be more engaged with their treatment and more open to advice and support.
    - When social workers work to build hope with a person using a service, this person is more likely to feel empowered and to follow a care plan.
* Review the unhelpful and helpful behaviours listed in the table below. Be sure to add those brainstormed with the group during the module.

|  |  |
| --- | --- |
| **Unhelpful and helpful promotion of hope** | |
| **Unhelpful or potentially harmful behaviours** | **Helpful behaviours** |
| * Giving a person unrealistic expectations (e.g. “Everything will be cured”) * Making negative statements about a person’s doubts (e.g. “How do you expect to get better if you have no hope?”) * [Add other behaviours brainstormed by the trainees here] | * Explaining how the person can be hopeful about the possibility of change * Praising the person for asking for help or seeking care * [Add other behaviours brainstormed by the trainees here] |

## Session 3: Eliciting feedback

**This module covers the following**:

* Why is eliciting feedback important?
* What does it mean to elicit feedback?

Module structure:

* Introducing the concept (5 mins)

**Materials (**Optional) Facilitators may use the “Unhelpful and helpful” table of behaviours at the end of each module as a handout for trainees.

**Instructions:** One facilitator introduces the concept and then both facilitators deliver activities following this introduction. Facilitators take notes on the brainstorming activities and add suggestions to the table of helpful and unhelpful eliciting feedback at the end of this module.

* The facilitator tells trainees: “In the following activities, you will be brainstorming some different ideas. I will add the behaviours you identify to our list of eliciting feedback.”

## Introducing the concept

**Timing:** 5 minutes

***Note: Below is a sample text to cover the concepts and points above. Facilitators may adapt the language to the context as necessary, but must ensure that the points are adequately covered.***

**What does it mean to elicit feedback?**

When we elicit feedback, we are continuously checking in with the person to share their experiences and perspectives on suggestions we provide, their progress with treatment and their overall expectations. We should always try to ask for a person’s feedback when we provide advice, suggestions and recommendations.

Sometimes a person might ask directly for advice or suggestions. When this happens, you may offer a few suggestions related to their problem or question, and then immediately ask for their feedback on those suggestions. For example, after providing advice, you might ask, “Was that advice helpful? Is there something you might try differently?”

When we elicit feedback, it also allows us to clarify our responses and better understand the interaction. This is also a great time to use your skills in verbal communication and reflection of feelings.

**Quiz and discussion**

1. “Which of the following are helpful behaviours when eliciting feedback?”[[9]](#footnote-9)
   1. Explaining to a person that because you have training and experience, you always know what is best for them.
   2. Using questions like, “How does that sound?” or “What do you think about that?” during or after a conversation or interaction.
   3. Clarifying and summarising what you heard in a conversation or interaction, e.g. “What I heard you say is…is that right?”
   4. Both ‘B’ and ‘C’.

* “Give examples of how the helper could use the eliciting feedback skill to improve the conversation? How could this be helpful?”
* List (on a flipchart, sticky notes, blackboard/whiteboard, etc.) the discussion points agreed upon and answers to the short quiz.
* Briefly summarise the behaviours demonstrated by the facilitators, along with any that were brainstormed by the trainees.
  + For example: lecturing without eliciting feedback, etc.

Outline helpful and unhelpful behaviours in the table below. Be sure to add suggestions brainstormed with the group during the module.

|  |  |
| --- | --- |
| **Unhelpful and helpful elicitation of feedback** | |
| **Unhelpful or potentially harmful behaviours** | **Helpful behaviours** |
| * Lecturing person about what to do without asking for their feedback * [Add other ideas brainstormed by the trainees here] | * Asking for feedback from the person to see if any offered suggestions are helpful * Providing clarifications, reframing or alternative suggestions based on feedback * [Add other ideas brainstormed by the trainees here] |

**Brief Role Play for Module 8** – Collaborative goal setting, promoting hope for change, and giving psychoeducation

* Module 8 Role Play
* ENACT Scoring Template: Collaborative goal setting
* ENACT Scoring Template: Promoting hope for change
* ENACT Scoring Template: Elicit feedback

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**Overview:** Trainees will work again in pairs, this time to show facilitators their “helpful” skills assessing risk of harm and promoting safety. During the role plays, facilitators observe (e.g., walk around the room, join ‘break out’ rooms) and rate trainees on the ENACT item #11, 12, and 15.

**Materials needed:** Timer (clock, watch, other) and bell and/or other alarm for timekeeping. The two facilitators will need to use the ENACT rating tool for Items #11, #12, and #15 to rate each trainee. This can be done on the EQUIP digital platform (which can be used to view score summaries and review of helpful and unhelpful behaviours at the group level) or on paper copies of ENACT. (See the scoring form for competencies #11, 12, and 15 reproduced below.)

**Instructions**:

1. The facilitators explain to the group how this practice exercise strengthens their learning and gives facilitators feedback on their strengths.

**For example**: **“**Now we will practise helpful behaviours. To bring together our learning from this session, in this role play, you will practise your skills to set goals, promote hope, and elicit feedback. While you all are practising, we (the facilitators) will be walking around to see your skills in action. We will be taking some notes to give you all feedback on how to improve how you set collaborative goals, promote realistic hope, and elicit feedback.”

1. Divide into **groups of 2**. The two roles are:
   * One person will play the helper
   * One person will play the person in distress
2. Ask each member of the group to take turns, with one playing the helper, and the other the person in distress; then they switch. Make sure that each person gets a chance to practise being a helper.
3. Tell the group that each role play should be about 5 minutes.
4. Share the specific instructions with the group. These role-play instructions can be provided on a PowerPoint slide, written on a white board, or given as paper handouts to trainees:

This role play takes place after the helper and person being helped have already met, done introductions, and explained confidentiality. The helper and person being helped already know each other’s names and what they preferred to be called. The group members can use their own names for the purposes of the role play.

Instructions to **helper**: Start the role play by asking the person seeking help about what they would like to accomplish through the care and support provided by the helper. Possible ways to ask this could be: “*What is your goal for how I can help you?”* or “*What do you hope will get better in your life?”* or “*What change do I hope to see in your life?”* or “*What is your goal for how I can help you?”*

Instructions to the **person being helped**: When asked about goals, first provide a goal such as “*get a job*”, or say something such as “*Will meeting with you make all of my problems better? Will meeting with you help me get a job?*” Then, if aided by a helper, provide a more psychosocial goal, e.g., “*I would like to worry less so I can come up with a plan for looking for work…*” In addition, if the helper provides the goal for the person being helped, then reply that “*I don’t think that I can do what you are saying,”* or “*I don’t think I can do that.”*

1. The facilitators walk around the room to observe the pairs as they practise. While observing, facilitators rate ENACT item #11, #12, and #15 trainees act as the helpers. Observe each trainee for about 3-4 minutes to identify what helpful and unhelpful behaviours are displayed for involvement of family members. The full role play does not need to be observed.

Key behaviours to record on the ENACT form are:

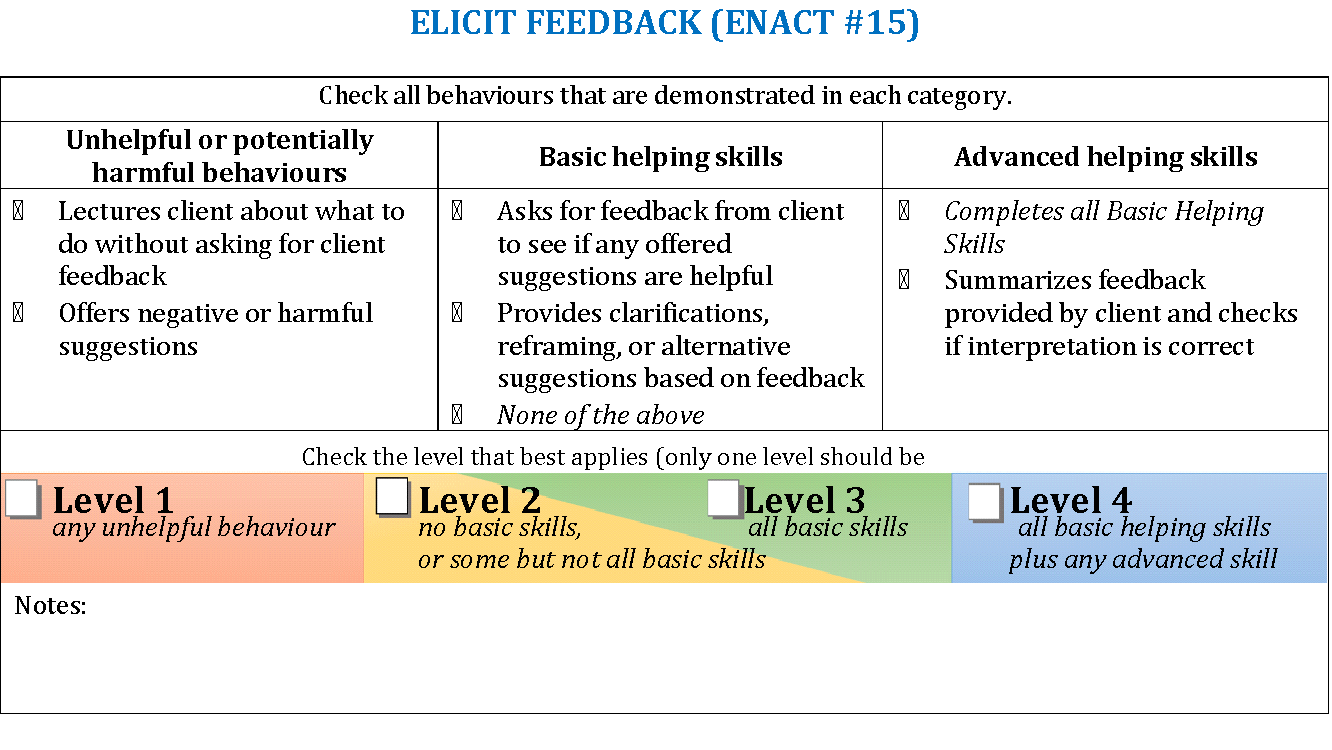
* Does the helper encourage the person to come up with her own goal?
* Does the helper praise the client for seeking help and for trying to come up with a goal?
* Does the helper assist the person in reframing the goal to what can be accomplished through psychosocial support (for example, reframing get a job, to reduce worry and hopelessness that prevents you from applying for a job?
* Does the helper ask about things that may help or be a barrier to accomplishing the goal?
* When the helper provides suggestions, does the helper ask the person whether the suggestions fit in with her life, e.g., are the suggestions and advice

Behaviours that may be harmful should also be recorded on the ENACT form:

* Does the helper come up with a treatment goal without the person’s input or suggestions?
* Does the helper give false hope, (e.g., if you talk to me regularly, I am sure you will get a job)?
* Does the helper lecture the person about what to do without checking if the suggestions are desired for feasible

1. After all trainees have been observed and rated by one of the facilitators, the facilitators should thank the trainees for doing the role plays. General feedback on some of the helpful behaviours observed can be shared. Facilitators can conduct a full review of the competency ratings in the evening after the second day’s training is completed, then more specific feedback provided on the morning of day 3.





# **Final Role Play for foundational helping skills**

**Final role play for foundational helping skills training** – This role play is intended to be completed in approximately 10 minutes and includes prompts for the actor/client to elicit all 15 competencies covered in the FHS training.

Sections

* Part 1. Overview of comprehensive FHS role play
* Part 2. Instructions for facilitators on conducting the final FHS 10-minute role play
* Part 3. How a facilitator should act as the client instructions for actor/client: vignette and prompts
* Part 4. Enhancing Assessment of Common Therapeutic factors (ENACT) with actor prompts

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## Part 1. Overview of the final foundational helping skills 10-minute role play

At completion of the training, all trainees will be assessed again in a comprehensive role play that covers all 15 foundational helping competencies. Each trainee will be given **10 minutes** for this role play. The role play should be ended at 10 minutes. The role play can be ended earlier if all of the competencies are addressed. For these role plays, the facilitators should act as the actor/clients to be sure that the appropriate prompts are used to elicit all 15 competencies within the 10 minutes.

**Time needed: 2 ½ hours -** This activity will require approximately 20 minutes per trainee. This includes 10 minutes for the role play, a few minutes to score the ENACT after each role play, and then approximately 5 minutes for personalized feedback. Trainees should be divided up among the 2 facilitators. With 12 trainees and 2 facilitators, each facilitator would work with 6 trainees at 20 minutes each. Then in total, this session would require **2 hours** at the end of the training. In addition, there can be a **30-minute** group feedback and reflection session after individual role plays.

**Materials needed:** Timer (clock, watch, other) and bell and/or other alarm for timekeeping. The two facilitators will need to use the ENACT rating tool for Items #1 through #15 to rate each trainee. This can be done on the EQUIP digital platform (which can be used to view score summaries and review of helpful and unhelpful behaviours at the group level) or on paper copies of ENACT. (See the scoring form for competencies #1 through 15 reproduced below.) A space to conduct the role plays where individual trainees will not be disturbed by other trainees is ideal. This could be a separate room or a space away from the other trainees.

## Part 2. Instructions for facilitators on conducting the final 10-minute role play

1. The facilitators explain to the group how this final role play exercise will be used to provide each person with individualized feedback so that they can best use foundational helping skills in their professional roles.

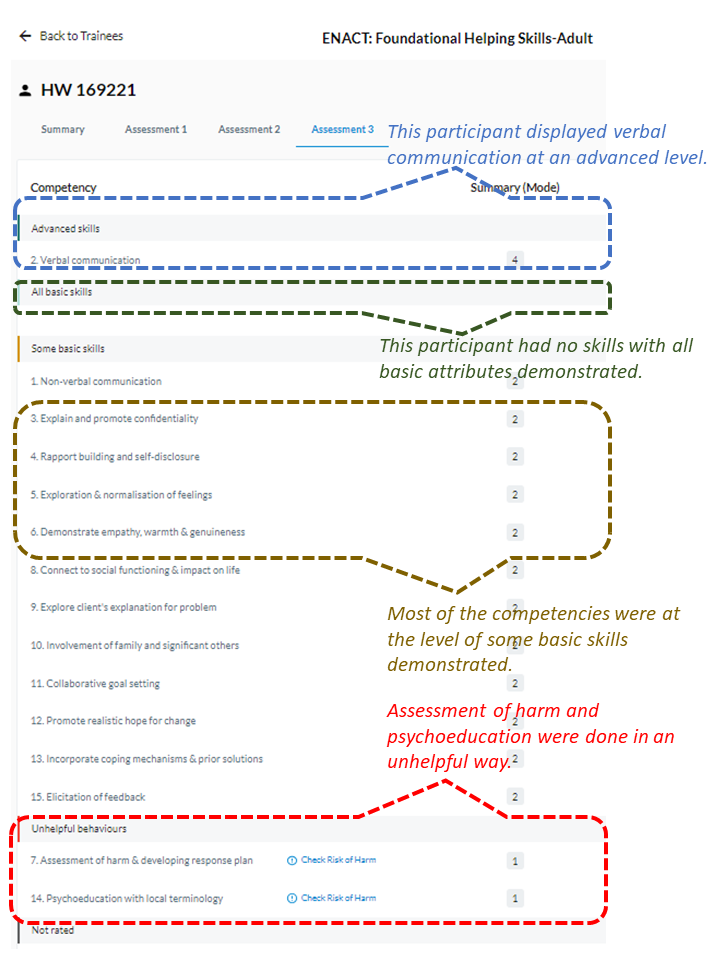
**For example**: **“**Now we are going to conduct the final role play of this foundational helping skills training. This will be a longer role play. We will stop each role play after about 10 minutes. In this role play, we will see how you use the different skills that we have worked on in this training. The purpose is to give you feedback so to support you in using these skills in your ongoing professional activities. For this role play, we the facilitators will act as the clients with whom you would typically interact in your work. We will give you the basic context of the encounter with the client, then you can use the skills as we have practiced in this training. After the role plays, the facilitator will take a few minutes to make some notes about the role play, then we will give you personalized feedback.”

1. Then give the group the context for the role play. The context should be adapted to represent what the trainees typically encounter. For example, if the trainees are obstetricians or midwives, the scenario can be a pregnant woman coming into their clinic describing some distress. If the trainees are teachers of adult education classes, then the clients could be a new adult student who tells the teacher after class about some difficulties they are encountering. Here is an example that can be adapted:

Assume that the helper and the person being helped have not had formal introductions previously. The helper and person being helped do not know each other’s names, and the person being helped has not previously described their problem to the helper.

For the **trainees**: Start the role play by introducing yourself and asking the person to introduce themselves, then ask them if there is something they would like to share or anything that has been bothering them.

1. The facilitators should then divide up the trainees. If there are 2 facilitators and 12 trainees in the group, then facilitator 1 can do the 10-minute role plays with 6 trainees, and facilitator 2 can do the 10-minute role plays with the other 6 trainees. The role plays should be done in a space away from the other trainees, so it is just the facilitator (acting as the client) and one trainee together at a time.
2. Start a timer, then the facilitator performs the role play with one trainee. The facilitator should use the **Story** included below as a base for the role play. The story should be adapted to fit the context of the types of trainees (e.g., community health workers, nurses, obstetricians, case managers, teachers, religious leaders, etc.). The facilitator should use the **prompts** to elicit different responses from the trainees. Do not rate on the ENACT tool during the role play; instead, try to maintain the role of the client throughout the ten minutes. If the trainee ends the role play early, then it can be stopped. Otherwise, end the role play after the 10-minute timer goes off.
3. Immediately after each role play, the facilitator should spend a few minutes completing the ENACT rating scale, scoring all 15 competencies. If using the digital ENACT, then submit the results after rating all 15 competencies.
4. Then take about 5 minutes to give personalized feedback to the trainees. Begin by discussing some of the competencies that they displayed well (at either the Level 3 or Level 4 criteria). Then discuss potentially harmful behaviours (Level 1). Be as specific as possible. This can be done by referring to the specific potentially harmful behaviours displayed that are reported in the platform summary feedback. Ask for the trainee to reflect on the potentially harmful behaviours and how they could be improved. Then conclude by giving positive feedback on overall progress and improvement throughout the training. The figures below are screenshots from the EQUIP platform that organize the competencies into the different Levels achieved by the trainee in the final role play.



**Figure A.** Screenshot of individual competency levels after comprehensive assessment of   
15 competencies in 10-minute role play.



**Figure B.** Screenshot of specific behaviours demonstrated that can be used to give   
specific feedback on strengths and areas for improvement.

1. After finishing with one individual trainee, then invite the next trainee. Remind them of the instructions and conduct the 10-minute role play, then score them, and give personalized feedback.
2. After all trainees have undergone the individual role plays, the facilitators can then give some general feedback to the whole group about areas of strength and improvement during the training, as well as areas where there should be continued improvement and practice. It is ideal to give trainees an opportunity also to reflect on what they have learned and where they have seen improvement as this leads to them remembering the positive areas of development. It is helpful to budget an additional 30 minutes for this group feedback after the approximately 2 hours of individual role plays.

## Part 3. How a facilitator should act as the client

**Part 3.1. Story background for the client**: Facilitators should rehearse prior to the comprehensive 10-minute assessment role plays. The facilitator should have enough time to practice the character, the prompts, and make changes as needed to fit the context. Each story is a description of the pretend client’s background, including name, age, gender, location, brief description of current situation and current or past concerns.

**Part 3.2. Actor prompts:** This is unique to each role play narrative. It is in a table format. The client-actor should use the prompts with the helper during the role play. These prompts will cue the helper on what skill we’re looking for. Each prompt is linked to a corresponding competency. *Note:* As each helper is unique, not everything is scripted for the client-actor. The client-actor should feel comfortable to carry along with the helper, while ensuring the actor-led prompts are used at some point in the role play.

**Part 3.1. Story background**

***Note****: Please do not read this to the helper. They are only for the actor and give information on the background and needs of the pretend person using services, to help the actor feel comfortable and confident in their role as a pretend person using services*.

You are a 34-year-old person. You have a family of 4. This includes you, your partner (wife or husband), and two sons. You now have been trying to make money in service jobs but are struggling to get enough hours per week. Your partner (wife/husband) stays home with your younger sons (ages 6 and 12), and you are responsible for all of the finances. You have been struggling to make the transition from living in a rural area and now to more urban, and the lack of hours at your new job leaves you very stressed and worried about how you and your family will manage. You are finding it very difficult to stay motivated and are feeling more tired and sluggish every day. Lately, your entire body will feel painful, and you struggle to get out of bed in the morning to make it to your shifts. You have not told my wife/husband that your hours are getting cut. You are having difficulty deciding if you should tell her/him. You feel guilty and ashamed that you cannot provide properly for your family and you feel like you’re failing them. You are feeling so alone, and it is like you cannot do anything about it. You are not sleeping well and feel very tired all of the time. You have trouble concentrating and sometimes feel like the world is closing in on you. It feels as though your life is falling to pieces and you are afraid that you and your family will end up homeless. Or what if your family leaves you? You haven’t been able to spend time with your sons. You notice lately that your children are crying and complaining more when you are home. Your oldest son, Michael, has been acting out, hitting his mother/father when he is angry, breaking or throwing things, and disobeying you and your wife/husband. You are worried that Michael is getting in trouble at school and outside with his friends, like getting into physical fights and staying out late. You used to enjoy going for morning walks and seeing friends on the weekend for games. But, with all of your problems, it is hard to find energy for walks and you feel like your friends don’t want you around anyway.

**Part 3.2. Actor prompts:**

The actor prompts are used to elicit responses from the helper:

1. When first asked by the helper why you have come to see them, **say that** *“I was told by the community health worker in my community that I could come see you for help.”*
2. If the helper then asks you what your problem is, **say that** “*I am tired and very nervous lately, I am having headaches and problems sleeping.”*
3. After, based on the helper’s questioning, respond using descriptions from the background above, and the specific actor prompts listed below. Make sure to pay attention to your actor-led prompts and allow the helper to guide you for the Helper-led prompts.
4. The background of your character is included below, followed by the actor prompt checklist with key concerns and responses for your meeting.

| **COMPETENCY** | **ACTOR PROMPTS** |
| --- | --- |
| Opening  **ENACT** #4 | 1.When first asked by the helper why you have come to see her/him, you should say that **“I was told by the community health worker that I could come see you for help.”** |
| 2.Do not provide your name or personal information unless asked to do so by the helper |
| Exploring feelings  **ENACT** #5 | 3.When the helper asks you what your problem is, you should say, “I am tired and very nervous lately. I’m having headaches and problems sleeping.” |
| 4. Do not share about feelings or emotions unless the helper asks, for example, the helper might say, *“How are you feeling; please tell me about anything that has been bothering or worrying you lately; I notice that you seemed sad when you came in, please tell me if something has been upsetting you.”* |
| Body language and empathy  **ENACT** #1 and #6 | 5.**Hold head when speaking about trouble** with work, not finding new work, not being able to discuss these problems with your family, and worrying about your son |
| 6.**Avoid eye contact most of the time**, especially when you talk about feeling like a failure |
| 7.**Speak in a low tone of voice**, speak quietly |
| Verbal communication  **ENACT** #2 | 8.When the helper uses closed-ended questions “Do you, did you, can you…?” Respond with short yes/no responses |
| 9.When the helper uses open-ended questions “Please tell me about, please share with me, how did that… etc.?” Respond with more detailed answers |
| Confidentiality  **ENACT** #3 | 10. After describing psychosocial problems or other concerns ask the helper, *“Are you going to tell anyone these things that I tell you?”* or *“I am afraid you will tell other people the things I am telling you?”* |
| Self-harm  **ENACT** #7 | 11. Tell the helper, **“It feels like the world is falling to pieces. Some nights I go to bed, and I don’t want to wake up in the morning.”** |
| 12. If asked if you want to die or kill yourself, say, *“No, I’m very religious, that is a sin. I want to stay alive and care for my family.”* |
| 13. If asks about prior attempts, say, *“No, I have never tried to kill myself.”* |
| Daily activities  **ENACT** #8 | 14. When the helper asks about problems or difficulties in your life, say, *“I feel like a failure and useless”* |
| 15. When the helper asks about daily activities, say, “I have no energy, and I know that my friends wouldn’t want to see me this way. ” |
| Coping  **ENACT** #13 | 16. Provide examples of positive coping “I used to like walks in the morning, and sometimes I would see friends on the weekend for games.” |
| 17. Provide examples of negative coping, “I yell at my son” or “  I argue with my wife/husband” |
| Social support  **ENACT** #9 | 18. If asked about perceived cause of problems, provide different types of answers to see how helper responds. For example, *“I don’t know if I have these problems because I am so worried about not making enough money. Or maybe I am just cursed.”* |
| 19. If asked about family’s perception, provide a different perceived cause, e.g., *“I talk with my brother sometimes, and he thinks I am being lazy and not working hard enough to care for my family.”* |
| Close-person involvement  **ENACT** #10 | 20. If asked about close persons in your life, describe wife/husband and son with whom you live. But, if asked about whom you would like involved in care, describe someone else, e.g., an aunt, uncle, neighbor, that you call regularly |
| Goal setting  **ENACT** #11 | 21. If asked about goals, first provide a goal such as “Find a full-time job.” |
| 22. Then if aided by helper, provide a more psychosocial goal, e.g., *“I would like to worry less and feel confident in finding more work. ”* |
| Promote  realistic hope  **ENACT** #12 | 23. During the role play, ask the helper questions such as, **“Will meeting with you make all of my problems better?”** or **“Will meeting with you get me a full-time job?”** |
| Psychoeducation  **ENACT** #14 | 24. If the helper uses technical terms, ask, “what does that mean” to see if the helper can describe it in lay language. |
| Eliciting feedback  **ENACT** #15 | 25. If the helper asks for feedback about suggestions, reply, “some are helpful, but some seem too hard for my situation,” then ask if there are other options or activities. |

## Part 4. Enhancing Assessment of Common Therapeutic factors (ENACT) with actor prompts

1. Non-verbal communication & active listening

Actor instructions: *At appropriate times during the interview use culturally appropriate body language for feelings of sadness or worry.*

|  |  |  |
| --- | --- | --- |
| Check all behaviours that are demonstrated in each category. | | |
| **Unhelpful or potentially harmful behaviours** | **Basic helping skills** | **Advanced helping skills** |
| * Engages in other activities (e.g., answers mobile, completes paperwork) * Laughs at client * Uses inappropriate facial expressions * Inappropriate physical contact | * Allows for silences * Maintains appropriate eye contact * Maintains open posture (body turned toward client) * Continuously uses supportive body language (head nod) and utterances (uh huh) * *None of the above* | * *Completes all Basic Helping Skills* * Varies body language during the session in relation to client’s content and expressions |
| Notes:  **Level 1 Level 2 Level 3 Level 4**  Check the level that best applies (only one level should be checked)  *any unhelpful behaviour no basic skills, all basic skills all basic helping skills*  *or some but not all basic skills plus any advanced skill* | | |

1. Verbal communication skills

Actor instructions: *When helper uses closed-ended questions “Do you, did you, can you…?”, respond with short yes/no responses. When helper uses open-ended questions “Please tell me about, please share with me, how did that… etc.?”, respond with more detailed answers.*

|  |  |  |
| --- | --- | --- |
| Check all behaviours that are demonstrated in each category. | | |
| **Unhelpful or potentially harmful behaviours** | **Basic helping skills** | **Advanced helping skills** |
| * Interrupts client * Asks many suggestive or leading closed-ended questions (e.g., You didn’t really want to do that, right?) * Corrects client (what you really mean...) Or uses accusatory statements (you shouldn’t have said that to your husband) * Uses culturally and age-inappropriate language and terms | * Open ended questions * Summarizing or paraphrasing statements * Allows client to complete statements before responding * None of the above | * Completes all Basic Helping Skills * Encourages client to continue explaining (tell me more about...) * Uses clarifying statements in first person (I heard you say, I understood...) * Matches rhythm to clients, allowing longer or shorter pauses based on client |
| Notes:  Check the level that best applies (only one level should be checked)  **Level 1 Level 2 Level 3 Level 4**  *any unhelpful behaviour no basic skills, all basic skills all basic helping skills*  *or some but not all basic skills plus any advanced skill* | | |

1. Explanation & promotion of confidentiality

Actor instructions: *During the role play, ask the helper “Are you going to tell anyone these things that I tell you?” Or “I am afraid you will tell other people the things I am telling you?”*

|  |  |  |
| --- | --- | --- |
| Check all behaviours that are demonstrated in each category. | | |
| **Unhelpful or potentially harmful behaviours** | **Basic helping skills** | **Advanced helping skills** |
| * Forces client to disclose to helper or others * Describes confidentiality inaccurately (e.g., I will only tell your family) * Promises all things will be kept confidential without exceptions * Minimizes client’s concerns about confidentiality (e.g., it doesn’t matter if anyone else hears us) | * Explains concept of confidentiality * Lists exceptions for breaking confidentiality for self-harm or harm to others * Explains why it can be important to break confidentiality * *None of the above* | * *Completes all Basic Helping Skills* * Details the referral process related to confidentiality and exceptions * Asks questions to assess client’s understanding of confidentiality * Topics of discussion are appropriate to confidentiality of setting |
| Notes:  Check the level that best applies (only one level should be checked)  **Level 1 Level 2 Level 3 Level 4**  *any unhelpful behaviour no basic skills, all basic skills all basic helping skills*  *or some but not all basic skills plus any advanced skill* | | |

1. Rapport building & self-disclosure

Actor instructions: *Do not provide your name or personal information unless asked to do so by the helper.*

|  |  |  |
| --- | --- | --- |
| Check all behaviours that are demonstrated in each category. | | |
| **Unhelpful or potentially harmful behaviours** | **Basic helping skills** | **Advanced helping skills** |
| * Dominates session describing a personal experience * Minimizes client's problems by describing how the helper has dealt with this * Asking unnecessary embarrassing personal questions * Discusses confidential information of other clients | * Introduces self and explains role * Makes casual, informal conversation * Asks for client's introduction, e.g., what client prefers to be called * Shares general experience to relate to the client (e.g., about one's community/region) * *None of the above* | * *Completes all Basic Helping Skills* * Asks for client’s reflection related to helper’s information that is shared * Checks with client that they are comfortable (e.g., offer seat, preferred language) |
| Notes:  Check the level that best applies (only one level should be checked)  **Level 1 Level 2 Level 3 Level 4**  *any unhelpful behaviour no basic skills, all basic skills all basic helping skills*  *or some but not all basic skills plus any advanced skill* | | |

1. Exploration & normalisation of feelings

Actor instructions: *Do not share about feelings or emotions unless the helper asks, for example, “How are you feeling; please tell me about anything that has been bothering or worrying you lately; I notice that you seemed sad when you came in, please tell me if something has been upsetting you.”*

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| Check all behaviours that are demonstrated in each category. | | |
| **Unhelpful or potentially harmful behaviours** | **Basic helping skills** | **Advanced helping skills** |
| * Makes statements that client's response is unusual or atypical for others in similar situations (e.g., people don’t usually react this way) * Minimizes or dismisses client's feelings or emotions * Forces client to describe emotions | * Appropriately encourages client to share feelings * Explain that others may share similar symptoms, reactions, and concerns, given similar experiences * Asks client to reflect on the experience of sharing emotions * *None of the above* | * *Completes all Basic Helping Skills* * Explores potential reasons for hesitance to share emotions * Comments thoughtfully on client’s facial expression to encourage emotional expression * Validates emotional responses while also reframing potential harmful emotional reactions |
| Notes:  Check the level that best applies (only one level should be checked)  **Level 1 Level 2 Level 3 Level 4**  *any unhelpful behaviour no basic skills, all basic skills all basic helping skills*  *or some but not all basic skills plus any advanced skill* | | |

1. Demonstration of empathy, warmth & genuineness

Actor instructions: *At appropriate times during the interview use culturally appropriate body language for feelings of sadness or worry, and when asked describe sadness to see how helper responds.*

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| Check all behaviours that are demonstrated in each category. | | |
| **Unhelpful or potentially harmful behaviours** | **Basic helping skills** | **Advanced helping skills** |
| * Critical of client's concerns * Dismissive of client's concerns * Helper's emotional response appears inappropriate, fake or acting | * Is warm, friendly, and genuine throughout session * Continuously shows concern or care for the client (e.g., That sounds sad, can you tell me more about it?) * Asks question to identify what emotions the client was feeling (e.g., I wonder if you felt sad or angry when this happened) * *None of the above* | * *Completes all Basic Helping Skills* * Asks client to reflect on empathic statements from helper (e.g., What did you think when I said you sounded sad?) |
| Notes:  Check the level that best applies (only one level should be checked)  **Level 1 Level 2 Level 3 Level 4**  *any unhelpful behaviour no basic skills, all basic skills all basic helping skills*  *or some but not all basic skills plus any advanced skill* | | |

1. Assessment of harm & developing collaborative response plan

Actor instructions: *During the role play, express that “Sometimes when I go to sleep, I wish I wouldn’t wake up in the morning.” If asked if you would ever hurt or kill yourself, explain “Sometimes I think about dying, but I wouldn’t hurt myself on purpose.” If asked about reasons for leaving describe, “I want to stay alive to care for my family. If I died, who would take care of them.” If asked about any prior attempts, reply, “No, I have never tried to kill myself.”*

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| Check all behaviours that are demonstrated in each category. | | |
| **Unhelpful or potentially harmful behaviours** | **Basic helping skills** | **Advanced helping skills** |
| * Does not ask about self-harm * Lectures client with religious or legal reasons against self-harm (e.g., this is sin, or this is against the law) * Expresses disbelief (e.g., accuses client of discussing self-harm to get attention; states that others would not actually harm the client or client’s children) * Encourages client not to tell anyone else about self-harm or harm to others | * Asks about self-harm or harm to others, or explores harm if raised by client * Asks about current intent, means, or prior attempts * Asks about risk and/or protective factors * *None of the above* | * *Completes all Basic Helping Skills* * If current risk is high or low, helps client to develop safety plan (e.g., coping strategies and help seeking) |
| Notes:  Check the level that best applies (only one level should be checked)  **Level 1 Level 2 Level 3 Level 4**  *any unhelpful behaviour no basic skills, all basic skills all basic helping skills*  *or some but not all basic skills plus any advanced skill* | | |

1. Connection to social functioning & impact on life

Actor instructions: *If helper asks about daily activities, share that your worries or sadness sometimes make it hard to do typical activities, like take care of oneself, take care of one’s children, spouse, or other family members.*

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| Check all behaviours that are demonstrated in each category. | | |
| **Unhelpful or potentially harmful behaviours** | **Basic helping skills** | **Advanced helping skills** |
| * Criticizes client for letting symptoms impact functioning (e.g., you are weak, you have no willpower) * Tells client there is no connection between mental health concerns and daily functioning or does not ask about how mental health is affecting daily functioning * Criticizes client for impact of their problems on children, spouse, or family members * Makes client feel guilty for impact on children, family, and others | * Asks about daily functioning * Discusses the connection (the relationship) between daily functioning and mental health * *None of the above* | * *Completes all Basic Helping Skills* * Clarifies and/or support client’s connections between functioning and mental health or reframes as needed * Explores relationship in both directions (daily life to symptoms; symptoms to daily life) * Asks about history of daily functioning compared to current social context (e.g., COVID19; how long has this been going on?) |
| Notes:  Check the level that best applies (only one level should be checked)  **Level 1 Level 2 Level 3 Level 4**  *any unhelpful behaviour no basic skills, all basic skills all basic helping skills*  *or some but not all basic skills plus any advanced skill* | | |

1. Exploration of client’s and social support network’s explanation for the problem

Actor instructions*: If asked about perceived cause of problems, provide different types of answers to see how helper responds. For example, “I don’t know if I have these problems because I lost my job and worry all the time now. Or maybe, I am just cursed.” If asked about family’s perception, provide a different perceived cause, e.g., “My family thinks I have these problems because I am weak and lazy.”*

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| Check all behaviours that are demonstrated in each category. | | |
| **Unhelpful or potentially harmful behaviours** | **Basic helping skills** | **Advanced helping skills** |
| * Criticizes client's view of problem as ignorant, superstitious, etc. * Endorses harmful beliefs of client or social network | * Asks about client's view on cause of problem * Asks about family’s or social support network’s view on cause of problem (e.g., What does your family say caused this?) * *None of the above* | * *Completes all Basic Helping Skills* * Incorporates client's perspective of cause in care planning in non-harmful manner * Discusses alternative to harmful explanations (e.g., You said this was because you failed your family, I wonder if there is another way to think about this situation?) * Addresses differences in client's view of cause and others' view of cause |
| Notes:  Check the level that best applies (only one level should be checked)  **Level 1 Level 2 Level 3 Level 4**  *any unhelpful behaviour no basic skills, all basic skills all basic helping skills*  *or some but not all basic skills plus any advanced skill* | | |

1. Appropriate involvement of family members & other close persons

Actor instructions: *If asked about close persons in your life, describe immediate family members. But, if asked about who you would like involved in care, describe someone else, e.g., an aunt, uncle, neighbour*

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| Check all behaviours that are demonstrated in each category. | | |
| **Unhelpful or potentially harmful behaviours** | **Basic helping skills** | **Advanced helping skills** |
| * Tells client not to involve family or close person in any way during treatment or recovery * Forces client to involve family or close person in treatment process * Demands to speak with family or close person without permission from client * Allows an accompanying close person to disempower the client | * Asks about close person(s) in client’s life (e.g., household members, family, or other) * Asks client how they would like to involve close person(s) in the care process * Asks client who they live with * *None of the above* | * *Completes all Basic Helping Skills* * Explores client’s choices or reasons for involving or not involving close, familiar person * Does role-play or discusses options for successful interaction with close person (e.g., helper plays role of family member) |
| Notes:  Check the level that best applies (only one level should be checked)  **Level 1 Level 2 Level 3 Level 4**  *any unhelpful behaviour no basic skills, all basic skills all basic helping skills*  *or some but not all basic skills plus any advanced skill* | | |

1. Collaborative goal setting & addressing client’s expectations

Actor instructions: *If asked about goals, first provide a goal such as “get a job”, but then if aided by helper, provide a more psychosocial goal, e.g., “I would like to worry less so I can come up with a plan for looking for work…”*

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| Check all behaviours that are demonstrated in each category. | | |
| **Unhelpful or potentially harmful behaviours** | **Basic helping skills** | **Advanced helping skills** |
| * Tells client that their goals (expectations) can’t be met but does not give a reason. * Gives incorrect, misleading, or unrealistic information about treatment goals. * Dictates goal for client (forces goal upon client) | * Asks client about goals (expectations) * Clearly explains how client's goals and expectations fit with treatment plan. * *None of the above* | * *Completes all Basic Helping Skills* * Prioritizing and modification of treatment plan to fit client goals (expectations) * Works with client to reframe their goals within scope of the treatment plan (e.g., Your goal is to get a job, could we work together on a goal that will help you do that?) |
| Notes:  Check the level that best applies (only one level should be checked)  **Level 1 Level 2 Level 3 Level 4**  *any unhelpful behaviour no basic skills, all basic skills all basic helping skills*  *or some but not all basic skills plus any advanced skill* | | |

1. Promotion of realistic hope for change

Actor instructions: *During the role play, ask the helper questions such as “Will meeting with you make all of my problems better? Will meeting with you help me get a job?” Also, mention something that gives you hope (e.g., I did it before, so I can do it again) and something that takes away hope (e.g., Nothing that I am trying works)*

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| Check all behaviours that are demonstrated in each category. | | |
| **Unhelpful or potentially harmful behaviours** | **Basic helping skills** | **Advanced helping skills** |
| * Makes negative statements about client's doubts (how do you expect to get better if you have no hope…) * Gives unrealistic expectations (everything will be cured or solved…) * Provides no hope for change (this problem cannot be solved...) | * Explains how client can be hopeful about possibility of change * Praises client for seeking care * *None of the above* | * *Completes all Basic Helping Skills* * Solicits and explores client's doubts about the treatment * Helper shares reasons for hope based on helper’s prior experience or client’s behaviours * Discusses reasons for hope when client is doubtful or dissatisfied |
| Notes:  Check the level that best applies (only one level should be checked)  **Level 1 Level 2 Level 3 Level 4**  *any unhelpful behaviour no basic skills, all basic skills all basic helping skills*  *or some but not all basic skills plus any advanced skill* | | |

1. Incorporation of coping mechanisms & prior solutions

Actor instructions: *During the role play, provide examples of positive coping (e.g., working in the garden) and negative coping (yelling at others to go away, using alcohol).*

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| Check all behaviours that are demonstrated in each category. | | |
| **Unhelpful or potentially harmful behaviours** | **Basic helping skills** | **Advanced helping skills** |
| * Makes negative statements about client's coping mechanisms (that would never work...) * Encourages or shows acceptance of harmful coping mechanisms | * Asks client about current or past coping mechanisms (how they keep going after the problem started…) * Praises client for positive or safe current or prior solutions * *None of the above* | * *Completes all Basic Helping Skills* * Encourages use of continued positive coping mechanisms * Reflection on prior unhealthy strategies and brainstorm positive alternatives |
| Notes:  Check the level that best applies (only one level should be checked)  **Level 1 Level 2 Level 3 Level 4**  *any unhelpful behaviour no basic skills, all basic skills all basic helping skills*  *or some but not all basic skills plus any advanced skill* | | |

1. Psychoeducation & use of local terminology

Actor instructions: *If the helper uses technical terms, ask “what does that mean” to see if the helper can describe it in lay language.*

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| Check all behaviours that are demonstrated in each category. | | |
| **Unhelpful or potentially harmful behaviours** | **Basic helping skills** | **Advanced helping skills** |
| * Uses technical terms without checking client’s understanding * Uses stigmatizing mental health terms | * Conducts accurate psychoeducation using simple terms * Includes local concepts and terminology into psychoeducation * *None of the above* | * *Completes all Basic Helping Skills* * Incorporates client's description of the problem * Checks that client understands psychoeducation |
| Notes:  Check the level that best applies (only one level should be checked)  **Level 1 Level 2 Level 3 Level 4**  *any unhelpful behaviour no basic skills, all basic skills all basic helping skills*  *or some but not all basic skills plus any advanced skill* | | |

## Elicitation of feedback when providing advice & suggestions

Author instructions: *If the helper asks for feedback about suggestions, reply that some of the advice is helpful but some of it would be hard in your situation, then ask if there are other options or activities.*

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| Check all behaviours that are demonstrated in each category. | | |
| **Unhelpful or potentially harmful behaviours** | **Basic helping skills** | **Advanced helping skills** |
| * Lectures client about what to do without asking for client feedback * Offers negative or harmful suggestions | * Asks for feedback from client to see if any offered suggestions are helpful * Provides clarifications, reframing, or alternative suggestions based on feedback * *None of the above* | * *Completes all Basic Helping Skills* * Summarizes feedback provided by client and checks if interpretation is correct |
| Notes:  Check the level that best applies (only one level should be checked)  **Level 1 Level 2 Level 3 Level 4**  *any unhelpful behaviour no basic skills, all basic skills all basic helping skills*  *or some but not all basic skills plus any advanced skill* | | |

1. Quotes can be replaced with locally appropriate sayings and idioms. [↑](#footnote-ref-1)
2. Smith M, Segal J and Robinson L. Suicide Prevention. 2019. <https://www.helpguide.org/articles/suicide-prevention/suicide-prevention.htm> [↑](#footnote-ref-2)
3. Chowdhary N, Dabholkar H, Velleman R, Dimidjian S, Fairburn C and Patel V. Premium Counselling Relationship Manual. 2013. In Sangath (eds). [https://www.sangath.in/wp-content/uploads/2015/08/Counselling Relationship\_Manual.pdf](https://www.sangath.in/wp-content/uploads/2015/08/Counselling%20Relationship_Manual.pdf) [↑](#footnote-ref-3)
4. WHO. Preventing Suicide: A global imperative. 2014. <https://apps.who.int/iris/bitstream/handle/10665/131056/9789241564779_eng.pdf?sequence=1> [↑](#footnote-ref-4)
5. ANSWER KEY: 1-d; 2-d; 3-d. [↑](#footnote-ref-5)
6. ANSWER KEY: 1-d. [↑](#footnote-ref-6)
7. ANSWER KEY: 1-c. [↑](#footnote-ref-7)
8. Quotes can be replaced with locally appropriate sayings and idioms. [↑](#footnote-ref-8)
9. ANSWER KEY: 1-d. [↑](#footnote-ref-9)